AN EXPLORATORY STUDY OF RECOVERY AND RECOVERY MAINTENANCE FOR VICTIMS OF CHILDHOOD SEXUAL ABUSE WHO COMPLETED FAITH-BASED RESIDENTIAL TREATMENT PROGRAMS

by

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Liberty University

A Dissertation Presented in Partial Fulfillment Of the Requirements for the Degree Doctor of Philosophy

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ABSTRACT

AN EXPLORATORY STUDY OF RECOVERY AND RECOVERY MAINTENANCE FOR VICTIMS OF CHILDHOOD SEXUAL ABUSE WHO COMPLETED FAITH-BASED RESIDENTIAL TREATMENT PROGRAMS

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This interpretive phenomenological analysis of the experience of recovery and recovery maintenance for women with a history of childhood sexual abuse and its sequelae included interviews and a non-standard questionnaire. Ten women with this history who had completed a faith based treatment program for substance abuse and/or eating disorders described recovery. Themes that emerged related to the process of change included: Changes in Relationships with Others, to Self, to God, and lastly, Forgiveness as a Catalyst for Change. Six practices emerged in the exploration of maintenance recovery. This research highlighted the need for thorough bio-psycho-social-spiritual assessment and areas of concern for treatment, and illuminated an alternative path to recovery that involved a spiritually integrated treatment approach.
DEDICATION

This project is dedicated to my family: my husband, Gerald, and children Amanda and Austin, son-in-law Marius, and grandchildren Will and Anna Florence. For all the hours I spent with my face glued to a computer screen, please forgive me!

This project is also dedicated to the memory of my mother, Florence Lydia Knisely Glass, who lost her long battle with cancer on October 24, 2012.
ACKNOWLEDGEMENTS

I would like to thank and acknowledge my long-suffering and patient family who has been with me on this long academic journey for the last decade. Their love, care, and assistance made this attempt possible.

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I am also grateful to my church and community, who have allowed me to participate in many ventures and gave me support in a variety of ways.
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CHAPTER ONE: INTRODUCTION

Childhood sexual abuse (CSA) is a very negative event, and may leave emotional, physical, or spiritual scars that can last a lifetime. It occurs in both female and male children, and unfortunately occurs much too often. In the United States, prevalence rates are estimated to be as high as 36% (Draucker & Martsolf, 2006). About twenty years ago, some groundbreaking research began with this population (Finkelhor, 1991). Both professional counselors and pastoral counselors have become more aware of the nature of the problem and its frequent occurrence. Treatment models that are effective are still needed (Taylor & Harvey, 2010). CSA is a very individualized experience, and adults who seek treatment have spent at least a few years coping with these memories in their own unique way (Draucker & Martsolf, 2006).

This chapter describes issues related to CSA. It begins with the background of the problem, the purpose of the study, the research questions, the assumptions and definitions used by the researcher, and the theoretical and conceptual framework of the research. It concludes with the section describing the interest and location of the researcher.

Background of the Problem

One of the most devastating experiences a person can endure is to be sexually violated in childhood. When a child endures repeated episodes of abuse, the term complex trauma is used as a descriptor (Briere & Spinazzola, 2005). This experience can lead to a range of difficulties because it may affect so many aspects of the person. Research on childhood sexual abuse (CSA) has shown a negative impact on attachment
style (Cook, Hoffman, Powell, & Marvin, 2005; Fonagy & Bateman, 2007), affect regulation (Walker, Holman, & Busby, 2009), overall mental health (Chunis, 2009; Fergusson, Boden & Horwood, 2008; Lundqvist, Hansson, & Svedin, 2004; Sachsen-Ericsson, Medley, Kendall-Tackett, & Taylor, 2011; Zink, Klesges, Stevens, & Decker, 2009), the biological system (Sachsen-Ericsson, Blazer, Plant, & Arnow, 2005; Wilson, 2010), neurological and neurocognitive processes (Minzenberg, Poole, & Vinogradov, 2008; Pierrehumbert et al., 2009; Shenk, Noll, Putnam, & Trickett, 2010), dissociative propensity (Briere & Runtz, 1989; Thomas, 2005; Murthi, Servaty-Seib, & Elliott, 2010) and self-concept (Cook et al., 2005). CSA has been linked to early sexual contact and prostitution (Wilson & Widom, 2008), sexual dysfunctions (Blake, 2007; Cobia, Sobansky, & Ingram, 2004; Rellini & Meston, 2011; Testa, VanZile-Tamsen, & Livingtons, 2005), relationship dysfunctions (Rumstein-McKean & Hunsley, 2001; Walker, Sheffield, Larson, & Holman, 2011); and revictimization (Barnes, Noll, Putnam, & Trickett, 2009; Ericksen, 2010). CSA has also been correlated with spiritual disruptions (Gall, Basque, Damasceno-Scott, & Vardy, 2007; Houg, 2008; Ryssel, 2010). A history of CSA has been correlated with substance use disorders, particularly alcohol (Boles, Joshi, Grella, & Wellisch, 2005; Briere & Scott, 2006; Draucker & Marsoff, 2006; Khoury, Tang, Bradley, Cubells, & Ressler, 2010; Sartor, Agrawal, McCutcheon, Duncan, & Lynskey, 2008; Seifert, Polusny, Murdoch, & Maureen, 2011). Gilbert et al. (2009) conducted a meta-review of the literature in high income countries, and connected all forms of child maltreatment to negative consequences in adulthood, including suicide attempts based upon retrospective and prospective studies.
Unfortunately, CSA is very common. The Fourth National Incidence Study of Child Abuse and Neglect is based on data reported by 50 states (Sedlak, Mettenburg, Basena, Petta, McPherson, Greene, & Li, 2010). According to this report, 135,300 children were sexually abused in the years 2005-2006. These statistics do not reflect the unreported cases which may never make it into the light of the judicial system; this report suggested that about one third of all cases are actually reported. Other estimates regarding the rates of sexual abuse are based on sampling and extrapolated to the general population, and range from 3% to 36% (Draucker & Martsolf, 2006).

Outcome research on treatments for this population is in its infancy. Martsolf and Draucker (2005) conducted a meta-analysis of research studies in the literature that included participants with a history of CSA, as did Taylor and Harvey in 2010. However, there was no research study on residential, faith-based treatment programs included in either meta-analysis. These analyses did not mention alcohol or substance use as a comorbid disorder. Each research study targeted only one mental health issue.

Purpose of the Study

The purpose of this study was to add to the exploration of the nature of recovery from the sequelae related to a history of CSA, including substance abuse/use. The quantitative studies mentioned in the previous section did not address treatment programs that integrated spirituality with professional counseling. There are no studies that explore the phenomenon of recovery from the sequelae of CSA that include conservative Christianity. And as an auxiliary purpose, there is also a need for phenomenological exploration of recovery from substance abuse and mental health issues. According to the
Institute of Research, Education and Training in Addictions (IRETA, 2009) there is a need to explore the elements of sustained recovery, through phenomenological research that explores the changes themselves and the mechanisms of change. This is directly related to the substance abuse issue. The goal of defining and measuring recovery and resiliency was also adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA) for 2011. SAMHSA is also advocating for exploration of paths to recovery in both mental health issues and substance abuse. Specifically mentioned are those that combine religion and spirituality, professional treatment models, and those with a variety of alternative approaches.

Research Questions

Because recovery is an anomalous term, the intention of this study was to explore the experience of recovery. This will be done by interviewing women with a history of CSA who have completed a residential treatment center designed for women and having them complete a non-standard questionnaire. The research questions were:

1. What is the experience of recovery from the sequelae of CSA, including alcohol or substance abuse, in a faith based residential treatment center?

2. What changes do participants recognize as part of healing or recovery?

3. How are graduates of this program functioning post treatment?
Assumptions and Definitions

An assumption made by the researcher is that her understanding of conservative evangelical Christianity will parallel that of the participants when they speak about how their spirituality or faith affects recovery. A definition of this and other key terms follows.

Religion and spirituality and/or faith. Religion has been defined in recent years as a search for the sacred within institutions, while spirituality is more of an independent venture and based on experiences rather than dogma. Many people understand these two definitions as overlapping (Worthington & Sandage, 2001). In this study, both will refer to Christianity, as rooted in a conservative, biblical, Protestant tradition. Faith will refer to belief in a Trinitarian view of God.

Child abuse. The Federal Child Abuse Prevention and Treatment Act (CAPTA), (42 U.S.C.A. §5106g), as amended by the Keeping Children and Families Safe Act of 2003, defines child abuse and neglect as:

Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or
An act or failure to act which presents an imminent risk of serious harm (p. 44).

Sexual abuse of children. This is defined as:

The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children (CAPTA, 2003, p. 44).
**Complex trauma.** This is defined as:

Complex psychological trauma as resulting from exposure to severe stressors that are (1) repetitive or prolonged (2) involve harm or abandonment by caregivers or other ostensibly responsible adults and (3) occur at developmentally vulnerable times in the victim’s life, such as early childhood or adolescence (when critical periods of brain development are rapidly occurring or being consolidated. (Ford & Courtois, 2009, p. 13)

**Theoretical/Conceptual Framework**

This research was an interpretive phenomenological analysis. By exploring the process of recovery and recovery maintenance through the recollections of participants, the researcher hoped to learn more about changes these women experienced and possibly some information on how they occurred. The possibility of the reduction of trauma symptoms, depression, anxiety, and any possible improvements in attachment styles, whether with God or with other adults have important implications for treatment. Recovery from substance abuse and how these women explained their continued abstinence is also of value for treatment planning. Recovery maintenance includes not only abstinence from alcohol or substance use, but overall healthy living which may or may not differ from the participants’ self-described patterns before entering treatment.

**Locating Myself as a Researcher**

I set out to find myself, but got lost! Since I constantly get lost in a more “grounded” sense, I am not too terribly surprised when I consider this in retrospect. I am an Excel oriented, financial calculator, accounting type of person at heart. Numbers are nice; they do not get arrested, commit suicide, hoard things, or get diseases, and they are pretty passive entities. And money is nice! Despite my love for things financial, I ended
up doing phenomenological research in an aspect of counseling and its integration with religion, as expressed in conservative Christianity. I am not sure I could explain clearly how I ended up in this position; even to myself!

I was engaged in a career in which I was well-paid but not challenged. Life happened and I re-started down an academic path, uncertain of my direction. I enjoyed the pursuit of knowledge for its own sake; just as I enjoyed the pursuit of God. I seem to recall complaining a little bit during this diversion from an undergraduate degree in accounting to a master of divinity. But during my study in seminary, I got an inkling of the importance of hermeneutics. According to Fry (2009): “Hermeneutics is the art and principles of interpretation.” Proper interpretation of Scripture is vital, especially if you hold those words to be sacred. The way one interprets the Bible is based on more than just the definition of individual words; context is critical. Context refers to individual word placement, sentence structure, paragraphs, sections, chapters, books, and the other literature and/or records from the same time period (McQuilkin, 1992). You have to know a bit about who was doing the writing and what was happening when he was writing.

I chose counseling as my area of concentration in seminary because it involved the application of theology, which seemed very practical. Context in literature parallels context in life. People are situated in particular contexts. Family systems theory became my favorite counseling approach because it accounted for the circles of influence in a person’s life (Bowen, 1992). Counseling is interpretation. It is a beautiful process in the abstract; helping people as they work at discovering how they are embedded in life, and
helping them unfold, uncover, and reveal where they are and where or how they want to “be.”

I seemed to have a little trouble with the application of all this knowledge I was chasing, and became engulfed in reading existentialism, the integration of spirituality and health, philosophy of mind, trauma and posttraumatic stress disorder (PTSD), attachment theory, and developmental psychopathology. I also wanted some sort of anthropology of man that I could really agree with! When it was time to complete my doctorate in counseling, I was thinking about some sort of medical-psychological-spiritual experiment, but life intervened … again.

During internships, I was back with the real world and struck by the long lasting effects of childhood sexual abuse on the patients, and by how many of them had this history in their lives. During that same semester, I ran into a woman with a t-shirt that had a ministry mission theme. I asked her about it, and learned it was one I was familiar with; a residential treatment program for women who were in need of a new start in life. Because it was based in Christianity, it seemed to fit with my educational pursuits; both seminary and in professional counseling. I wondered if I had found the object of my research.

Because I was very interested in attachment theory, and God attachment theory, I wondered if these women were able to make changes in how they related to people and how they would describe their relationship with God. I wondered about the abatement of trauma symptoms, because I had studied a bit about trauma and Post Traumatic Stress Disorder. I wondered if they would be able to sustain their abstinence from alcohol or drugs, and whether they felt free from it or were still working hard on the process of
recovery in that realm. I wondered what it was like to live in a house full of strange women for a year. I wondered how they would describe their process of recovery. And I realized I had indeed found my research project.

Phenomenological analysis was the most logical choice of an approach to this research because I would be trying to understand someone else’s experiences. Because CSA is very physical and relational, I wanted a research method that reflected that sense of context. Interpretive phenomenological analysis (IPA) has been used in qualitative studies in nursing (Pringle, Dummond, McLafferty, & Hendry, 2011). It is also compatible with the notion of extended cognition (Larkin, Eatough, & Osborn, 2011), which I find intriguing. IPA appealed to me as the perfect method to explore recovery from a physical event that can cause crippling not only of the body, but also to the mind, spirit, and relationships (Chandler, 2010). I have seen its results in family members, in counseling clients, and in friends. And I am currently seeing the longer term results on the children and spouses of its victims. It touches too many of us.

Organization of Remaining Chapters

This study sought to explore the phenomenon of recovery for women with a history of childhood sexual abuse (CSA) and resultant negative long term consequences. Using a phenomenological research method requires openness on the part of the researcher. The following chapter describes the research on adults who continue to have long term negative outcomes based on a history of CSA, as well as the theoretical constructs most influential to the researcher. It also describes quantitative and qualitative studies that link long term outcomes to CSA, as well as studies that review treatment
protocols. Chapter Three describes interpretive phenomenological analysis as a research method, and includes the procedures for data collection, ethical concerns, and other research protocol. Chapter Four outlines the results of the research endeavor. Chapter Five addresses the implications of the findings and possible further research indicated by the study.

Summary

This chapter introduced the nature of the study and the background of the problem being investigated. It also examined how the researcher was oriented towards the research methodology, as well as her interest in the question at hand.
CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction

There has been a great deal of interest in the phenomenon of childhood sexual abuse (CSA) and its relationship to mental and physical health as well as behavioral propensities and relationship qualities, not only in childhood, but also in adult survivors. CSA has been correlated with many negative long-term outcomes. This chapter contains a brief summary of the research related to negative sequelae correlated with a history of CSA. Outcomes that are especially pertinent to this study have subheadings.

Following this section, the theoretical framework for this research project is given. Because this researcher is interested in the possibility of change in attachment styles, with people, and with God, the interview questions target this area. Trauma symptoms in general have been connected to a history of CSA, along with depression, anxiety, and alcohol and/or substance use. Of interest for this study, is how such changes may have occurred and how or if participants are able to maintain positive changes after leaving the treatment program. The literature review gives an overview of CSA and trauma symptoms, which include anxiety and depression, CSA and Attachment Theory, CSA and God Attachment, and CSA and substance use and/or abuse.

Effective treatment programs targeting this population, which may be 30% of the adult females in the United States, are needed (Martsolf & Draucker, 2005; Taylor & Harvey, 2010). Males also suffer sexual abuse, making this population even larger. Identifying patients who have a history of CSA is important for professional therapists.
and pastoral counselors in order to address underlying trauma symptoms (Briere & Scott, 2006). Treatment recommendations from the literature are included in the third section of this chapter.

Sequelae Correlated With Childhood Sexual Abuse

Long-term outcomes for people with a history of childhood sexual abuse vary from individual to individual. John Briere is a noted researcher in the field of trauma, and the author of several trauma-related instruments, one of which is the Trauma Severity Checklist-33 (Briere & Runtz, 1989). CSA is a traumatic event, and when it is ongoing or repeated, is considered complex trauma (Ford & Courtois, 2009). Briere (2002) identified six primary areas that may be affected in trauma victims:

1. negative preverbal assumptions and relational schemata,
2. conditioned emotional responses (CERs) to abuse-related stimuli,
3. implicit/sensory memories of abuse,
4. narrative/autobiographical memories of maltreatment,
5. suppressed or “deep” cognitive structures involving abuse-related material,
6. inadequately-developed affect regulation skills (p. 176.)

For victims of CSA, damage to these areas may occur at developmentally important periods. The negative preverbal assumptions and relational schemata are the basis for the child’s formation of an internal working model (IWM) which comprises his or her view of himself and of others as trustworthy and valued (or not). This is part of the attachment style of the individual, which is an enduring state throughout the lifetime (Ainsworth, 1969). Because early trauma, like childhood sexual abuse, may affect this attachment style...
process, much research has been done evaluating attachment as a mediator for the
symptoms that occur in adults with such a history (See Whiffen & MacIntosh, 2005 for a
review of the literature). In addition to these areas outlined by Briere that are part of the
developmental process in the formation of personality, other outcomes from a history of
CSA have been the subject of much research. The following paragraphs highlight some
of these other negative sequelae.

A history of CSA has been correlated with poorer general physical health
(Wilson, 2010). A National Institute of Health study involving 5,877 participants found a
correlation between CSA and physical health (Sachs-Ericsson et al., 2005). In a study on
1,396 older adults with a mean age of 67, childhood abuse of all types was correlated
with greater medical problems, highlighting the long-lasting effects of negative childhood
experiences (Sachs-Ericsson et al., 2011). CSA has also been linked to eating disorders
(Carter, Bewell, Blackmore, & Woodside, 2006; Fischer, Stojek, & Hartzell, 2010;
Holzer, Uppala, Wonderlich, Crosby, & Simonich, 2008; Welch & Fairburn, 1996) and
body image disturbances (Van Gerko, Hughes, Hamill, & Waller, 2005).

Dissociation has been connected with trauma and CSA (Briere & Runtz, 1998).
Self-injurious behaviors have been researched on populations of CSA survivors with
mixed results. In an interesting five year prospective study with 195 depressed patients,
Joyce et al., (2006) found that a combined history of childhood sexual abuse and
polymorphisms on the T allele of GNβ3 increased the likelihood of self-mutilation. In
contrast, Wachter, Murphy, Kennerly, and Wachter (2009) found that childhood physical
abuse was correlated with self-injurious behavior, not sexual abuse; perhaps as a
reenactment of earlier trauma. It is unclear in this study if sexual abuse with force or pain

were separated into different categories. In a follow-up assessment of the Putnam and Trickett (1987) longitudinal study of the psychobiological lifetime impact of CSA, Noll, Horowitz, Bonanno, Trickett and Putnam (2003) reported that 32.2% of their sample had engaged in self-harm versus 8.8% of their comparison (non-abused) group. In this study, self-injurious behaviors were defined as a suicide attempt, or any attempt to cause themselves pain or injury. This number may be low, because they stated the first twenty-one participants were not asked these questions. Further research may illuminate this issue.

The literature has suggested that those who experience CSA will have earlier sexual contact, engage in risky sexual behaviors, and are also at risk for more sexual abuse later in life (Sansone, Muennich, Barnes, & Wiederman, 2009). In a fifteen year, longitudinal study, women with a history of CSA were found to be 1.99 times more likely to experience sexual re-victimization and 1.96 times more likely to experience physical re-victimization than women in a comparison group without a CSA history (Barnes et al., 2009). A study by Young, Deardorff, Ozer, and Lahiff (2010) found that women ages 18-22 (n=1790) with a history childhood sexual abuse had a 20% greater risk for early pregnancy. If the sexual abuse occurred in adolescence, they were at 30% greater risk, and if they experienced sexual abuse during both periods, they were 80% more likely to have an early pregnancy.

In a review of the literature related to sexual dysfunctions in women with a history of CSA, Leonard and Follette (2002) identified a lack of desire or arousal and an aversion to sexual experiences as being the most commonly reported in the studies they reviewed. Leonard and Follette (2002) identified attachment style as one of the
theoretical constructs that helped explain how a history of CSA is related to sexual dysfunction. Avoidant attachment styles prevent intimacy needs from being met within the relationship. Emotion theory describes emotion schemes as adaptive and that they serve as a warning system. Leonard and Follette (2002) stated, “Emotion schemes contain complex cognitive, affective, motivation, and relational action components,” (p. 366). These schemes become maladaptive when they are not appropriate but are still functioning. An example given by the authors suggests that a child may have sought emotional support and was given sexual abuse instead, and this emotional need becomes coupled with danger, thus inhibiting intimacy. Other theories described in this article include guilt and self-blame for the occurrence of the CSA, anger, and experiential avoidance.

Rellini, Hamilton, Delville, and Meston (2009) investigated whether cortisol levels were involved in the lower sexual arousal rates of women exposed to CSA. Their findings were inconclusive, but they did help substantiate other literature that found trauma symptoms moderated sexual arousal, not simply the occurrence of CSA itself. Similarly, Leonard, Iverson, and Follette (2008) sought to determine the relationship between sexual satisfaction and sexual functioning in this population, and found no statistically significant correlation between these two measures. Both of these latter two research studies indicated that more clarification is needed on this topic.

A relationship where one partner has a history of CSA is at risk for problems, including a dysfunctional sexual relationship (Cobia et al., 2004). Walker et al. (2009) conducted a research study on 15,831 respondents, twenty percent of whom reported CSA. Using statistical modeling, they demonstrated that all negative childhood
experiences moderate adult relationships. Negative childhood experiences may lead to emotional flooding or depression, which in turn, affect adult relationships. Testa et al. (2005) conducted research on women (n=732) and found a greater number of sexual partners, more lifetime sexually transmitted illnesses, more sexual risk taking and more partner aggression in women with a CSA history when compared with women without such a history.

**Depression**

Greater levels of depression have been found in women with a history of CSA (Briere & Runtz, 1998; Finkelhor, 1991; Wilson, 2010). In a study of 235 patients diagnosed with major depression, Zlotnick, Mattia, and Zimmerman (2001) found that those with a history of CSA had an earlier onset of the index depressive episode and longer duration of major depression. They also found this group had more hospitalizations, more suicide attempts, and more affect regulation problems. Participants in this study also had elevated rates of post-traumatic stress disorder, higher rates of borderline personality disorder diagnoses, and multiple Axis 1 disorders.

**Anxiety**

Because trauma symptoms may include some startle response and hyper-vigilance, anxiety seems to be part of the general picture for CSA survivors. Cougle, Timpano, Sachs-Ericsson, Keough, and Riccardi (2010) conducted research on a large sample (n=4141) as part of the National Comorbidity Study on the effects of childhood abuse. Participants in this study included those who had endured physical, mental, and
Sexual abuse in childhood. The researchers found a unique variance between CSA and generalized anxiety disorder, social anxiety disorder, panic disorder and PTSD.

**Spiritual Problems**

Experiencing sexual violence at any age may impact one’s spirituality. According to Ganje-Fling and McCarthy (1996) spiritual development in children may be arrested around the time of abuse. Gall et al., (2007) conducted a study using 101 participants who were survivors of CSA. Their study found that a relationship with a higher power or a benevolent God was related to more personal growth and resolution of the abuse and indirectly related to less negative mood through mediating factors of self-acceptance and hope. Earlier, Gall (2006) researched this population and found that spiritual coping had more impact than demographics, severity of abuse, cognitive appraisal and support satisfaction. Negative spiritual coping methods were strong predictors of depressed mood and anxiety, while positive spiritual coping methods, such as religious forgiveness and spiritual support led to less distress. For those with a history of CSA, spirituality may be affected negatively, and may include a reappraisal of one’s faith or relationship with God (Crisp, 2007).

**Substance Abuse**

Addictions and/or substance abuse issues are also frequent outcomes linked to a history of childhood sexual abuse (Draucker & Marsoff, 2006; Fergusson, Boden, & Horwood, 2008; Finkelhor, 1991; Sartor et al., 2008; Zink et al., 2009). Various reasons for these behaviors have been examined in the literature. Negative coping or avoidant
coping styles may lead one to use a substance to self-medicate. Emotional distress was identified as a mediator between CSA and alcohol use (Whiffen & MacIntosh, 2005). Alcohol, prescription medications, and illegal drugs have all been used by people in an attempt to deal with their painful memories and negative affect (Sartor et al., 2008). Developing an effective and healthier way to cope with a painful past is one of the goals of treatment. In the population under study, substance abuse is one of the common presenting issues.

**Other Issues Related to CSA Experiences**

It has been suggested that a large percentage of people diagnosed with borderline personality disorder (BPD) may have such a history (Briere & Scott, 2006). Minzenberg et al., (2008) found that a history of CSA was correlated with neurocognitive deficits and adult attachment disturbances in a sample of 43 women with BPD. Self-esteem problems, guilt, and incorrect blame attributions are common difficulties. Affect regulation, boundaries, and a sense of personal identity are also areas that may be affected by such a history, according to Draucker and Martsolf (2006). Because the structure of the brain itself is growing and changing during childhood, CSA can negatively affect brain functioning in a variety of ways (Pennington, 2005). One way in which brain functioning may be altered is through heightened and prolonged stress responses in infants and children, resulting in hypocortisolism in adults (Pierrehumbert et al., 2009), or through an asymmetrical stress response (Shenk et al., 2010). As researchers learn more about brain functioning and the way it responds to trauma, perhaps more treatment methods will be developed to avert some of the long-term effects of CSA.
Theoretical Constructs Correlated With Childhood Sexual Abuse

The list above is just a broad outline of possible symptoms that may be correlated with a history of CSA. There is extensive research on CSA and long-term negative outcomes. The following areas, including trauma symptoms, attachment, God attachment, and substance abuse are of interest to this researcher.

Childhood Sexual Abuse and Trauma

John Briere is a noted researcher in the field of trauma psychology and one of the creators of the Trauma Symptom Checklist-40 {(TSC-40) Briere, 1996}. The TSC-40 was developed to measure a variety of symptoms that are linked to CSA in research. People with a history of CSA are sometimes diagnosed with full-blown PTSD; others display a range of trauma symptoms. It has been hypothesized that the type and severity of the abuse correlates with the severity and types of dysfunctions in adults. Zink et al. (2009) developed a scale to measure the severity of sexual abuse and sought to correlate the type of abuse with the symptoms experienced by adults. This study will not attempt to discern between the types of childhood sexual abuse, only to establish that it existed in the participant’s history.

Childhood Sexual Abuse and Attachment Theory

This study is grounded in the literature linking insecure attachment styles with negative outcomes, and secure attachment styles with better outcomes in the aftermath of CSA (Blake, 2007; Sypeck, 2004), and in the general population (Levy, Ellison, Scott, & Bernecker, 2010). In the models developed by Shapiro and Levendosky (1999),
psychological distress and coping styles were mediated by attachment style. Coping styles have also been found to have been affected by attachment style; specifically avoidant coping, active coping, and cognitive coping (Barker-Collo & Read, 2003). In this study, the focus will be on the possibility of change in the self-described relationship qualities of the participants.

Attachment Theory

There is a robust literature related to attachment style and the role it plays throughout the lifespan, which has developed in the last forty years (Roisman, Fraley, & Belsky, 2007). Attachment style develops in early childhood through interactions with the primary caregiver(s). John Bowlby is credited with the development of this theory. His initial work, Attachment was published in 1969; Attachment and Loss was published in 1973, and Separation: Anxiety and Anger, in 1973. Dr. Ainsworth’s 1969 paper united psychoanalytic schools of thought, ego psychology, and object relations theorists with Bowlby’s attachment theory. Her paper was written after she spent time collecting fieldwork data observing the behaviors of Ugandan women and their infants. After her return to the United States, she continued observing infant and mother behaviors, which led to the development of the “Strange Situation” laboratory experiment (Ainsworth & Bell, 1970). This experiment illuminated behaviors in toddlers when separated and reunited with their mothers. Based upon these experiments, the researchers described attachment, was included (Main & Solomon, 1986). Ainsworth (1969) indicated that attachment styles were enduring states, but not necessarily permanent.
Adult Attachment Relationships

Mary Main added to attachment theory by developing the Adult Attachment Interview (Hesse, 1999). She could predict with great accuracy what the child’s attachment style would be based upon information elicited from the mothers. The Adult Attachment Interview has been used in over 10,500 research studies (Bakermans-Kranenburg & van IJzendoorn, 2009). Adult attachment measures were further developed by the addition of the Experiences in Close Relationships Scale, a self-report measure developed by Brennan, Clark, and Shaver (1998). This measure assesses adult romantic relationships in terms of attachment theory based on self-report rather than interviews. The interviews in this study seek to add to the literature by exploring adult relationship styles and possible changes in them.

Attachment theory is considered one of the factors that influence the outcomes for people with a history of CSA (Dimitrova et al., 2010; Gottfried, 2004; Morúa, 2011) and outcomes in psychotherapy (Levy et al., 2010). Secure attachment style offers some protective factors for those who experienced CSA, while insecure styles are associated with negative outcomes (Elklit & O’Connor, 2008; Hankin, 2005). Because the attachment system develops in relationships with the earliest caregivers, attachment styles are thought to influence the way the child reacts to the abuse. According to Corbin (2007): “An early secure attachment experience forms the foundation of children’s healthy object-relationships and provides the dyadic and reciprocal experience shaping infant intersubjectivity,” (p. 541). Attachment style describes the way a child learns how to be with others, how to regulate emotion, develop resilience, and problem solve. These early interactions are believed to be stored in implicit memory, which is mostly
unconscious. This implicit memory sets up enduring rules and guidelines for future interactions (Corbin, 2007). As an adult, attachment style continues to influence how the person reacts to the environment, and also to psychotherapy (Shorey & Snyder, 2006).

According to Whiffen and MacIntosh (2005), research has shown that a history of CSA is linked with a variety of emotional distress disorders, especially depression and anxiety, dissociation, and PTSD. These researchers reviewed the literature for empirical studies using a mediator model and found 19 applicable studies. In their analysis, Whiffen and MacIntosh found that shame or self-blame, interpersonal problems including attachment insecurity and negative coping techniques all could be factors linking CSA to adult emotional distress. They suggested that emotional distress itself may be the risk factor linking CSA to substance use and other negative outcomes. The traumatic experience of CSA is considered an attachment trauma. It prevents the process of mentalizing between the perpetrator and the child. Allen (2008) stated that the child does not want to imagine the way the perpetrator is thinking of her, especially if that person is a beloved caregiver. This trauma is an evil that may lead to intolerable mental and emotional pain, which the victim must live with.

Aspelmeier, Elliott, and Smith (2007) conducted a survey of college females (n=324). They found that strong parental and peer attachment relationships were protective against the negative effects of sexual abuse. The researchers used the Trauma Severity Index as part of their study, and found more symptoms in women with a history of CSA on the Self, Trauma, and Dysphoria scales. The self-scale measures negative thoughts and feelings about themselves and their sexuality, and engagement in negative sexual and behavioral practices. The Trauma scale measures avoidant and dissociative
cognitive strategies and more intrusive thoughts. The Dysphoria scale measures negative mood states, such as anger, irritability, depression, and anxiety.

Levy et al. (2010) performed a meta-analysis on fourteen studies, involving a sample size of 1,467. They were looking for an association between attachment style and outcome in psychotherapy. The study statistics were compared using effect size and Pearson product-moment correlation coefficient ($r$). They found that when they analyzed psychotherapeutic outcome in relationship to attachment style, attachment anxiety yielded a result of -.224; avoidant attachment was -.014; and attachment security was .182. This study was one of the few to attempt to measure psychotherapeutic outcome correlated with attachment style. They did state that attachment security could be enhanced through therapy and recommended assessing for attachment style in order to foster the therapeutic alliance. This research project hopes to add to the literature by exploring such changes that may have occurred in participants.

Childhood sexual abuse violates the very early relationships built on trust. Kwako, Noll, Putnam, and Trickett (2010) researched a population involved in a longitudinal research study on childhood sexual abuse. In a small pilot study they found that survivors of CSA with children were more insecurely attached. Shaver and Clark found the same results in a 1994 study which reviewed the literature extant at that time. People with insecure attachment styles have also been found to be more likely to use avoidant coping methods which have been correlated with depression and substance abuse.

Sandberg (2010) used path analysis to determine whether he could substantiate that adult attachment styles are mediators for posttraumatic stress symptoms and
dissociation with a history of childhood abuse. He used the Bartholomew and Horowitz (1991) Relationship Style questionnaire to determine attachment status in a sample of 199 female college students with a history of childhood abuse; 32 experienced childhood sexual abuse. He was unable to substantiate the mediator model, but did find that secure attachment style was negatively correlated with posttraumatic stress and dissociation. He found that preoccupied and fearful attachment styles were positively related to posttraumatic stress and dissociation. Dismissing attachment styles moderated the relationship between victimization/abuse and posttraumatic stress. Muller, Sicoli, and Lemieux (2000) conducted a similar study and found that in their sample of 66 adults with a history of childhood abuse, 76% reported an insecure attachment style. Those with a fearful and preoccupied attachment style had the highest mean scores on the measures of posttraumatic symptom measures. Exploring the process of recovery from a traumatic event like CSA, and asking about changes in stress and relationship styles may add to the literature.

Dimitrova et al., (2010) tested whether adult attachment style acts as a mediator between CSA and psychopathological outcomes in adults. This study used the Collins Relationship Styles Questionnaire, which evaluates attachment style on three measures: closeness, dependence, and anxiety. They found that closeness did mediate CSA and psychopathology. Using multiple regression, they found that attachment did predict psychopathology when controlling for abuse, but abuse did not directly predict psychopathology when controlling for attachment style.

Pierrehumbert et al. (2009) compared women with a history of sexual abuse who had an organized attachment style (n=9), unorganized attachment styles (n=13), and a
control group without a history of sexual abuse (n=14). They found that women with a history of sexual abuse in childhood or adolescence had higher perceived stress in a laboratory experiment than the control group. They found women with unorganized attachment styles had significantly lower cortisol response to the stress. The authors stated that this supports the research on attachment style as a mediator of the long term consequences of stress exposure. Hypocortisolism was explained as an exhaustion of the stress response of the endocrine system.

Rickards (1995) assessed 495 females from a community and college student population on the domains of childhood trauma, attachment, and adult traumatic symptomatology. She found strong support for the effects of insecure attachment and dysfunctional family events on the variance in adult symptomatology.

McCarthy and Taylor (1999) performed a cross-sectional study examining the role of attachment style, self-esteem, and relationship attributions in relation to childhood abuse and relationship problems. In order to assess attachment styles, they used the Hazan and Shaver (1987) adult attachment questionnaire. This assessment provides three descriptions of attachment styles and asks participants to rate each one on a 7-point Likert scale according to how much they identified with it. The researchers also asked them to choose the one style they most identified with. Although only six of the participants reported experiencing CSA rather than other forms of abuse, McCarthy and Taylor did find that an avoidant/ambivalent attachment style was a mediator between childhood abuse and relationship problems.

The Adult Attachment Interview (AAI; Hesse, 1999) analyzes responses to interview questions to distinguish between three attachment styles. Secure, dismissing
(which roughly equates to avoidant attachment styles), preoccupied (similar to anxious/ambivalent classifications), and unresolved with respect to loss or trauma (which corresponds to disorganized attachment in infants) are the three categories. Brennan, Clark and Shaver developed the Experiences in Close Relationships measure (ECR) in 1998, a self-report assessment which included two scales measuring anxiety and avoidance. This self-report measure has four classifications: secure (low anxiety and avoidance); preoccupied (High anxiety and low avoidance), dismissing (low anxiety and high avoidance) and fearful (high anxiety and high avoidance). Generally the literature links insecure attachment models with a variety of psychopathology on Axis I and personality disorders on Axis II.

In the first study using the AAI that correlated unresolved attachment with a history of childhood abuse, 57% of the sample (n=60) were found to have an unresolved classification. Those with an unorganized attachment style were found to have more Axis I disorders, and 7.5 times more likely to be diagnosed with PTSD. They also found that those with an unresolved attachment style were more likely to have avoidant symptoms of PTSD (Stovall-McClough & Cloiotre, 2006).

Dimitrova et al. (2010) found that close attachment relationships mediated the effects of CSA on later psychopathology. They interviewed 28 women with a history of CSA and 16 controls and assessed attachment style using the Adult Attachment Scale {AAS, (Collins & Read, 1990)}. Using regression analysis, they found that attachment style predicted psychopathology when controlling for abuse. CSA did not predict psychopathology when controlling for attachment style. Based on their findings, they recommended that treatment include helping adult women with a history of child or
adolescent sexual abuse regain trust and confidence in others and develop closer relationships.

Twaite and Rodriguez-Srednicki (2004) found that adult attachment and dissociation mediated the relationship between all forms of childhood abuse and PTSD symptoms in their sample (n=284). These researchers used the Attachment Style Questionnaire with their participants. The study participants had a history of childhood abuse and some exposure to the World Trade Center and the attack upon it.

One hundred fifty-four women were studied from 1990-1995 and followed up in 1995-1999 to examine the role of insecure attachment style and its relationship to depression and anxiety. Using the Attachment Style Interview, the researchers found that insecure attachment styles mediated psychopathology, including depression and anxiety. They expressed interest in further studies which would determine what type of insecure attachment might predict what type of psychopathology (Bifulco et al., 2006).

The literature has also examined attachment style and its relationship to stress. Because attachment styles are enduring, CSA can have a very negative effect on the child’s perception of herself and her perception of others (Ainsworth, 1969). If the abuse occurs during the very early formative years, the brain’s functioning and response to stress activation can be altered. Physical harm may occur to the rest of the body, but physical harm may also occur inside the brain of the child. Neurobiologists and neuropsychologists are studying the genesis of psychopathology based on trauma that occurs in early childhood (Pennington, 2005; Siegel, 1999).
Attachment to God

Because God is referred to as the Father, in Scripture and in active prayers, attachment theory was envisioned as a way of measuring aspects of one’s faith relationship in evangelical Christianity. Scripture also describes God the Son as the husband of the church, and includes symbolism of a wedding feast as one’s union with Christ. Richard Beck and Angie McDonald (2004) developed the Attachment to God Inventory (AGI) in an attempt to measure the relationship one has with God based on attachment theory. The AGI was modeled after the ECR. Fujikawa (2010) sought to illuminate the implicit functioning of an individual’s attachment to God by using the Spiritual Experiences Interview and comparing it with the AAI in a sample of 19 college students. Other research explored the idea that God acts as a compensatory attachment figure or corresponds to the attachment figures experienced in daily life (Hall, Fujikawa, Halcrow, Hill, & Delaney, 2009).

Spiritual development or faith may be negatively impacted by CSA. Women have reported that they turned away from God or the church based on their negative experiences or use negative styles of spiritual coping (Gall, 2006; Crisp, 2007). One study found that women with a strong spiritual life and faith were able to be more resilient when dealing with similar negative events. For an overview of the literature, see Gall et al., 2007). According to these researchers, there is some ambiguity about the relationship between spirituality and CSA, and the directionality of effects each has upon the other. It is unclear whether negative experiences affect one’s faith, and/or whether faith acts as a protective factor for times when bad things do occur.
A dissertation on adult and God attachment as predictors of coping strategies and well-being was created by Morúa (2008). Using college students as her population (n=200), she used the AGI and the ECR as measures to predict coping strategies and emotional well-being. In her analysis, she found that adult attachment avoidance (r=.37) and anxiety positively correlated with negative affect (r=.37 and r=.42) and with stress (r=.46 and r=.56); and inversely correlated with well-being (r=-.34 and -.32), all at a statistically significant level (p<.01).

Reinert, Edwards, and Hendrix (2009) reviewed the literature on attachment and religiosity, and provided recommendations for the integration of spirituality into clinical practice. In the summary of the literature they reviewed, they described the compensatory and correspondence views of God attachment. Their findings indicated that a relationship with God may be either similar to satisfying human relationships, or as a relationship that substitutes for human attachments. Questions have also been raised as to whether it is possible to tap into the implicit perception of one’s relationship with God using a self-report measure, or whether an interview would be the more suitable instrument (Proctor, Miner, McLean, Devenish, & Bonab, 2009). Positive spirituality and religion can buffer stress, physical health complaints, mental health issues, and provide social support in a church community (Clinton & Straub, 2010). Reinert and Edwards (2009) recommended that therapists assess for attachment style because this information is helpful in developing the therapeutic relationship, helpful in understanding the client, and the therapist can model a secure relationship for the client. In this study, the interview questions include items about the participants’ changes in relationship to God before and after the treatment program.
Substance abuse has been correlated with CSA in a variety of studies (Brems, Johns, Neal, & Freemon, 2004; Gottfried, 2004; Kendler et al., 2000; Khoury et al, 2010; Sartor et al., 2008; Spatz Widom, Marmorstein, & Rashkin White, 2006; Zlotnick et al., 2006). In a sample of 830 (274 women) who entered an abuse treatment center for detoxification, Brems, Johnson, Neal, and Freemon (2004) found that 31% of the females had a history of sexual abuse. Physical and sexual abuse histories for either gender reported earlier onset age of drinking, more psychopathology, and more legal problems related to substance use and mental health symptoms.

Gottfried, in her dissertation with a sample of 292 low income participants, used path analysis to examine the relationship between CSA and attachment styles (2004). She found that CSA and anxious-avoidant attachment style were predictive of dissociation and that dissociation was predictive of substance use. She cautioned that other risk factors related to low income status may also be correlated with substance use.

In a twin study with 1411 participants, Kendler et al. (2000) found that 30.4% reported a history of CSA, and these participants also reported a higher rate of psychopathology, in particular, bulimia and substance use. In another study on 587 (359 females) low income participants, recruited at a hospital, the researchers found that females with CSA were significantly correlated with lifetime use of cocaine, marijuana, and tobacco. Selection criteria required participants to be age 18 and older, without a clinical diagnosis. The research team also found that childhood trauma of all types contributed to increased alcohol and marijuana use after controlling for adult trauma exposure (Khoury et al., 2010).
Sartor et al. (2008) provided a review of the literature and the methodological issues in examining the relationship between CSA and alcohol use/abuse. Some of the related issues are how and why people with a history of CSA use alcohol, if there are any mediating factors involved, and ways to define terminology used in various approaches to research.

As part of a long term study on children who were maltreated and entered the justice system between the years of 1967-1971 (n=892), Spatz Widom et al. (2006) found higher rates of substance use, particularly marijuana, in middle adulthood (mean age 39.5 years). The abuse reported in this sample included physical, sexual, and neglect cases that occurred in childhood before age twelve. Rates of use were higher in women than in men.

Zlotnick et al., (2006) conducted research on 336 patients with alcohol dependence or abuse. Of this population, 17.6% had a history of CSA. They found that those with CSA had an earlier onset of drinking age, but had lower drinking frequencies. Those with CSA also had a significant relationship with PTSD, greater Axis I comorbidities, and greater social problems.

Attachment styles are also connected with substance use in the literature (Kassel, Wardle, & Roberts, 2007; Molnar, Sadava, DeCourville, & Perrier, 2009; Salerno, Bottoms, & Hernandez, 2010; Schindler, Thomasius, Sack, Gemeinhardt, Kustner, & Eckert, 2005; Smith & Tonigan, 2009). Kassel et al. (2007) conducted a study on 225 college students in which they measured attachment style, self-esteem, dysfunctional attitudes, and substance use. They used Collins and Read’s (1990) attachment measure, and included cigarette smoking, marijuana use, and alcohol consumption in their study.
Results indicated that insecure attachment, particularly anxiety, was significantly related to frequency and stress motivated use of all three substances.

In a study exploring drinking motivations and their relationship with attachment styles, a college student sample of 696 students was compared with a substance abuse inpatient population of 213 adults. Attachment was measured using the Relationship Scales Questionnaire. In the student sample, attachment anxiety was positively related to all four motivations for drinking: enhancement motives, social facilitation motives, conformity motives, and coping motives. Anxious attachment was also positively correlated with heavy drinking and adverse consequences from drinking. In the clinical sample, anxious attachment was again positively correlated with all four drinking motivations, enhancement motives and coping motives mediated the relationship between anxious attachment styles and heavy drinking and adverse consequences of drinking. Avoidant attachment styles were not significantly correlated with these measures (Molnar et al., 2009).

Schindler et al. (2005) conducted a literature review of studies correlating attachment styles with substance use. They found avoidant attachment styles were generally characteristic of substance users. Schindler et al. (2005) also conducted a study using a German version of Bartholomew and Horowitz’ (1991) Family Attachment Interview. In this assessment, the inner working models claim to follow Bowlby’s theoretical model. People may have secure, fearful, preoccupied or dismissing attachment styles. People with a fearful attachment style have a negative view of themselves, and of others, and are afraid of intimacy. They avoid socializing or close relationships out of
fear of rejection, feeling insecure, and distrust others. Preoccupied attachment styles are based on a negative model of the self but a positive model of others. They tend to become overly involved in relationships, dependent on feeling accepted by others, idealize other people, and are incoherent or exaggerate when discussing emotions in relationships. They found a significantly larger percentage of the substance users in their study were fearfully attached, and preoccupied attachment styles were also significantly higher than in the control group.

Salerno et al. (2010) conducted a study with 429 college students. This study was the first to attempt to find a correlation between God attachment and alcohol use. Using the AGI, they found that 52% of the participants identified themselves as secure, 5% as avoidant, and 43% as anxious-ambivalent. They assessed religious problem solving using an assessment to determine whether a person uses mostly self-directing, deferring, or collaborative spiritual coping. The research team found that those with a secure God attachment drank less than the avoidantly or anxiously attached groups. Those who were securely attached used deferring and spiritual coping more than the anxious or avoidantly attached groups. God attachment had an effect on alcohol use, mediated by self-directed coping styles, which is an important finding for future research and substance abuse treatment.

Smith and Tonigan (2009) attempted to explore whether the practices of Alcoholics Anonymous (AA) had any effect on attachment style. They mailed questionnaires to 158 participants who had attended at least 300 AA meetings, and more AA meetings than other 12-step type groups. They used the Hazan and Shaver (1987) measure of attachment and adapted the questions so that they were prefaced with,
“Currently,” or “Before becoming involved with 12-step programs.” They also asked participants about the types of practices of AA they engaged in. Results included statistically significant changes in mean scores on all attachment measures; all changes moved toward a more secure attachment style. The authors found that practices, not merely attendance, were correlated with these changes, and suggested that entering into an intimate relationship with a sponsor could be one way that attachment styles were altered.

Clearly, the literature supports the idea that a history of CSA is related to the onset and lifetime use of substances, particularly alcohol. Attachment styles, both adult attachment, and God attachment, have also been examined in relation to substance abuse, and are generally correlated with insecure styles of attachment. Whether this is due to the use of substances as a coping method, social facilitation, social conformity, or an enhancement motive is undetermined (Molnar et al., 2009). This study is seeking to explore the way participants understand their own recovery process, and perhaps to explore whether attachment styles with adults or God contributed to recovery from substance use or dependence. Recovery from substance use or dependence is a large factor with this group of participants.

Treatment Recommendations

Briere (2002) outlined the self-trauma model for treatment of individuals with histories of trauma, including CSA. In this model, the premise is that people who are experiencing flashbacks, dissociative events, or affective responses to trauma related
stimuli are caught in a process that is meant for the initial survival of the individual. What needs to occur for recovery from these symptoms is gradual exposure to the trauma so that the memories can be integrated and more control over emotions are gained as the conditioned emotional responses are “unlearned.” This process is gradual, and the individual who participates in therapy can only recover when there is adequate emotional activation in relation to the recalled trauma, but not so much exposure that the client is overwhelmed. This “therapeutic window” will be unique for each person. He reminded therapists that this type of therapy requires a certain amount of bravery from the client, which should be acknowledged.

In a review of the literature, Whiffen and McIntosh (2005) recommended that psychological treatments address interpersonal difficulties, promote attachment security, soften self-blame, and encourage emotional expression rather than avoidant coping methods. Chaikin and Prout (2004) recommended a multi-modal approach, including individual and group counseling, and described a program with various phases that encompassed about eighteen months. Chunis (2011) conducted a grounded theory exploration involving seventeen women. One of the themes mentioned was that therapists did not ask about childhood sexual abuse and the patients were frustrated that this topic was not directly addressed.

Johnson’s (2005) book, \textit{Emotionally Focused Couple Therapy with Trauma Survivors: Strengthening Attachment Bonds} outlines her approach when one or both members of a couple have been through trauma. This treatment addresses the differences in attachment styles when designing interventions within the partner dyad. It is also
designed to help the couple understand their attachment styles, and as they progress in therapy, to help the traumatized partner move toward a more secure attachment style.

Murray-Swank and Pargament (2005) evaluated the use of *Solace for the Soul: A Journey Toward Wholeness* (Murray-Swank, 2003). This is an 8-week treatment program for those with a history of sexual abuse and targets spiritual integration. This study used an interrupted time series design on two case studies, with assessments at pre-test, post-test, and 1-2 months follow-up. ARIMA calculations were also used; all results showed positive moves towards healthier spiritual coping methods. Participants were initially angry with God for allowing the sexual abuse to occur or to continue and gradually worked toward attributing the abuse toward the perpetrator and/or reconnecting with God in a more positive manner. According to Pargament (2007) spiritual assessment is an important part of the diagnosis of clients. In his book, he provides many examples of ways this could be an integral facet of treatment planning. It may also be an indication that the client needs to explore their religious beliefs with a religious leader, as well.

Pollock (2001) advocated the use of a cognitive analytic approach for treating adults with a history of CSA. This model, used in individual counseling sessions, examines behavioral patterns and helps the patient recognize that additional options exist. This model uses dilemmas, traps, and snags to define problem areas and involves a lot of charting and visual representations to help the client link cognition, affect, and underlying behavioral patterns. Leahy, Pretty and Tenenbaum (2003) recommended that therapy target resolving the traumatic attachment to the perpetrator of the abuse. This was one of the findings when examining the differences between clinically distressed and non-distressed groups who both had a history of CSA.
Draucker and Martsolf (2006) reviewed the literature and recommended a three-phase treatment model including: a) creating a relationship with the client, b) remembering and mourning the event, and c) developing a healthier sense of self and healthier relationships. There are no empirically supported treatments that have substantial research, according to these authors. Some of the difficulties in designing and researching one specific treatment plan are the individual experiences of each person, the unique wide range of sequelae, and the unique ways individuals respond to treatment.

Briere and Scott (2006) recommended using treatments generally used for PTSD. They strongly advised developing a trusting relationship between the therapist and client as the first step. Recommendations for treatment include psychoeducational materials, using progressive relaxation techniques, various exposure therapies, and using psychotropic medications to help the client deal with the symptoms. They advised therapists to address affect regulation, underlying schemas, and memory intensity. They recommended that treatment be tailored to the client.

Witold (2009) described two case studies using NEST (New Experiences for Survivors of Trauma) that involved mourning the person one could have become if the trauma or abuse had not been experienced. Although this is an interesting concept, one of the women in the article had a breakdown, was hospitalized, and placed on mood stabilizers for three months, and was only able to return for the last few sessions of the group. Thomas (2005) described psychotherapy that dealt with dissociative symptoms and internal models of protection with survivors of child abuse, but included no empirical support for this model.
Barker-Collo and Read (2003) stated that treatment should focus on reducing self-blame, reducing emotion-focused coping, and improving attachment styles. The therapeutic relationship itself can be an active part of therapy: it can be a secure attachment relationship with which the client interacts and learns from. The authors also recommended a thorough assessment in clinical practice, including questions about childhood abuse of all types, as well as training for staff when responding to disclosure. They recommended that therapy focus on the above items, and that the therapeutic relationship itself can be a model of secure attachment for clients to experience in the same way they experienced relationships that led to insecure attachment styles.

Generally, the treatment recommendations in the literature include assessing for the existence of CSA in an intake interview because of its multi-faceted effects throughout the lifespan. Assessing attachment styles, developing a strong therapeutic bond in order to model secure attachment, and helping the client grow in this area was mentioned by some of the previous literature cited. Addressing the sexual abuse incidents and using exposure techniques was also part of the treatment recommended. General trauma treatments for PTSD were also indicated.

Taylor and Harvey (2010) conducted a meta-analysis on 44 studies targeting 59 treatment conditions. Twelve of the studies were treatments for PTSD. The rest of the treatment studies addressed the psychological effects or symptoms of CSA, and generally targeted one specific problem area. A variety of therapeutic approaches were compared in these studies. These studies (as cited by Taylor and Harvey, 2010) contained independent samples: Interpersonal transaction group therapy versus process group therapy (Alexander et al., 1989); Written disclosure about CSA versus a control group (Batten,
Follette, Hall, and Palm, 2002); CPT for sexual abuse (Chard, 2005); Interpersonal process group therapy (Cloitre & Koenen, 2001); Cognitive Behavioral Therapy (Cloitre et al., 2002); Trauma-focused group therapy with incarcerated women (Cole et al., 2007); EMDR vs routine individual therapy (Edmond et al., 1999); Long-term forgiveness therapy (Freedman & Enright, 1996); Feminist group therapy (Hébert & Bergeron, 2007); Short versus long-term group therapy for women outpatients (Lundqvist et al., 2006); CBT versus present-centered therapy (McDonagh et al., 2005); Group therapy for Women (Morgan & Cummings, 1999); Emotion focused therapy (Paivio & Nieuwenhuis, 2001); Process Group Therapy (Richter et al., 1997); Group Rational Emotive Behavioral Therapy (Rieckert & Möller, 2000); with HIV patients; a trauma coping group versus a support group; Body focused feminist group therapy (Westbury & Tutty, 1999); and Affect management group therapy (Zlotnick et al., 1996).

Studies with repeated measures designs (as cited by Taylor & Harvey, 2010) included: Long-term group therapy (Bautz, 1997); Cognitive Analytic Therapy (Clarke & Llewelyn, 1994); Trauma-focused vs. effect-focused discussion group therapy (Dodds, 1996); Long term group therapy (Hazzard, Rogers, & Angert, 1993; Kreidler, 2005); Long term analytic versus systemic group therapy (Lau & Kristensen, 2007); Process group therapy (Longstreth, Mason, Schreiber, & Tsao-Wei, 1998); Trauma-focused group CBT (Lubin, Loris, Burt, & Johnson, 1998); Long-term psychodynamic group therapy (Lundqvist & Öjehagen, 2001); Emotionally focused couple therapy (MacIntosh & Johnson, 2008); Cognitive Processing Therapy, with group and individual therapy (Owens et al., 2001); Psychodynamic therapy (Price et al., 2004); CPT versus CPT-cognitive therapy only versus written accounts (Resick et al., 2008); Group versus
individual therapy (Ryan et al., 2005; Stalker & Fry, 1999); Group therapy (Saxe & Johnson, 1999; Threadcraft & Wilcoxon, 1993); Coping intervention for women and men with HIV (Sikkema et al., 2004); Long-term individual therapy plus other support (Smith et al., 1995); Group treatment as usual versus group abuse-specific therapy (Talbot et al., 1999); Short term group therapy for women with severe mental illness (Weiner, 1997); Stress management group (Wilson, 2006); Trauma focused group therapy (Wright, Woo, Muller, Fernandes, & Kraftcheck, 2003) and EMDR (Zeper, 1996).

Taylor and Harvey’s (2010) meta-analysis considered these treatments to be important clinically and practically based on a binomial effect size display. They found moderate effect sizes across all treatments, but the highest effect sizes were found with treatments targeting PTSD and trauma symptoms (.77). The other areas targeted by these studies were grouped into externalizing and internalizing symptoms, self-concept/esteem, interpersonal functioning, and global symptoms/functioning. After examining possible moderators for the effect sizes, they found that individual therapy had consistently higher effect sizes, as did treatment that involved homework. Because there are so many symptoms that were targeted in the various studies, Taylor and Harvey (2010) recommended further research studies in order to gain a clearer picture of what works with what symptoms. Not all studies included follow-up measures, which are also important for assessing maintenance of recovery according to the authors.

Qualitative Research Addressing Recovery from the Sequelae of CSA

Several studies have researched the experience of recovery from the sequelae related to CSA using qualitative methodology. These include original research conducted

Anderson and Hiersteiner (2008) conducted a narrative analysis as part of a grounded theory approach with 27 sexual abuse survivors (two of whom were males). They discovered three elements through the narratives of participants, along with the perspective that they believed recovery is possible, but healing is not. These three elements include disclosing the abuse, making meaning out of the trauma, and developing supportive relationships. All of these are elements that would be helpful in guiding treatment planning for this population.

Chandler (2010) examined resiliency in adult survivors of CSA (n=10). She used a mixed methods approach, combining three assessments, interviews, and artwork as part of her dissertation. She was interested in integrative therapy that may be used to enhance resiliency and recovery in women who had experienced dissociative symptoms among other sequelae from CSA. The therapies considered in this study were body work and other integrative practices, traditional psychotherapies and spiritual practices. She reported that 40% of the group tried “organized religion, (dogmatic, patriarchal)” and none found it helpful.

Draucker et al., (2009) conducted a qualitative meta-analysis of studies conducted in the United States or Canada. Of the fifty five studies included, 514 statements were then analyzed and organized into a taxonomy. Of these statements, the dialectic approach was utilized to arrive at four major themes. These are: calling forth memories, regulating
relationships with others, constructing an “as safe as possible” life-world, and restoring a
sense of self. The restoration of relationships involved moving from the protective phase
of avoiding contact, breaking off relationships and avoiding intimacy and closeness to a
stance of seeking people out, disclosing the abuse in some manner, resolving the
relationship with the perpetrator (not necessarily a reunion), and forming new
relationships with appropriate boundaries. The authors recommended that treatment
approaches focus on these dialectics of healing instead of isolated processes, such as
replacing negative thinking.

Knapik et al. (2008) conducted open-ended interviews with 27 women and 23
men who had experienced sexual violence at some time in their lives. Using a grounded
theory approach, they developed a model based on these accounts of being delivered
from the effects of that sexual violence. The model included three aspects; a spiritual
connection, a spiritual journey, and a spiritual transformation. Survivors spoke of finding
meaning in their suffering.

Houg (2008) conducted a qualitative study of fourteen female survivors of sexual
abuse and their conception of the role of spirituality in their recovery. She identified five
major themes using Consensual Qualitative Theory. These themes were:

1) Participants distinguished between spirituality and religion;
2) The role of spirituality varied across their recovery process;
3) Many had a positive spiritual role model/mentor during their childhood;
4) Ongoing sexual abuse led to rebellion as adolescents/young adults (e.g., anger
against God’s failure to intervene, self-destructive behaviors that further exacerbated
mistrust, shame and alienation; and
5) Participants eventually reached spiritual reconciliation, which they viewed as the greatest single factor in their recovery (Houg, 2008, p. iii.)

Leahy et al. (2003) conducted a negative case analysis using two groups of ten participants each. One group was clinically distressed and the other was not and both had a history of childhood sexual abuse. They found that the clinically distressed group experienced affect dysregulation and peri-traumatic dissociation around the time of the abuse. Both groups blamed themselves for the events, and had a locus of control shift, but the non-distressed group was able to view the perpetrator in a more negative light, which effectually disempowered him, and also were able to attribute some meaning to the event, such as being in the wrong place at the wrong time. The clinically distressed group were still showing evidence of the locus of control shift and unable to resolve the attachment relationship with the perpetrator in order to develop trusting relationships with others as adults.

Parker et al (2007) published an exploratory phenomenological study based on the experience of women with childhood trauma who participated in the Woman Recovering from Abuse Program (WRAP). WRAP is an eight week outpatient program. Each week includes one hour of individual therapy scheduled within the four days of group therapy. Each day begins with a process oriented group and is followed by one or two groups that deal with boundaries, enhance skills through cognitive behavioral therapy techniques, groups focused on empowerment, psychoeducational groups focused on trauma, art therapy, and/or leisure skills training groups. Using interviews from seven participants, who were six months post treatment or more, the researchers found three themes and eleven categories in their analysis. The first theme was “Breaking Trauma Based Patterns,” and included
changes in beliefs, behavioral patterns, and connectedness, and opening up to new experiences. The second theme was “Doing Therapy,” and included categories such as figuring out the way the program works, feelings about the group process, helpful strategies and techniques, and gains from the program. The third theme, “Understanding the Healing Journey,” included three themes: readiness for change, continuing problems and taking the next steps.

Using assessments and written responses to the research questions, Wright et al. (2007) explored meaning making, perceived benefits, and coping styles in CSA survivors. Half of the respondents (30) indicated they learned a great deal from their experience with CSA. Thirty percent (18) found meaning in the experience; thirty five percent (21) found positive meaning. The authors suggested this is an example of post traumatic growth. The benefits they found included personal growth and development (16), spiritual or religious growth (11), increased knowledge about sexual abuse (16), improved relationships (22), acquired coping skills (26), and improved parenting skills (18).

Summary

None of the qualitative studies addressed were based on participation in a Christ-centered residential treatment center. This study will add to the literature based on the analysis derived from women who have completed such a program, and be of value for future studies with these treatment programs individually. There is support for considering attachment security as a factor in the sequelae of CSA (Aspelmeier et al., 2007). Spirituality is a source of strength and a protective factor (Pargament, 2007).
Attachment to God is one way of measuring spirituality and also has shown to influence mental health status. Because so many of the women in treatment present with substance or alcohol abuse, this is an important symptom to consider when assessing treatment progress and recovery. This study was based on the theoretical concepts described above but is exploratory in nature. This study was designed to describe and view the phenomena of recovery from the sequelae of CSA, including substance abuse, through a treatment program that incorporates the study of Christianity as one of the key components.

There is a need for exploration of recovery for substance abuse in addition to the exploration of recovery from a history of CSA. The Institute for Research, Education, and Training in Addictions (IRETA) and the Northeast Addictions Technology Transfer Center created a research brief on the science of recovery (2009). Some of the questions they suggested needed more research include exploration to discover the common themes in recovery, research into special populations including women and trauma survivors, and the pathways to recovery that include spirituality and religion. They also mentioned the need for research to address long term recovery and a need to view the process of recovery in a more holistic or global picture. Mental health and substance abuse recovery are connected. The Substance Abuse and Mental Health Services Administration (SAMHSA) adopted strategic initiatives for 2011-2014, one of which addressed the need to define recovery. Objective 7.2.3 is: “Establish standards for defining and measuring resilience and recovery for substance abuse and mental health,” (SAMSHA, 2011, p. 90). Perhaps this phenomenological exploration of recovery from the sequelae of CSA, including substance abuse, will address some of these issues.
CHAPTER THREE: METHODS

Introduction

The preceding chapter examined the long-reaching effects a history of CSA may have throughout adulthood and the need for research on treatment programs that are effective. The treatment of addictions is not directly addressed in this study, but is also an area that needs research, and is a common comorbid treatment presentation with CSA. While there is some research that examined spirituality in the context of CSA and its long term effects, none explore the experiences of women with a history of CSA who participated in a Christ-centered residential treatment program. The purpose of this study was to explore the process of recovery and recovery maintenance related to a history of CSA and its sequelae for former participants of such programs. Phenomenological research is an appropriate research model, and will be explored below. The rest of the chapter deals with the practical implementation of this model.

Phenomenological Research

The advent of phenomenological research in this century owes its existence to Edmund Husserl, a German mathematician and philosopher. His first important work was *Ideen zu einer Einen Phänomenologie und Phänomenologischen Philosophie*, published in 1913. He continued writing and developing his descriptive/transcendental phenomenology throughout his lifetime (Spiegelberg, 1978). Husserl (1913, 1983) is considered the father of phenomenology and is known for his rallying cry, “to the things themselves,” (*Zu den Sachen selbst*, p. 35), and his eidetic reduction (p. xx); also known
as the *epoché* or bracketing. Husserl believed that radical subjectivism is the source of objectivism, and his study of phenomena focused on the essential structure of actions of intentionality and the contents of consciousness (Spiegelberg, 1978). He approached his philosophy on the basis that man is an entity constituted by his consciousness. Other philosophers following Husserl and agreed or disagreed with his approach and the limits of the eidetic reduction, but phenomenology began its development with him.

Martin Heidegger was Husserl’s successor to his post at the University of Freiburg and his successor in phenomenology, but approached it from an ontological rather than epistemological angle. He believed that consciousness was an activity of man and that existence or being should be the focus of phenomenological exploration. Heidegger claimed, “the essence (*Wesen*) of human being lies in its existence,” (as quoted by Spiegelberg, 1978, p. 327). Heidegger’s most well-known work, *Sein und Zeit* (1927) included the concept of groundedness or connection; man exists in context, in the world, and in his historicity. According to Heidegger, phenomena cannot be explored without considering this “being-in-the-world.” Heidegger is considered a hermeneutical phenomenologist, as well as an existentialist. Heidegger believed, in contrast to Husserl, that we can never see things as they are, because we come to the process of observing with our preconceptions and prejudices, and we cannot purposely set them aside. This does not necessarily mean these preconceptions are wrong but it means we cannot leap into interpretation without considering them (Fry, 2009). Heidegger’s phenomenology focused on intersubjectivity rather than subjectivity a la Husserl. His relational and participatory concepts of “being” are also important ideas that relate to this study. He described man’s fundamental nature as one that is ahead of self, looking to the future,
already involved in factual being, and constantly being absorbed into the activities of daily living; *Sorge* roughly meaning care or concern (Overgaard, 2004).

Hermeneutics (initially named after Hermes, who brought messages from the gods) became an important discipline after the Protestant Reformation (Smith, Flowers, & Larkin, 2009). Hermeneutics as a discipline expanded to the study of law, and in the 1800s to literature in Romanticism. Schleiermacher, Dilthey, Heidegger, and Gadamer were important contributors to its development (Fry, 2009). Gadamer (1976) described the process of interpretation as “the bridging of personal or historical distance between minds.” (p. 95.) He described hermeneutics as an iterative process between the part and the whole, the reader and the text. Gadamer (1976) also wrote about aesthetics, as did Heidegger. He said that hermeneutical understanding of art involves what we allow it to say to us. “It is not only the “This art thou!” disclosed in a joyous and frightening shock; it also says to us, “Thou must alter thy life!” (p. 104). I humbly suggest Scripture says this to us as well.

Phenomenology expanded after World War II across the European continent. There have been French and Dutch schools of phenomenology that generally diverged based on differences in descriptive versus interpretive stances and employment (or not) of the *epoché*. American philosophers also embraced phenomenology, and the model of phenomenological research to be used in this study originated in the United Kingdom (Smith et al., 2009).

Phenomenology as a research method is slightly easier to grasp than phenomenology as a philosophy. Existential philosophy may have had some impact in helping it gain acceptability as a research method. Through the past century,
phenomenology as a philosophy has been refined into a rigorous research method with varying approaches (Moustakas, 1994; Smith et al., 2009; van Manen, 1990). A hermeneutical phenomenological approach seems best suited for understanding the process of recovery via the narrative reflections of those who experienced it.

The capacity of humans to make meaning of life events and to exercise a sense of agency in their lives is not considered a confounding variable to be controlled through research procedures. Rather, these interpretive acts of meaning-making lie at the heart of what is to be understood through qualitative—that is, interpretive—research. (Piantanida & Garman, 2009, p. 50)

For that reason, interpretive phenomenological analysis was chosen as the research method in this study.

**Interpretive Phenomenological Analysis**

Interpretive phenomenological analysis (IPA) developed primarily in the United Kingdom over the past twenty years and is based on an approach to research enjoining hermeneutics, idiography, and phenomenology (Smith et al., 2009). The hermeneutic approach is grounded in Heidegger’s hermeneutic phenomenology, along with Schleiermacher’s grammatical and psychological interpretation, and Gadamer’s emphasis on language and dialoging with the text. The concept of a hermeneutic circle is also a key part of the philosophy of IPA research (Smith et al., 2010). Interpretation in this project involves live interviews, written transcripts, and the participants’ reflections upon the phenomenon in question. Moving between levels in the circle adds depth to analysis as the project progresses.

Idiographic research is based on in depth descriptions of individuals rather than generalizations drawn from large samples (nomothetic). IPA is committed to detailed, in
depth analysis, which is “uniquely embodied, situated, and perspectival” (Smith et al., 2009, p. 29). Generalizations may be made based on detailed case studies rather than nomothetic research which generalizes from large groups to the individual. These differences in approach distinguish qualitative studies from quantitative research methods.

Merleau-Ponty, in his work *Phenomenology of Perception* (1962) emphasized the embeddedness of existence and how our individual perspectives influence the phenomena one encounters. Understanding phenomena someone else experiences is never the same as what one might experience individually. Phenomenological research attempts to interpret an experience someone else had through their reflection upon it. Sartre’s “existence before essence” and Kierkegaard’s emphasis on “becoming” are also influential backdrops for this “in the world” model of interpretive phenomenological analysis. Hans-Georg Gadamer (1976, 1989) is also an influential source for IPA. His philosophical hermeneutics and stress on the importance of linguistics underlie inherent concerns of interpretational phenomenology.

Because of IPA’s “embeddedness” and connection with work in the field of grounded cognition, this model is appropriate for working with a population whose history includes bodily violation. The symptoms or sequelae related to CSA are linked to their physicality, the context of the relationships they were in, and the way they interact with their world now. IPA has been used in many nursing studies for similar reasons; it is grounded in context and what is more contextual to humans than the body itself? A person cannot escape his or her body and still encounter phenomena that can be described. Recently, CSA and its long term effects have been considered from a
developmental and neuropsychological standpoint. According to this discourse, not only can it leave lingering psychological or behavioral concerns, but it also may interfere with physical brain structure, function, and development (Briere, 2001; Pennington, 2002; Siegel, 1999; Williams, 2006). It is a psycho-psychical-relational-environmental violation.

Defining the Case

What changes occur in recovery? What brings them about? After a traumatic event like CSA, what does it take to “undo” its long-term effects? Even if some momentous change in perspective or understanding occurs, how is possible to maintain such changes without falling back into the ways one has lived, thought, or behaved most of one’s life?

The Research Questions

What is the experience of recovery from the sequelae of CSA, including alcohol or substance abuse, in a faith based residential treatment center? What changes do participants recognize as part of healing or recovery? How are graduates of this program functioning post treatment?

Data Collection

The Sample

Purposive sampling was used in this research study. This type of sampling is designed to target a population with the characteristic of interest; in this case, that
characteristic is having completed a program matching the criteria described above within the past three years. Purposive sampling is a standard for IPA and all phenomenological researchers, since the research itself is exploring some particular phenomena rather than sampling a large population and looking for shared characteristics or those that diverge (Moustakas, 1994; Smith et al., 2009; van Manen, 1990). In this research project, graduates with a history of CSA were located with the assistance of program administrators. From this population, ten women who have completed a program within the past three years were selected to participate in the study. Purposive sampling of a homogenous population is recommended for phenomenological research and a sample size of three to six participants is recommended for an IPA study (Smith et al., 2009), but generally a sample size of ten is recommended (Guest, Bunce, & Johnson, 2006).

Once the sample participants were chosen, they were contacted and the research study was described to them. A copy of the informed consent document (available in Appendix B) was given to them to sign, along with the Questionnaire found in Appendix C. After the informed consent document was returned, the interview was scheduled at a place convenient and comfortable for the research participant.

*Interviews*

Face to face interviews are the most common method of collecting data for phenomenological research (Moustakas, 1994; Smith et al., 2009; van Manen, 1990). Face to face interviews provide rich sources of data and the researcher can explore the phenomena of interest by using open-ended questions that invite reflection. Because the
researcher is also present, observation of body language can add to the data collected and will be briefly noted during the interviews. However, some participants were more than 12 hours away from the researcher’s location, and five interviews were conducted by phone and/or Skype.

Planning the interview included letting participants know about the time frame that would be needed, which was approximately 60-90 minutes. Allowing the participant to choose a comfortable site helped to develop rapport and open the channels of communication. Interviewing participants involved the use of a semi-structured interview protocol, which may be found in Appendix D. The interview questions were designed to be open-ended, with prompts to explore the participant’s experiences, and were based on the framework given in Chapter Two.

Follow up interviews were conducted in order to clarify any questions about the data, as needed. The transcripts were made available to participants for their perspective on the accuracy and the breadth of content. Each participant was asked to verify the transcript and a summary of their narrative for accuracy. These two procedures also enhanced validity and trustworthiness of the data.

Documents and Observations

The researcher visited two program sites on several occasions and interacted with current participants and past participants, as additional research for this study. The researcher also obtained a copy of one curriculum, along with examples of individualized lessons given clients. She has read a book written by the founder of one treatment program. The researcher volunteered on a limited basis with the supporting ministries as
well as with clients in one program. This observation, visitation, and data collection provided some background information.

This research study included a non-standard questionnaire that asks demographic questions. It also included questions about medication use and treatment before and after entering the program. The questionnaire asked the participant if they have experienced CSA as a way of validating that this is part of their history. It did not ask for details about that experience. It also asks about substance use. A copy of this instrument is located in Appendix C.

The Process of Analysis

The analysis followed the model described by Smith et al. (2009) for IPA researchers, and is similar to that of Moustakas (1994). The interviews were recorded and transcribed by the researcher. The first step involved reading and rereading the text and listening to the recorded interviews in order to become immersed in the original data and to check the transcriptions for accuracy. This process included note taking about first impressions and synthesis of the material. An attempt was made to bracket the researcher’s assumptions in order to set them aside. According to Küpers (2009), this bracketing is not a suspension of one’s total belief systems, but is a process:

Realizing this phenomenological clarification can metaphorically be compared with using a brush, (a) negatively, doing away with the “dust” of entrenched interpretations or theories, etc., and (b) positively, polishing (and) revealing the phenomena in their full brightness (p. 58.)

After this purposeful move, or series of movements, the researcher more deeply engaged with the participant’s statements, rather than her own preconceived ideas.
The second stage involved the initial noting and commentary on the written transcript, including voice inflections. These were descriptive, linguistically oriented, or conceptual comments and it was a process, not simply a read-through of the material. A timeline of each story was written out, and then a summary was created, and a poem using their words was created. These summaries and the poems were sent, along with the initial transcript to each participant. If necessary, any corrections they indicated that needed to be made were amended at that point. Responses to the non-standard questionnaire were created in aggravate form. A chart of symptoms was created, along with a chart comparing program elements.

The third step involved developing emergent themes that begin to appear in the transcripts. This is an interpretive process and part of the hermeneutic approach to phenomenology. The fourth step involved searching for connections between the emergent themes in the transcript. This process may involve abstraction and the search for a super-ordinate theme. Subsumptions, polarization, contextualization, enumeration, and function are other ways that emergent themes may be analyzed and grouped. This process also included note taking about why and how these themes emerged and were organized. Extracts from the interviews were compiled under each theme as a way of grouping them.

These processes occurred with each transcript and then patterns between cases were examined for similarities. Interpretation was the final level of the analysis. IPA includes a hermeneutic of empathy and one of suspicion; questioning by the researcher as well as understanding are both involved. The final process involved writing up the finished project which included quotes from the transcripts. The finished project was
intended to be a readable narrative that flows from theme to theme, explaining and exploring the experiences of the participants related to the research questions (Smith et al., 2009).

Assumptions and Limitations

It was assumed that the information gleaned from the interviews will be informative and truthful. There is no way to substantiate narrative accounts based on personal recollection. The ability of this study to be generalized to all participants of Christ-centered residential treatment programs is not an assumption but a tentative hypothesis. Other assumptions are based on the researcher’s philosophical viewpoint that may vary from those of the reader, and are also based on the choice of theoretical structure.

Because CSA is such a personal event, and is experienced differently by each person, the recovery that was recounted varied. Each woman who entered these programs was unique, and the experiences in this small sample of women may not be representative of everyone who goes through a similar program. There was also the possibility that participants skewed their narratives in order to try to please or displease the researcher, or the program itself.

It is also possible that the theoretical orientation of the researcher was influential in the analysis of the interviews, resulting in some eisegesis. It is also possible that the beliefs and theoretical orientation of the researcher influenced participant responses during the interviews. For that reason, leading questions were avoided other than those described in the semi-structured interview.
Ethical Issues

Conducting research on human subjects raises many ethical concerns. The American Counseling Association (ACA) published a Code of Ethics (2005) that contains guidelines for conducting research. Section G outlines the responsibilities of researchers toward participants, and following those guidelines, this project was submitted for institutional approval from Liberty University’s Internal Review Board. By approaching the treatment program administrators for possible participants, their consent was also obtained.

Informed consent from all participants was obtained prior to conducting any research. A copy of the informed consent document is available in Appendix B. The ACA Code of Ethics (2005) requires that researchers use language that:

1. Accurately explains the purpose and procedures to be followed.
2. Identifies any procedures that are experimental or relative untried.
3. Describes any attendant discomforts and risk.
4. Describes any benefits or changes in individuals or organizations that might be reasonably expected.
5. Discloses appropriate alternative procedures that would be advantageous for participants.
6. Offers to answer any inquiries concerning the procedures.
7. Describes any limitations on confidentiality.
8. Describes the format and potential target audiences for the dissemination of research findings, and
9. Instructs participants that they are free to withdraw their consent and to discontinue participation in the project at any time without penalty (ACA, 2005, p. 17).

Because this research project involved the recording of interviews, participants were also informed of this in writing as part of the consent process (8.03). A copy of this consent form is found in Appendix B. This project included small monetary inducements for participation, but will follow guideline 8.06. A debriefing and/or referrals were made available if participants desired/needed them, but this was not necessary (8.08).

Maintaining confidentiality of the participants was also important and mentioned in Section G.2.e. (ACA, 2005). The protection of participant identity was described within the consent form (Appendix B). Participant’s real names will not be divulged and recordings and written data were coded to disguise their identities. Information obtained from assessments and interviews remain in the possession of the researcher and were transported only by said researcher. They are stored on a removable storage device and on the researcher’s personal computer, which is password protected. This data set will be devoid of identifying information related to the participants. It will remain in the personal files of the researcher. Interviews were transcribed and stored on the researcher’s computer and a remote storage device.

Data collected and stored after the original research study is complete will remain in the possession of the original researcher, sans any personal identifying information for a maximum of twenty years. Any data that is published as a result of the research will not contain or reveal participants identities as required in Section G.4.d. of the ACA Code of Ethics (2005).
Validity

A constructivist approach is a stance that attempts to embrace the results of the findings realizing that the researcher brings along her own limits and bias, the participants have their own limits and biases, and an exact understanding between the two may never be possible. According to Teddlie and Tashakkori (2009), constructivists believe that the known and the knower are inseparable, that inquiry is not value free, and that reality differs from the individual’s viewpoint. While the researcher believes there are truths that can be discovered, each individual’s perceptions are grounded in their metaphysics, personal history, and current context. Being and perceiving are not static activities, but ones of engagement. As the research participants reflect on and recount their own experiences, the researcher is hearing and engaging with them, but also trying to make sense of this recount; this meaning-making is interpretation, or a double hermeneutic (Smith et al., 2009).

By attempting to describe the theoretical vantage point of the researcher, several important points are made. 1) The researcher is not value free, and chose a stance from which to begin this inquiry 2) The researcher recognized that participants will differ 3) The results from this study included interpretation, albeit following guidelines for phenomenological inquiry. While it was important to frame the study in a theoretical lens, it was also important to identify the position of the researcher and for the researcher to embrace “epoche.” Bracketing one’s presuppositions while analyzing the findings was important, but most likely absolute neutrality is not possible as in a strict Husserlian phenomenology. According to Merleau-Ponty (1962), “the most important lesson which
the reduction teaches us is the impossibility of the complete reduction” (1962, p. xv). The reduction refers to one’s ability to reduce the influence of presuppositions in order to more clearly perceive/understand the object under study. By proclaiming them in advance, perhaps their influence, if any, in the analysis, will be more visible.

Smith et al. (2009) suggested several ways for enhancing validity claims based on Yardley’s (2000) principles. One of the ways this may occur is by enhancing the sensitivity of the researcher to the context. In this case, this meant familiarization with the philosophy and history of the research method and its appropriateness for the study, knowledge of the existing literature on the subject to be explored, and sensitivity to the data to be obtained from the participants. The first two have been addressed already.

Including verbatim statements which support the analysis is one way of showing sensitivity to the data and was included.

Commitment and rigor are Yardley’s second recommendation. These involve the time spent and the diligence in learning the skills in order to properly conduct an IPA study. Appropriateness of the sample based on the research, as well as learning the skills to properly interview were part of this study. Transparency and coherence are the third recommendation to enhance validity. This project included the planning of the research project and the finished project was written in a way that explains the convergent and divergent findings. The final recommendation from Yardley is impact and importance. If research is conducted well, it should have something important to say and be interesting to the field it impacts. The findings of this study should inform professional and pastoral counselors who treat patients with a history of CSA of changes that may occur in the process of recovery from the associated sequelae.
Another way to increase validity is having the researcher retain all materials, including the initial research proposal, the interview transcripts, the write-up in the analysis and interpretation phases, and the final product, so that an audit can occur by an independent researcher. This researcher retained all this information. Because this researcher was also working with a committee in the dissertation process, audit checking occurred as portions of the research project were submitted and reviewed.

The validity of any qualitative research project is based on its trustworthiness, rigor, readability, and triangulation methods (Golafshani, 2003). Triangulation can involve approaching the research from different vantage points. This project included peer review along with program investigation, visits and observations, reading of the curriculum used by the centers, and the use of a questionnaire in addition to the interviews. It also included member checking with participants to enhance validity claims. This process involved sending the completed transcripts, a summary and a poem to participants for their review on the accuracy and breadth of the project. But in the final analysis, IPA is an interpretation and involved deriving meaning from the data.

Summary

This research project sought to provide a greater understanding of the process of recovery and recovery maintenance for women with a history of CSA through IPA methodology. The phenomenological analysis yielded a picture of their experiences through the programs and the way they viewed their recovery, as well as what they understood themselves to be recovering from. Exploring the maintenance of their recovery was another aspect that may have implications for treatment planning. Of
particular interest to the researcher were the possibility of changes in attachment styles, both with other adults and with God; changes in trauma symptoms, depression, and anxiety levels, and substance abuse recovery and maintenance.
CHAPTER FOUR: RESULTS

Overview

The purpose of this study was to add to the previously established findings related to recovery from the sequelae of childhood sexual abuse (CSA). As delineated in the previous chapter, the research questions were: a) What is the experience of recovery from the sequelae of CSA, including alcohol or substance abuse, in a faith based residential treatment center? b) What changes do participants recognize as part of healing or recovery? c) How are graduates of this program functioning post treatment? In order to explore these questions through the phenomena of lived experience, 10 women were interviewed. This chapter presents the interpretive phenomenological analysis of that data.

Their narratives answer the research questions, and excerpts are included below as part of the phenomenological text. In order to properly ground these narratives, background must be established. Interpretive phenomenological analysis is an approach that is influenced by idiography, and the Dasein of Heidegger. It “is thoroughly immersed and embedded in a world of things and relationships,” (Smith et al., 2010, p. 29). Therefore, this chapter begins with a description of the treatment programs, the group of participants, and personal vignettes. After this initial section, the chapter culminates with the themes that emerged in answer to the research questions. When necessary, minor grammatical corrections were made to the narrative transcripts of the participants, and elisions are indicated.
The Treatment Programs

Elizabeth, Erica, Tina, Hope, Heather, Leigh, Grace, Bella, Wanda, and Ally (all pseudonyms) attended five different treatment programs, although two of the programs are part of the same international organization. Each woman was asked to choose a pseudonym, and those who did not were assigned one that seemed to reflect their narrative. All five programs followed curricula which will be described below, and utilized individual counselors with a variety of qualifications and unique limits on psychopharmacological medication. These factors are summarized in Table 4.1

Table 4.1

Comparison of Residential Treatment Programs

<table>
<thead>
<tr>
<th>Participants</th>
<th>Treatment Protocol</th>
<th>Length of residential program</th>
<th>Counselor Qualifications</th>
<th>Psychopharmacological interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leigh Hope</td>
<td>“Deep Roots” curriculum Individual counseling and study material</td>
<td>1 year plus transitional living option</td>
<td>Licensed therapists</td>
<td>Not allowed</td>
</tr>
<tr>
<td>Wanda Ally Erica</td>
<td>Chemical Dependency Codependency Developing Life Skills Individual Counseling and study material</td>
<td>3, 6, &amp; 9 months plus optional halfway house</td>
<td>Licensed therapists</td>
<td>Dispensed by staff only</td>
</tr>
<tr>
<td>Tina Heather</td>
<td>14 Consecutive Classes Individual counseling and study material</td>
<td>12 months Recommends 6 months transition program</td>
<td>Pastoral, Certified addictions counselor</td>
<td>Not allowed</td>
</tr>
<tr>
<td>Bella</td>
<td>14 Consecutive Classes Individual counseling and study material</td>
<td>12 months Recommends 6 months transition program</td>
<td>Pastoral</td>
<td>Not allowed</td>
</tr>
<tr>
<td>Elizabeth Grace</td>
<td>“Choices that Bring Change” Curriculum Individual counseling and study material</td>
<td>6 months plus pre-admittance and aftercare guidance</td>
<td>Licensed therapists</td>
<td>With physician oversight through community of care</td>
</tr>
</tbody>
</table>
Hope and Leigh attended a program that used a proprietary curriculum developed in-house. This curriculum was centered on exploring who God is and how to relate to Him. In addition to this curriculum, which incorporated videos, books, articles, and skits, participants were given study packets to work through issues such as anxiety, depression, codependency, forgiveness, and other similar topics. Each woman saw a licensed professional staff counselor weekly. A typical weekday included three group studies, individual study time, group devotions, group exercise, and household duties. Substance abuse issues were addressed in group and individual sessions. Household duties in this center, as well as all the others, included cooking, cleaning, laundry, and general home maintenance. This program was designed to last a year and included transitional living arrangements afterwards. The center was located in a rural area in a beautifully decorated home, with office space located on the lowest floor. Life coaches resided in the facility with the women. A separate counseling center with capacity for crisis housing was located on the property.

Wanda, Ally, and Erica attended a program that was designed to be completed in three phases. The first three month phase was centered on chemical dependency and the teachings were based on a workbook using a 12-step approach. They also had in-house 12-step groups and attended outside recovery groups. Relationships were the focus of the second curriculum module, and were based on a codependency workbook written from a Christ-centered perspective. Wanda, Ally, and Erica completed the six month modules. The third phase of the program was focused on work skills in order to help the women transition back into full-time employment. Licensed counselors met with the women
weekly. The daily schedule began at 7:00 a.m., with breakfast and Proverbs. Wanda and Erica were living in the program’s halfway house, located several miles away from the recovery program center itself. The recovery program was located in a rural area and included two dorms, a chapel, and the administrative offices.

Tina, Heather, and Bella completed two different branches of an international treatment program. These were 12 month programs, with highly recommended post treatment care offered for an additional six months. This program had its own in-house curriculum, developed and perfected over a period of 30 years. The curriculum was composed of fourteen consecutive classes which began with one that introduced residents to the Bible. Besides a strict schedule, the program involved teaching accountability to authority. Mentors and one-on-one pastoral counselors met with the program residents weekly, at a minimum. Tina and Heather’s program also included a certified addictions counselor. Each participant was assigned study materials to deal with personal struggles.

Both the treatment centers were large, tastefully furnished homes, which included apartments for live-in interns, along with office space for administrators.

Elizabeth and Grace attended a program that has been in existence for almost thirty years and has four different locations. The program administration developed a curriculum based on best practices in the mental health field combined with Christian spirituality. This curriculum was a six month module, with options for longer stays. Both Elizabeth and Grace attended the program for seven months. Licensed counselors met individually with residents, and other staff members were available for general support. Classes covered material such as financial management, life skills training, forgiveness, setting boundaries, anger management, Bible study, and daily worship. Nutrition was an
important part of this program, and staff closely monitored those like Elizabeth and Grace, who have been identified as having an eating disorder. Physical fitness was also a program element, and each resident received an individualized plan. The recovery centers are large buildings and the ministry had many options for support and transitional living both before entrance and after leaving the program. Unlike the other programs, this one was focused on young women, ages 13-28.

Research Participants as a Group

The women in this study ranged from 21 to 56 years of age. The group included one Hispanic woman, and the rest were Caucasian. All participants except Wanda were a minimum of six months post-treatment. Wanda had been in post treatment for five months at the time of the interview. Wanda’s story involved a plethora of treatment options before this current program, so she was included in this research project because she could compare this program to others. The education level of participants spanned from one without either a high school diploma or a GED, to one with a Master’s degree. Three were married; two for the first time. One participant was single. The rest were divorced; some were divorced multiple times.

Participants in this study had a range of prior treatments before entering residential care. Ally spent six weeks in one treatment program, and two weeks in a second one before the program in this study. Wanda attended eight residential centers, was hospitalized multiple times for suicide attempts, had extensive individual counseling from age 14 to her entry date, and attended Alcoholics Anonymous (AA) since age 16. Everyone else fell somewhere between these extremes. Table 4.2 summarizes the
research participants’ symptoms prior to entrance to their respective residential programs, based on retrospective self-report.

Table 4.2

Comparison of Participants and Symptoms Reported at Program Entry

<table>
<thead>
<tr>
<th></th>
<th>Elizabeth</th>
<th>Erica</th>
<th>Tina</th>
<th>Hope</th>
<th>Heather</th>
<th>Leigh</th>
<th>Grace</th>
<th>Bella</th>
<th>Wanda</th>
<th>Ally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>37</td>
<td>43</td>
<td>26</td>
<td>35</td>
<td>21</td>
<td>35</td>
<td>23</td>
<td>31</td>
<td>31</td>
<td>56</td>
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<tr>
<td>Depression</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Anxiety</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Insomnia</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promiscuity</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance of sex</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Sexual abuse as adult</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>Body image issues</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Flashbacks</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide attempts</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Anorexia</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bulimia</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraines</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Physical illness</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Jail</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of psychopharmacology</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
All but Elizabeth reported a history of substance abuse. Everyone experienced depression before entering their treatment program and everyone described a variety of other symptoms. A checklist of symptoms was not utilized in this study; the symptom list was derived from the transcripts.

Introduction to Individual Participants

The women who participated in this study were given the option of selecting a pseudonym to be used, as a way of honoring their contribution. Several chose names important to them in one way or another. The researcher chose for those who did not indicate one. Hope was so named because she seemed to be the one most in need of this characteristic. Tina was chosen because it is an anagram of the last four letters in Christian, and Tina was very interested in proclaiming her faith. And Bella was chosen because it means beautiful in Italian and seemed most fitting with this participant’s real name and story.

In order to understand the process of recovery, it is necessary to have a picture of both the ‘before’ as well as the ‘after’. This summary of each person also begins to answer the first research question, which was: “What is the experience of recovery in a faith based residential treatment center?”

Elizabeth

Elizabeth, at 31 years old, was a newlywed. She was working as a nanny at the time of the interview. She holds a Master’s degree, and was a teacher by profession. Growing up, Elizabeth was an overachiever in sports, education, music, and as a volunteer at church. As a child and young woman, Elizabeth experienced a lot of
physical problems including the growth of bony tumors called osteochondromas in her
back, disc degeneration and spinal collapse. She suffered from an eating disorder that
lasted twenty years and involved bingeing, purging, and over-exercising. She also
experienced depression and marked self-hatred. Her parents divorced when she was a
junior in college, an event that she described as “shaking her foundations,” possibly
because her father was a former pastor.

Elizabeth kept the eating disorder and depression hidden from others, and avoided
dating. Her first long-term romantic relationship began while she was working on her
Master’s degree. She described her avoidance of romantic entanglements:

I hadn’t really dated before. I think part of that was … [some] kind of internal
fear… I didn’t know what it was from. But I didn’t want to open it. I didn’t really
want to date anybody. I had my first real kiss when I was 24…. [I thought] I will
stay away from that and then I won’t get hurt without really knowing why I felt
like that.

She had no recollection of the CSA until she began a required internship with young
children. Elizabeth began to experience flashbacks and panic attacks as memories began
flooding her consciousness. With help from a counselor, and by consulting with family,
she was able to piece together the sexual abuse which occurred when she was
approximately five years old. When she disclosed this to her boyfriend, he raped her.
Elizabeth became suicidal, had constant migraines, and continued to suffer from panic
attacks and flashbacks as she went to counseling and tried to make sense of what was
happening to her. After a year, she entered a residential program and spent seven months
there, reintegrating and finding herself. She said she was looking for: “the real me, not
just the pretend me.” She found a great deal of healing and described one reason for her
growth:
I went into the program very determined. Basically this is my one shot to get what I need. I didn’t want to do what friends of mine did, going to various centers, and various things… I don’t want to be stuck in this the rest of my life.

Elizabeth’s eating disorder had been in remission for several years at the time of the interview. The flashbacks, panic attacks and depression gradually subsided, and she believed her eye color, which had darkened, returned to normal. Elizabeth maintained connections with individual counselors, friends, family, and church, and described her willingness to ask for help when needed. Her younger brother was also working through his issues related to CSA, which originated from the same person who molested Elizabeth.

*Erica*

Erica was interviewed at age 43, while living in a halfway house and working in the fast food industry. She never graduated from high school, but ran away from home after enduring CSA from a family friend and too many beatings from her adoptive mother. She reported that her adoptive father drank every night and her sister tried to kill her, and so she asked to be placed in the foster care system rather than return home.

After dropping out of high school, Erica worked at strip clubs and in prostitution until she married. When she discovered her husband was cheating on her, she violently attacked him, ending up arrested for aggravated stalking and terroristic threats. After the charges were dropped, her husband divorced her and her daughter chose to live with him. She began drinking heavily, became suicidal, and returned to a promiscuous lifestyle. Finally, after getting a DUI charge, she began looking for help. In addition to being suicidal, she said she was diagnosed with major depression, bipolar disorder, migraines, severe anxiety attacks, and heartburn requiring medication. She spent approximately
eight months in other programs, where she was unsuccessful until she entered the latest treatment facility and graduated from the six month treatment protocol.

Learning that God loved her, and learning about codependency were really helpful parts of the program, in Erica’s opinion. She also found that individual and group counseling helped to normalize her experiences. She said: “Because [I] just felt like all [my] life nobody can understand what I’ve been through … When you hear somebody say, “Yeah, I’ve been raped too,” it just helps you feel better. Erica said she felt: “happier than I have ever been. I’m not going back…to the past. I want that behind me. I’m moving on to my future.”

_Tina_

Tina, 26, spent a year in a residential program. At the time of the interview, she was working as an administrator at the same facility. She had taken some college courses and completed leadership training with the program as well. As a young girl, Tina’s parents divorced and her father moved hundreds of miles away; leaving Tina, the oldest child with her bipolar mother and younger siblings. Tina described her childhood:

I always had to take care of my younger siblings, and my mother, especially since I found suicide letters my mom wrote. I felt the pressure of [being] the oldest child on my shoulders, and that was part of the reason I snapped.

She began experimenting with drinking, and believes that she did it out of curiosity and because she did not know how to process her emotions when her grandfather died. She talked about her search for love outside the home and her first sexual encounter at age 13, with a 19 year old male:

…[He] continued to feed me alcohol and it was just to the point where I was pretty much gone beyond belief, and I was pretty much raped…And I felt like I
was a piece of trash that could just be put off to the side. So here I am thinking my worth now is in sex…so that is what I thought love was.

She became promiscuous from that point forward, stole to support a drug habit, dated drug dealers, and worked in strip clubs. She married at age 19, but cheated on her husband multiple times. She shared a description of herself that follows the typical pattern of anxious attachment (Clinton & Sibcy, 2002): “I was searching for that perfect close love relationship, but I was scared at the same time that I would be rejected by them, so I still kept them at a distance.” Like eight of the other participants or co-researchers in this study, she also experienced sexual violence as an adult, at age 19. Eventually, she was arrested for possession and spent six months in a residential treatment program, and eight months in a six month halfway house program; in the middle of that program she tested positive for drugs.

Tina also reported a history of multiple health problems. She said: “I always seemed to have something wrong.” She broke a lot of bones, and had a laparoscopy because, as she described it: “my organs were stuck together” and she had chronic pelvic pain. She was in several car accidents which ended in back and neck problems, and dealt with asthma, depression, complex PTSD, anxiety attacks, and chronic bronchitis.

Tina had two years of sobriety at the time of the interview. Central to her recovery was finding and accepting love from God. This also enabled her to find love for self. She said she has been able to come to a place of: “accepting myself because Jesus accepts me. The peace that comes from it is unexplainable. There’s hope.”
Hope

Hope, at age 35, had just quit her job and was in the process of moving to another state with a new boyfriend at the time of her interview. She had two children, both in the custody of their father, had been married twice, and has had a string of “companions.” Like Bella and Erica, the loss of custody of her children has played a central role in her story.

Hope described her childhood as: “wicked bad.” She added, “I have no memory of when I technically lost my virginity and I guess I’m blocking it out because it was when I was so young.” When she was seven or eight she was removed from the home where she suffered from neglect, abandonment, sexual and physical abuse, and where she was responsible for caring for her infant brother. Hope developed addictions to alcohol and drugs, and was involved in some violent altercations. A high point of her life was being adopted by a former counselor at the age of 19. In the past, she spent time at three different rehabilitation centers, was hospitalized several times, and had been in counseling on and off since she was nine years old. Hope was also violently raped as an adult. Before entering this current program, she was arrested for punching her male roommate and resisting arrest. She spent over a year in the treatment program, and a few months living with a host family who were part of the transitional living extension of the program she completed two years ago.

Hope’s interview was centered on the loss of the custody of her children, which is still a source of pain for her. Her younger brother was murdered and she shared a story of seeing him in a vision before knowing that he died. Hope was always spiritual, and described many visions and beliefs about God intervening in her life, but she did not
belong to any religious organization. During the interview she stated that she was surprised that the Bible was about God and principles she could apply to her life. She remained in contact with the women from her treatment center and called them her spiritual mentors. Quitting a job she loved and moving to follow a new boyfriend went against their advice, and the new boyfriend (Guy) shared a similar trauma and alcohol use history. Hope was drinking again, although claiming she was limiting her intake. When describing the process of recovery, Hope said:

I wanted to keep my promise and stay for a year and try to really heal for a year while I was there, but I had so much I don’t know how much I really did heal. But I got me a good start.

Heather

Heather, the youngest participant, was 21. She had been divorced once and had a GED. She spent a year in treatment and was working with the same program as an intern at the time of the interview. She lived onsite in an intern apartment at the residential program.

Heather’s history included a father who was an abusive alcoholic. Her parents divorced when she was thirteen. Heather had some sexual abuse as a five year old, and ended up in a three year abusive romantic relationship beginning at age fourteen, which included sex, alcohol, and drugs. She described the period after the breakup:

I just went out of control and went like guy crazy…I would sleep with just about anybody. I had one night stands all the time and stuff like that. I guess I had some sort of sex addiction, to be honest with you.

She was also addicted to pain pills and was using intravenously. After missing a vein, she developed an infection in her arm which she described as: “about the size of a lemon.”
Fearful of going to the hospital alone, and abandoned by her boyfriend, she recognized that her life was out of control and went to her mother for help.

In the meantime, Heather’s father had found sobriety and helped to locate a rehabilitation program for her. Heather was able to find forgiveness for her father, who told her, “I love you, and you can choose to believe that or not, but I do.” She described a key to her healing as: “understanding Christ’s love for me.” In the past, she said: “I just wanted to be loved and I couldn’t find it.” Heather found freedom from her drug addiction, along with a sense of inner peace, and reunited with her father.

Leigh

Leigh, who was 35, had a high school diploma. She was in her first marriage, and had two young children. At the time of the interview, she had 3 years of sobriety. She was a stay at home mother, with a part time sales business, and involved in leading Celebrate Recovery and a prison ministry.

Leigh grew up with a very controlling father, and learned to hide her emotions and learned to read people in order to give them what they wanted. She said this made her feel as if: “nobody knows the real me.” Her CSA occurred as a young teen. She did have a circle of friends and was enmeshed with her family growing up, but this changed when she and her husband moved to another state. Living several hours from family and friends created a physical and emotional isolation for Leigh, who birthed two children quickly after this move. One was colicky, and Leigh struggled with untreated postpartum depression. The marriage was not happy, and her husband worked twelve hours a day, which led to some sleep deprivation issues for Leigh. A third pregnancy ended in a miscarriage. During this time period, Leigh was drinking more and had gained weight,
further eroding her self-esteem, and she had no relationships in her new town. She isolated and continually fluctuated between drinking and trying to quit drinking. She had been to individual counseling and another residential program before completing this faith based program and had been prescribed both anti-depressants and anti-anxiety medication. Leigh became suicidal and so depressed that they had to hire someone to come in and care for the children. A friend put her in contact with the residential program and she entered it, fearful of separation from her young children but desperate for help because she was so suicidal. She stayed for seven months and went back home with a transition plan and contacts, but to a hostile husband. She fell back into drinking within a few months and became suicidal again, resulting in psychiatric hospitalization. There, she was prescribed Lamictal, which she described as a life-saving medication. Leigh returned for two more weeks at the residential program. During that time she said:

I was able to get honest...I was able to see in retrospect that the time I spent here I only dealt with certain things and there was more that I needed to look at. And so in two and a half weeks we did it! I mean intensive counseling every single day. I was exhausted. But I went home and I’ve been sober ever since!

Leigh worked through her sexual trauma, for which she blamed herself. She went home determined to succeed despite any decision her husband might make regarding the marriage. They decided to try marriage counseling. After returning home, she started making friends in the community, and getting involved with recovery as a leader; this helped her break the isolation that was such a big part of her past. Her spiritual journey deepened in her time with the program, and the bonds with her husband and children have been healed.
Grace

Grace was 23-years old and had been married one year at the time of the interview. She had a high school diploma and worked in the retail industry while taking a class to enhance her marketable skills. She attended a faith based residential program three years prior to the interview, but thought she was beginning to deal with the sexual abuse issues she experienced.

Grace was first sexually abused as a young child, and continually experienced it throughout her life from various people. She was also emotionally abused and trafficked by one boyfriend. She had a history of cutting and a severe eating disorder that led to multiple health issues, along with many injuries from over-exercising. She described herself as being “very good at hiding things,” when asked how her parents dealt with this. Finally, Grace began getting help from a therapist at age 18, who advised her to enter a treatment program at age 20. While she believed she did not heal much there, she did say it was the start of her recovery. She explained: “Because I feel like if I didn’t go, then I would not be alive today.” Her parents did not believe she needed counseling, but entering the treatment program helped her reveal to them how deeply troubled she was. She said she learned to battle her negative thoughts with truth statements from the Bible, and her experiences there changed the way she thought of God, both of which were part of her recovery. She had turned her back on God after years of abuse and got involved in occult practices that were antithetical to her faith. Her father was a Christian pastor, and some of her abusers were also professing Christians, both of which played a role in her distorted view of God.
Despite the gains she made, shortly after leaving the treatment program, Grace returned to cutting, bingeing, and purging. Within a few months, she overdosed. She was taken to a psychiatric facility and began psychopharmacological interventions along with more therapy and was diagnosed with borderline personality disorder and PTSD. Grace continued to experience flashbacks and have suicidal thoughts but instead of acting on these thoughts, as she had done in the past, is able to understand that they are temporary and part of her illness. She also had some auditory hallucinations, but listened to worship music to feel encouraged. She was hospitalized just before this interview for suicidal thoughts and depression that she felt were from a need to adjust her medication. Despite these issues, Grace was happy in her new marriage, and had avoided any self-harm such as bingeing, cutting or purging, for nine months.

*Bella*

Bella, 31, was divorced. She was distressed over the fact that her three young children were in the custody of her ex-husband. She worked as a server, after spending a year in residential treatment. She held a Bachelor’s degree and has also worked in the human services field.

Bella was molested by her sister for several years, beginning at age eight. Her sister had been molested by a neighborhood boy, and then acted out with Bella. Although her sister’s CSA was discovered by the parents, Bella’s was not. She did not reveal it to her parents until she was 19, and then felt that her parents did not acknowledge her pain. Bella married a former Marine and a sheriff’s deputy, an abusive and violent alcoholic who threatened her with a loaded gun, among other traumatic events. Bella developed chronic pelvic infections and had five surgeries in about a year and a half and then
developed an addiction to pain pills. She was admitted to a 26-day inpatient program at a mental hospital and then was transitioned to an intensive outpatient program, along with individual and pastoral counseling; all without success. She and her husband separated and reunited several times, and divorced while she was in the treatment program. She had been arrested for falsifying prescriptions and then violating probation before entering the program in this study.

Bella expressed a great deal of forgiveness for everyone, and admitted she sees the good in people, sometimes to her own detriment. She was working on establishing herself financially and being careful about men entering her life. She had two years of sobriety at the time of the interview. Bella hoped to become involved with a ministry to the homeless in her community as a way to begin working in her field once more.

Wanda

Wanda had never been married, and was 31 when interviewed. She was enrolled in college and living in a halfway house. She laughed, sometimes incongruously, while she described the dramatic and traumatic details of her life story.

After her parents divorced when she was a toddler, Wanda and her brother were in the custody of her mother, whom she described as “crazy.” When they were young, their mother would be gone for days or a week at a time leaving them to scrounge for food and wear dirty clothes to school. She said she was teased for her weight and believed that she must have smelled badly. She believed her teachers hated her, and resents the fact that the school did nothing despite evidence of neglect. Wanda was raped by two boys as a young girl and further victimized when the story spread that she willingly participated and the number of male participants was magnified. When she and
her brother entered her father’s custody, at age 14, she described herself as “out of control.” She entered AA as a teenager and then began a series of rehabilitation programs. She went to eight residential treatment centers, and lived in several transitional housing arrangements; some just so she had a place to live. When asked about psychotropic medication in the past, she listed them as “all.” At one point in her life, she hitchhiked all over North America alone, while in active alcoholism. Later she spent several years “holed up” alone in an apartment, living on disability and only emerging to buy food or alcohol. She began a process of healing there, and was able to quit drinking while living alone. She was looking for a halfway house when she entered this last treatment program, the first one she ever completed. Just as many aspects of her life fluctuated from one extreme to another, her weight varied between 114 pounds due to anorexia to 280 pounds when she quit drinking.

Wanda believed the codependency lessons really helped her. She said: “It never occurred to me that I didn’t have to be somebody different around every new person.” She said she always believed in God, and liked the program, despite being unfamiliar with the Bible or having a religious background. She said that the spiritual aspect helped to put her life into perspective. Wanda seemed at peace, with a lot of insight into her past. She did not blame her upbringing for her alcohol problems, despite having a mother she described as: “a pathological liar. Everything she ever told me about herself was a lie.” She learned to open up to relationships with residents, classmates, and others and was enjoying friendships in a new way. Wanda said she had been able to lose fifty pounds while in the program, and she gained insight regarding her anorexia. This weight loss freed her from the pre-diabetic diagnosis she had been given.
Ally, 56, was a beautiful woman with a gentle demeanor. She had a GED, and a history of CSA that occurred when she was preschool age. She was not sure who abused her. She was working as a program administrator in the same treatment program she graduated from at the time of the interview.

Ally’s parents divorced when she was very young. Both remarried, and Ally described her step-father as very critical. Ally ran away at age 16 and then forced her parents to allow her to marry the man she called: “the love of my life.” This turned out to be an abusive relationship, and her mother encouraged her to get an abortion and helped her leave the marriage. Ally married two more times. Her current marriage was successful, although they were both recovering alcoholics. They both eventually returned to drinking; he was a functional alcoholic; she was not as functional, and she also abused prescription medications. She spent six months in the treatment program, after two prior secular programs. She was reluctant to go, but was forced by her husband to either go to treatment or end the marriage. During treatment she described a sense of spiritual redemption and talked of finding herself. Initially, she planned to leave after three weeks but had a change of heart:

Yes …that was all God too, because I was ready to go. But it’s such a good program. The teaching is just amazing. And there is a lot of fun stuff that we do. So I just hung in there. And in the second session you can go home the last weekend of every month; the last full weekend. And it was like a relief to come back. It was so nice to be with my family, but it was so nice to come back; I felt like I was coming back home.

Ally and her husband sought marriage counseling, and began attending church and facilitating 12-step groups together. At the time of the interview, Ally was dealing
with some mild depression and working through natural life changes as her children moved out of the family home. She described herself as an isolator, but her career had her involved with people constantly. She had almost four years of sobriety.

All of these women have been through many traumatic experiences in addition to the CSA that disrupted their lives. All but Hope are free from substance abuse and are abstaining. Grace is dealing with a lot of psychiatric symptoms at present, but like the other participants, wanted to be included in the study, in the hope that her journey might be helpful to someone else. The next section provides answers to the research questions based on their experiences in recovery.

The Research Questions

When interviewing participants, the researcher followed a Semi-Structured Interview guideline (refer to Appendix D). These questions were open-ended, and covered many aspects of life. Through the process of interpretation, analysis and summarization, a picture emerged of several common themes. Through the process of member checking, which involved asking participants to review the transcribed interviews as well as summations and key points of their stories, these commonalities were further validated. Each research question is a heading in the following sections, with the emergent themes displayed respectively.

Research Question One

The first research question is, “What is the experience of recovery from the sequelae of CSA, including alcohol or substance abuse, in a faith based residential
treatment center?” In order to fully address this question, the information in this entire chapter is necessary. The previous section described the treatment programs, the characteristics of the women in the study, and gave an overview of their stories; the next research question explores the changes they experienced as part of the process of recovery. This section will focus on the day to day experiences of living in the treatment center. Themes that emerged were a) Re-Education, mentioned by all b) Bonding, which was mentioned by nine, c) Most Helpful Program Elements, which were mentioned by all participants; d) Least Favorite Program Elements, mentioned by four women, followed by e) Graduation, which was also mentioned by all women. Table 4.3 displays the frequencies these themes emerged in the interviews.

Table 4.3

<table>
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<tr>
<th>Themes</th>
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</thead>
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<td>Re-education</td>
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</tr>
<tr>
<td>Bonding</td>
<td>9</td>
</tr>
<tr>
<td>Most Helpful Program Elements</td>
<td></td>
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<td>Counseling</td>
<td>4</td>
</tr>
<tr>
<td>Spiritual foundation</td>
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<tr>
<td>Program structure</td>
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<td>Worship</td>
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<td>Least Favorite Program Elements</td>
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<tr>
<td>Controlled environment</td>
<td>1</td>
</tr>
<tr>
<td>Conflict</td>
<td>3</td>
</tr>
<tr>
<td>Graduation</td>
<td>10</td>
</tr>
</tbody>
</table>

Re-Education

All of the women talked of the treatment centers in terms of classes and studying.

When asked to describe the treatment center, Tina described those in the program as students, and further elaborated on the setting as follows:
It’s a home; a house. It’s a two-story split level house on two and a half acres of property and they converted into [the program]. There are a couple offices here. The rooms are upstairs and the offices are downstairs… Students in the program get counseled every other week. But if they are struggling in between and need to talk, they are available for us to talk to.

She described a typical day:

The average day starts at 7. You wake up and have morning devotions together led by the staff on duty. And then we have breakfast and do work duties. After work duties we have classes… The first phase is 14 basic classes. I don’t know how to really describe them but I can name a couple of them: Successful Christian Living, Temptation, Anger, Personal Rights, Obedience to Man, Obedience to God, Growing through Failure, [and] Life Skills. After that, we would have study halls for assignments from our counselors or our class assignments. Or we would have a chapel teaching done by one of the staff members. In the afternoons … maybe we would deep clean, or do yard work or arts and crafts, [and] journaling sometimes. Sometimes we would have something called share time where we would all get in a circle and it was led by staff. They would question you, [asking] how are you… what are you going through right now…. We would be able to talk about where we were at that time in our recovery… In the evening we had praise and worship about two or three nights a week. We would go into the chapel. It was just our time to pray and develop our relationship with God.

Ally also described a typical day in her program:

There are two ladies to each room. They get up at 7:00. If they get up before that they can go in the common area and have quiet time. They have breakfast at 8:00. After breakfast they read Proverbs – the chapter for the day. They have a memory verse every week. They each have to stand up and say that, and that was kind of intimidating when I first came, but you get used to it. Then Monday is a house meeting and they go over any type of conflict that is going on and they bring up their requests. Then they go on with the day. They have Bible studies. And then there is conquering chemical dependence in the first three months. There is conquering codependency in the second and third sessions. We have a workbook that we go through and there are different teachers for each one. We have lunch and some days we have independent study. There is a lot of class work to be done and then Bible studies to do. We have chores every day and at night… Some nights we go out to AA meetings. We have AA meetings come here every other week; twice a month. On Sunday nights we go to… a contemporary service [at a local church]. They come and pick us up; they’re a great church. Then on Tuesdays we have free time for three hours … and then on Saturdays we have free time. Sundays there is visitation.
With all the focus on class work and study, there was a sense of being in school. Elizabeth described the individual study process that was similar to all the programs:

    Every week our counselor gave us assignments to do which would be like to read books, or listen to tapes or DVDs and then we would have to turn those into our counselor.

    At Ally’s program, the buildings that house the “students” are called dorms, and they follow a schedule of classes and group sessions. In Ally’s program, each dorm housed up to 20 women, and 16-20 was the average number of women reported in each treatment center. She described this as a fond memory: “Twenty women living together! I survived it and I loved it…it was almost like I went to college.”

    This view of the treatment program was almost universal. Grace and Hope were somewhat less engaged than the others, but they also spoke about the classes and teachings as the major structure of treatment. The theme of re-education reflects the notion that each person learned to view themselves in a new light; instead of being damaged or a victim, they came to understand themselves as valuable and beautiful. Instead of expecting abuse and harm from relationships, they learned what healthy relationships were, and had the chance to practice developing more secure attachments while in the residential center. This leads to the next theme that emerged from the interviews, which was bonding.

    **Bonding**

    Elizabeth described the bonding process that happened between her and the women in the home, as very instrumental to her healing. Developing close friendships
was a common theme expressed by nine out of ten women. Elizabeth described this process as follows:

There were 11 of us that were there for the same chunk of time. We all came in the same two weeks. So just being there, things happened. We had a bus accident. A lot of things happened in the home. We walked through a battle with cancer with a staff member. We lost other staff to various things. We had a mono outbreak and we had to leave for five weeks. A lot of stuff just happened. We would have had to deal with issues whether we had any or not. So we formed a really strong bond.

They remain connected and had a few mini-reunions after graduating. Hope also talked about developing long term relationships through the program:

Our group was anything but quiet. We were loud and funny and everyone had a different sense of humor and it was hilarious. We would crack up all day long… I met my good girlfriend in the house. And I still keep in contact with Pam, Joan, and Roberta. Oh gosh, we lost Sue [all pseudonyms]. She’s not dead, but she’s out on the streets and we still worry about her. My girlfriends; a bouquet of roses is what I call them.

Hope continued to talk about administrators and the woman who opened her home to her for a period of transitional living:

These women … I know I could pick up the phone and call them any time and they would give me good advice… I am blessed that the Lord has given me this bouquet of roses. They mean so much to me. They are all yelling at me now, “Don’t go!” But I’m going. But I know they still love me. I have an amount of money put away … just in case this doesn’t work … I could get a bus ticket if I need it. But I also know if I didn’t have any money they would send me a bus ticket.

These close relationships were developed by all participants except Grace, who does remain in contact with program residents through a Facebook link. Bella took her children to visit the program. Most viewed their treatment programs fondly, and some, like Ally, described a reluctance to leave. Because several of the women in this study were isolated either mentally and physically before admission, these close relationships
were valuable elements of the recovery process. Other helpful program elements are the next theme that emerged.

**Most Helpful Program Elements**

The women were asked what program elements they found to be most helpful overall as one of the questions on the semi-structured interview. Ally talked about how helpful her individual counseling was, as did Leigh. Erica identified individual and group counseling as both important and beneficial program elements. Tina stated that she felt the pastoral counseling was the most helpful element, especially because those counselors had gone through addiction themselves. Heather talked about the counseling being helpful, but thought the experience of worship was central to her healing and growth:

> I would say honestly the worship… I know that’s probably not what you were looking for; it’s not counseling. The counseling totally helped… I needed help. I needed someone to guide me. I needed someone to point out to me the things I was in denial about. But the moments I found the most freedom and things that were broken off of me were the times that I had in worship with God where he was my counselor and I was looking up to him.

Grace and Hope thought the spiritual teachings were the best part of the program. Hope shared her thoughts on the program elements:

> I was looking for some magical formula, like [do] 20 Hail Marys, and that will take care of sexual abuse and do fifty pushups and that will take care of the physical abuse. I was waiting for someone to say the right thing that made me feel better, and no one ever did. So it ended up being the spiritual stuff that benefitted me the most. That’s why I said I don’t know how much I healed. I know that stuff is still there in my past. And it still left etching in my brain.

Elizabeth talked about her deliverance from being suicidal to enjoying life:

> That spiritual foundation for me is very important. That is something that you would not find in a non-spiritual setting. I mean if you have been through hell
and back, [because of the spiritual focus] you can have healing, you can have life, and live happy, and want to live.

Bella talked about the general tone and environment of the program:

But I would say that there is just something about the environment. It just naturally causes you to take a look at yourself. I guess I don’t know any other way to explain it than that. Things just happen. There’s all this support there. They’re not going to baby you, but they’re going to be supportive. They knew what my breaking point was. And they knew when to step in. But they knew how to let you feel things. I don’t know if I can pinpoint one part. They were very good about if you needed to talk to somebody, you could go talk to them. Pretty much, open doors. They tried to be available at all times.

Wanda shared her thoughts on program elements, and compared this program to others:

The codependency group was great. The Bible studies were very good. I think just the immersion … you know God being in every single part of everything was really, really very good. The program out there is very rigorous. You know you’ve got a full day from the minute you wake up until the minute you lay down. And that’s actually great. Because there’s so many treatment facilities out there, and I’ve been to tons of them… There was one place in New Orleans I went to where we had two groups in the morning and nothing to do the whole rest of the day but watch TV and smoke cigarettes. You know, that’s not treatment.

Each woman emphasized which parts of treatment were most helpful. Four identified counseling, one selected worship, Hope and Elizabeth focused on the spiritual foundation, and Wanda and Bella identified the overall structure as the most helpful aspect of the programs. Illuminating these choices helps understand their experience of recovery. The next section addresses their least favorite portions of treatment.

**Least Favorite Program Elements**

Not many women offered complaints, but a few were mentioned, and are listed anonymously. Not everyone who entered a treatment program completed it, and the experiences in this study were generally positive. Including some negative comments, although there were few, helps provide a balanced perspective.
If I had to pick one that I thought I learned from the most, that definitely wasn’t the 7 a.m. fitness classes. Definitely not! I used to bring my coffee downstairs and drink my coffee while doing my arm raises... I hated that. It was the worst!

One woman had mixed feelings about the program she attended, and believed she would have had a very different experience if she were to go now. At that time, she was dealing mostly with an eating disorder and addictions. She said:

It was really tough. I mean, in some ways it was really triggering. Because … [you are] constantly being around people that struggle with it and some of them being a lot thinner than you are. And when you have an eating disorder, you are constantly comparing yourself to who is thinner than you are. But I mean … it definitely was comforting in some ways to see that you’re not alone with what you struggle with.

She also expressed some dismay at being placed in such a structured environment:

It was rough. It was very rough, I will say that. It was like literally they had control over everything. You just had to go along with what they said. Like you didn’t really have control over anything…After a while it was kind of nice, because then I could just safely let go of my little control bubble and know that everything was gonna be okay. But … at first I was constantly trying to take control back. But that was a really bad idea as far as clashing with the staff. I did not get along with the staff or the girls. So, it took me a good four months before I actually … got along with people there and actually … talked to people and acted normal … It took me a long time.

Three women complained about living closely with 20 women for an extended time period. However, most viewed that as either a time to bond, or a time to learn to practice skills such as assertiveness, forgiveness, and other elements of personal growth in relationships. Overall, the complaints included one about the exercise program, three complaints about dealing with roommates and conflicts, one complaint about the rigid structure of the program, and one complaint about being triggered by others with the same disorder. Another aspect not touched on elsewhere had to do with leaving the program, which will be addressed next.
Graduation

Despite some differences between programs, discharge was just as important as entering treatment, and required some planning. All the women talked about their graduation date, not the time they completed treatment. The program Ally, Wanda, and Erica attended held graduation ceremonies for the women, and invited speakers and served a meal as part of the celebration. Leigh and Hope’s program also viewed graduation as an event to celebrate, not only for the girls, but for the community that supports the program. Graduation is a natural extension of the theme of re-education.

Heather talked about people who dropped out of the program or left prematurely. Even though this was sometimes very disturbing to staff or other clients, it did occur. She, like Ally, expressed hope that they had gotten the start of a foundation in faith, which might help them focus on recovery rather than falling back into old patterns of addiction or dysfunction. She talked a bit about people who were there when they were not ready to address their issues; some were court-ordered, and some were just difficult to connect with. When clients do leave, the program administrators try to help them plan their next phase of life, and Heather described the process:

After you have been here about 10 or 11 months you fill out a plan … it’s not like when you’re done, you’re done, and that’s it; they’re hands off. They’re very involved. [They ask], “What’s your plan when you complete?” It’s up to you but they’re gonna tell you what they think of it. Like if you say, “I’m gonna move back home where all my druggie friends are,” [they’ll say], “Well, I really don’t think that’s a good idea.” But when it comes down to it, it’s up to me what I do. Like I’m going to the college, but I’m staying here because I didn’t think it was wise to go straight to the college, because that’s a really big change. So this is my transition period. I have a lot more freedom but there are still a lot of rules.

Recovery maintenance is addressed in the final section of this chapter, but planning for it was an important phase of each program. Graduation was a meaningful
milestone for these women, and one they were proud of. Not every person who entered the programs completed it, and all the women viewed this marker with a sense of accomplishment, and as the beginning of a new life.

This section helped to answer the research question, “What is the experience of recovery from the sequelae of CSA, including alcohol or substance abuse, in a faith based residential treatment center?” The themes included: Re-education, Bonding, Most Helpful Program Elements, Least Favorite Program Elements, and Graduation. In order to more fully answer this particular research question, consideration must be given to the entirety of Chapter 4. The next section addresses the changes participants experienced while in the house, which is part of the experience of recovery itself.

Research Question Two

The second research question was: “What changes do participants recognize as part of healing or recovery?” Participants shared what they believed were important changes in their journey to recovery. These changes were collated and summarized by the researcher. Changes participants reported were: depression levels improved in all participants, all nine women with substance abuse issues found sobriety, at least for a period of time (Hope was drinking again), anxiety levels improved in nine women, eight described improvement in physical health, six reported less use of prescribed psychopharmacology, five reported no more suicidal ideation, five chose an abstinent lifestyle after a history of promiscuity, four reported an end to their anorexia, and three reported an end to their bulimia, and lastly, one person who avoided sexual intimacy, was able to get married. Table 4.4 summarizes the changes described and their frequency.
The women in this study identified the changes listed in Table 4.4 during their interviews. Participants were open about their substance abuse problems in the past, and even talked about progress as far as cravings and avoiding temptation. All simply stated that the depression had improved, and anxiety and problems with insomnia had abated, when asked directly. However, when participants were asked to identify three changes they felt were most important to them, the answers differed significantly. Seven spoke about improvements in relationships with others, six described improvements in their self-image, and eight talked about how important learning about faith and feeling loved by God were. These three categories were part of the interviews with every participant, even if not specifically named as the three most important changes. Three participants reported that learning to forgive was one of the most important changes, and nine women talked about it. Other unique responses included feeling more assertive, submitting to authority, and being less selfish, all of which could be part of the relationship category.
Two women mentioned hope for their futures, and one stated she felt she was much more positive overall. These changes are displayed in Table 4.5 below.

Table 4.5

<table>
<thead>
<tr>
<th>Three Most Important Changes as Identified by Participants</th>
<th>Elizabeth</th>
<th>Erica</th>
<th>Tina</th>
<th>Hope</th>
<th>Heather</th>
<th>Leigh</th>
<th>Grace</th>
<th>Bella</th>
<th>Wanda</th>
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Because the women in the study valued these changes the most, these categories of change were identified as major themes and were labeled: Changes in Relationship to Others, Changes in Relationship to Self, Changes in Relationship to God, and Forgiveness as a Catalyst to Change. The following sections describe these processes of change, through the voices of the study participants, in the order presented above.

Changes in Relationship to Others

All of the participants discussed aspects of relational healing that occurred, while seven of them identified this as one of the most important changes for them personally. Most participants reported being isolated from others before entering the program; sometimes that isolation had to do with their substance abuse, but all had some disruptions in relationships which began in childhood. It is not possible to determine attachment styles based on the interview protocol followed, but their stories do suggest
insecure anxious-avoidant attachment patterns (Gottfried, 2004). Feelings of rejection and abandonment and/or of not being acceptable or lovable were expressed by all the women in the study, in varying degrees. Examples of these issues are provided in vignettes below.

Relationship restoration for Elizabeth meant having relationships with males in general. She talked about not understanding her father’s role in the divorce. She also had to work through distress related to the male who molested her as a child and her boyfriend’s sexual attack. She realized she needed to spend some time focused on her own personal growth, and after completing the program, avoided romantic relationships for a year in order to fully heal. She shared: “I used to think, I’m never getting married. I’m going to be a nun. The fact that I am married now is like a huge miracle in itself.”

Falling in love and marrying involved some risk. Elizabeth described her fears and her husband’s supportiveness:

And my husband knew my story and was very supportive of anything that may have been hard for me. He said, “Whatever you need to do, we’ll do. We’re not going to do anything you are not ready for.” Just knowing that he was willing do to whatever it took, made it okay.

Erica’s divorce from a verbally abusive man who was 16 years her senior left her in despair. The marriage was abusive, but it was the most stability she had ever had in her life. She was still bitter about the breakup and in pain at the loss of contact with her daughter. She believed being separated and having to live alone was one of the causes for her depression. But Erica has restored the relationship with her mother since being in the program. When asked how this reunion came about, Erica said:

God tells us to forgive people from the past who have hurt us. Even if I told my mom at the age of 88, which is how old she is now, that I didn’t appreciate her
hitting me so much, it really wouldn’t make a difference. Because God says forgive, and that’s what I did. I forgave my mom and she loves me so much. And I love her so much too…I wish my dad was still around too.

When asked about current relationships with other women, she described living in the halfway house and working on trust issues. She commented further on relationships with males:

I’m happy. I’m happier today than I have ever been. Throughout my whole life, I have always made wrong decisions when it came to men. And I’m just happy because now I have committed myself to the Lord. I’m not having sex until I get married…. But God’s got my heart right now. And God will always have my heart. And if I can’t find someone who loves God I will stay single. Because I’m not going to be smacked by another man; I’m not going to get smacked again.

Tina described herself as having “a big codependency problem.” Besides being the oldest child and dealing with a bipolar mother, she described an avoidant attachment pattern (Schindler et al., 2005):

I can never be alone. I always had to be with a man, but I did not allow them in very far, if that makes sense. I always had to have a man in my life. I was married when I was 19. I was searching for that perfect close love relationship, but I was scared at the same time that I would be rejected by them, so I still kept them at a distance. I cheated on my husband multiple times.

Tina was divorced before entering the program, and described previous girlfriends with whom she shared drugs as those closest to her. When asked about relationships now, she described them as more open, or in attachment terms, as more secure (Barker-Collo & Read, 2003):

Oh, yeah, I have a lot of girlfriends. We talk about things. [It’s] much better. I’m more open with my girlfriends. I find acceptance within these friendships, especially learning about honesty and asking for forgiveness. There’s this new element in my relationships now ever since I learned how to communicate and not be fake and hide behind masks.
Tina, like several others, is purposefully not dating now. And she grew much closer to her mother. She stated that her mother’s mental health problems had improved, but added: “The most important thing, I think, was me putting down boundaries with my mom. And not letting her ruin our relationship by bringing every other relationship into ours.”

Hope’s story does not end as happily as some of the others. Her history included not only CSA, but physical abuse as well as neglect in childhood. Despite those negative events and the years she spent in foster care, she did connect to the people who adopted her as a young adult, and remained in contact with the women at the treatment program. She, like most of the other women, had a history of choosing males who mistreated them in some way. Like Erica, who stated she would have been uncomfortable around a man who was good to her, Hope had no good point of reference when choosing a mate. Her first husband was physically abusive in addition to his substance use problems, and her second husband cheated on her two weeks after the marriage. She shared:

I’d been through many boyfriends. I had ex-husbands. I always had a man in my life and he was always using me but I was convinced he loved me. I sure didn’t know how to pick them; that’s for sure. But I liked men that would talk to me about God because that was always big in my life. I was not always a ten commandment follower and I didn’t go to church but I love to talk about God and the amazing things he has done. But it was important whenever I did pick a companion…. He didn’t even have to be a good guy. He could be a real piece of crap and a lot of them were; but as long as we could talk about God…Some of them were real losers. I also had a lot of trauma in my life that’s why I always picked those losers.

Hope’s current romantic partner has the same trauma history she does, drinks, and talks about God. She may still be repeating her past pattern when selecting a partner.
Heather’s story was centered on her parent’s divorce and her anger at her father. Her recovery involved forgiving her father and reuniting with him, and her voice broke as she described this joyful reunion. She said: “And so now we have that bond and that connection and I can go to him.” She also described a relationship with her mother that is improving. Both of them are working on their issues to break the codependent relationship from the mother’s side and Heather’s tendencies to manipulate her. Heather said: “She’s learning to say no and I’m learning to respect that.” Her parents are still divorced, but her voice had a lilt to it when she talked about the relationship the three of them shared in recent years:

…but whenever I’m in need they come together. Like when I came into the program they came together. They brought me here together. And it’s cool to see how they can put aside all that and be there for me when I needed it.

Other friendships she had from the past have been broken off. She, like several others, is currently focused on her personal and spiritual growth and is not actively dating. She said:

I know I’m not ready for a relationship. I just got my life back. I still have more freedom to get. I’m free from the drugs, I don’t want that back. I need some ‘me’ time before getting into a relationship.

Leigh has undergone a restoration in her relationship with her husband and her parents, most of it marred due to her alcoholism. One of her big issues was a sense of isolation after her marriage, move to another state, and rapid procession of pregnancies. She talked about her social isolation when she entered the program:

I did not have any community whatsoever in [town]. I didn’t have roots there; we did not attend church there. A lot of it had to do with depression and a lot of it had to do with having kids and being depressed and giving all my energy … to take care of them. I had nothing left. I have severe body image issues and I was overweight and just didn’t want to go anywhere and just so uncomfortable in my
skin … I just couldn’t meet people… I have always been socially capable and that was just gone.

Being separated from her extended family and friends also possibly made it easier for her to hide her drinking. Part of her healing process after leaving the program involved connecting with other people, and reconnecting with her children and husband. She joined a gym and took her infant son with her every day. She described their reunion: “I needed that time to bond with him. You would never know from my kids that I was gone, it was such a restoration.” She talked about breaking the isolation that was involved in her addiction, by meeting women at the gym and at her recovery program:

I had my Celebrate Recovery friends at church and then I started to make mom friends from my daughter’s friends in the kindergarten classroom. And to this day I have this core group of girlfriends …And we work out together four days a week, [and] we run marathons together or half marathons. We exercise together at least four or five days a week [and] then go out to lunch and eat.

She became involved with a prison ministry, and developed an independent sales business. Life became full of people and the isolation and loneliness she described before were replaced with a busy life filled with purpose and meaning.

Grace, like many of the others, learned a lot about healthy relationships. She described her former female friends who also had eating disorders and engaged in self-harm as negative influences. She added: “I have always been kind of a loner; more isolating than anything.” She had been in relationships with men who abused her and one who sexually trafficked her. When asked if there was anything anyone could have done to get her out of those sexually, physically, and emotionally abusive relationships, she described a pattern of anxious attachment that put her in danger:

It depends; it would have to have been somebody I really loved and trusted, and they would have had to really say the right thing. Because I was at a point where I
really felt like I loved them, but I was also really scared at the time... just of them hurting me. It was like I went back and forth [thinking] of them hurting me and killing me to them loving me and [thinking] no; they’re not going to do anything to hurt me.

She described her time in the treatment program as difficult, because she found it impossible to connect with any other girls there. After the treatment program, she quickly resumed cutting and her bulimic and anorexic behaviors. She also overdosed, which led to psychiatric care and medication. These seem to have played a more central role in her recovery than the treatment program itself. She married a year before the interview, and described that as a positive, healthy relationship, and became more open with her parents. She talked about initially sharing some of the behaviors she had engaged in while in the midst of the treatment program itself. Her parents were initially against mental health care in general, and refused to pay for it when she was a teenager. As they learned more about their daughter, they have seen her begin to heal with psychiatric care and psychopharmacological interventions. Grace also credited experiences at work, where she interacted daily with the public as part of the reason for her growth in relationship skills. She also said she did dialectical behavior therapy with her counselor after the program and that has helped her develop more relationship skills and become more assertive.

Bella was somewhat isolated before the treatment program. Despite being married with three children, she kept the domestic abuse and alcoholism of her husband, as well as her own drug use, hidden from others. She described this phase of her life:

I didn’t want anybody to see that part. It was a surface thing. My life is perfect. I have this good job and these kids; they’re beautiful. And this husband that’s good looking and you know....My parents didn’t even realize for years how bad it was.
Despite the abuse, she resisted the final breakup. But he filed divorce papers while she was in treatment. She added: “I found that as much as I wanted to stay married it was not helping. I had to finally give up on that and realize it was just not meant to be.” She lost 65 pounds after the separation. After completing the treatment program, Bella lived with her parents for a year, and that relationship improved. She grew up feeling unwanted by her parents, but added: “They felt like they needed to mother and father me again because I wasn’t acting like an adult.” She described two friends she talks with, and has become more open and honest with all the people in her life. She said, “I have a kind of ’I want to fix people thing’ and I think maybe I can do it, and that’s not really the way it works.” She started dating one man who pursued her, but she found he was still troubled by his last relationship and said, “I had to let that go,” which she felt was a major step toward healthy relationships for her.

Wanda was literally isolated when she spent several years “holed up” in an apartment. She was able to quit drinking, and found she had a desire for friendships. She shared a description of an avoidant attachment pattern (Leonard & Follette, 2002): “It has always been hard for me to make connections with women…I realized it was something I wanted and I never wanted it before.” While living in her apartment, her father and step-mother were her only acquaintances, and she avoided them as well. But things changed since entering the program and she described it this way:

Since I am here, I’ve got friends, and I am in school, now, and I am able to just have acquaintances and I never could before. Everything was really intense. …If I sat down and talked with you, I needed you to know the depths of me.
She used to avoid people, and then when she would meet someone she wanted to talk with, it was difficult for her to know how to connect. She described this deep need to be accepted, but how she constantly felt rejected:

Exactly, because then they mean everything to me because they are the first person I’ve talked to in like a billion years. It’s just overwhelming for them and for me. And then I feel rejected. And then I never want to talk to anybody ever again. It’s just this vicious cycle.

Now she has found a way to trust and connect. She characterized it this way:

It’s just not like that anymore. I have people at school and we talk about class stuff and then go our separate ways... It’s not all so intense and…of great consequence because I just have so many more people in my life now…I can spread [myself] around, and I get this from this person and that from that person. My needs get met without exhausting anybody.

She has a more honest and open relationship with her father and stepmother and is not interested in a relationship with her mother, which she feels would be destructive. She is also not interested in a romantic relationship. Despite the improvement in relationships overall, she was still avoiding romantic ones. She shared:

I’m deathly afraid of marriage. I still am...I just assume if you get married, you’re gonna get divorced and I’m just not interested in marriage.

Ally characterized herself as an “isolator.” She tended to drink and do drugs in secret, away from her husband and family, and still finds a need to fight her tendency to spend time alone. The restoration of relationships involved the one she had with her husband and children, which improved after she found sobriety. She said her husband had some trust issues with her, and that eventually the marriage became healthier. When asked to describe her marriage today, she replied:

Well, we have changed and I have become more of an individual. I’m not dependent on him. Like he would have to (not have to, but I let him) put gas in the car. And now I haven’t let him put gas in the car for years and years and years. I
have just become more independent. I would let him treat me like a child and he doesn’t any more. So we get along a lot better.

Ally talked about changes in herself, including learning to handle conflicts and relationships in a healthier way, after having gone through the program. She shared the following:

And I learned how to really be honest with people. If they were doing something that bothered me, or that was wrong; you know they were talking war stories or something. I would just talk to them and tell them how I felt without being mean… That was something very different for me; very different. Because I had always been like: “It’s okay, it’s okay.” [I was] a people pleaser. And I fall back into that sometimes.

Each of these women was in some type of dysfunctional relationship; or no relationships at all before entering residential treatment. CSA is an attachment trauma (Allen, 2008), and one way of explaining this aspect of recovery is viewing it through the lens of attachment theory. These women did not know what healthy relationships are like; even Leigh, who experienced her CSA at an older age than the other women, grew up with a very angry, controlling father who she obeyed without protest until she was almost 30 years old. Most of the romantic relationships described were dysfunctional, if not abusive. Not only were these women mistreated by the men they encountered, Wanda, Erica, Hope, Bella, and Tina shared feelings of betrayal by their mothers. Currently, Tina, Heather, Erica, and Wanda are avoiding romantic entanglements as they continue to work on developing a healthy sense of self and preparing to meet men who would treat them in ways that agree with their improving positive self-image.

Bella, Grace, Tina, and Heather believed the separation from toxic individuals while in the residential program promoted healing and sobriety. Teaching on codependency was mentioned by several of the women as a program element that really
helped them to gain insight into some of their behaviors and dysfunctional relationships. For many women, learning that they had value through the religious teachings helped them begin to understand how they should treat others and how others should treat them in healthy relationships. One participant stated that she would not know how to react to a male partner who treated her with kindness; she had never experienced that before the program.

In addition to the changes in relationship qualities and styles reported by these women, participants also identified changes in relationship to self as being a very integral and important aspect of recovery. All reported a very negative self-image before entering their respective treatment programs and all described improvement in this realm. This theme is addressed in the next section.

Changes in Relationship to Self

Throughout the interviews, all these women expressed problems with self-esteem and many with outright self-hatred and suicidal ideation; seven voluntarily mentioned they were suicidal and five stated they were hospitalized for suicide threats or suicide attempts. The term self-esteem is sometimes used interchangeably with self-concept, but is “one's attitude, opinion, or evaluation toward oneself; it may be positive (high), neutral, or negative,” (Reevy, 2010, p. 520). Darity described self-hatred in the following way:

Self-hatred is as much a cause of as well as a result of depression, anxiety, substance abuse, and gender ambiguity. It can therefore be viewed as both the hub and a spoke of the wheel of social misfortune. As a hub it represents the central role that the self, however damaged or elevated, plays in the dynamics of social life. As a spoke self-hatred represents one of the negative consequences of the socialization process itself. (Darity, 2008, 417)
Self-hatred is part of the findings under the heading of “relationship to self.” Self-hatred and suicidal tendencies are two of the many outcomes from a history of CSA that have been noted in the literature (Abdulrehman & DeLuca, 2001). A negative self-image is also part of an insecure attachment style (Clinton & Straub, 2010).

In this study, a negative self-image and self-hatred were reported by women who engaged in risky behaviors, such as dating drug dealers, working as a prostitute or in a strip club, or promiscuity. Reported self-harm practices included suicide attempts, as well as cutting, and engaging in eating disorders. Self-hatred is not only connected to CSA victims in the literature (Abdulrehman & DeLuca, 2001), but is one of nine affective states that have been measured in an attempt to identify suicidal patients (Hendin, Maltsberger, Haas, Szanto, & Rabinowicz, 2004). In addition to self-hatred, seven of those other affective states, including guilt, loneliness, rage, abandonment, anxiety, hopelessness, and humiliation were each mentioned by one or more women in this study. Low self-esteem has also been connected to depression (Franck & Raedt, 2007) and low self-esteem has been connected to affect regulation in general (Wood, Heimpel, & Michela, 2003). If self-hatred is an extreme version of low self-esteem, as measured in these studies, then these women have correctly identified how important changes in their view of the self are. Having a self-image that was marred by CSA and subsequent events such as they described, molded the way they interacted with their worlds. Figure 4.1 displays the way emotional states and behaviors are related to self-hatred or a negative self-esteem, as reported in this study.
Elizabeth, who did not recall her CSA until she was in her early twenties, and dealt with an eating disorder for 20 years, described her self-esteem as negative when growing up:

I had this whole repertoire of things I’m doing well. But I still felt like I was a failure. I felt like I was never going to get anywhere or do anything… I couldn’t see what everyone else saw. And so I was still striving to find something to make me feel like I belonged or was accepted; even to myself. I hated where I was. I hated everything about me in and out. I hated it. But I was a good Christian girl. I sang with the worship team, helped in the children’s department and volunteering and doing all these things. But I hated myself. It was pretty exhausting; masking it all the time.

She stated that she internalized other people’s statements, which added to her negative self-image. She also felt that if she died no one would care. Her sister was hospitalized for a few days for suicidal ideation, which caused Elizabeth to be even more afraid to share her thoughts. She actually attempted suicide a few times after the flashbacks began and her boyfriend raped her:

And I had just realized this whole traumatic situation had happened in my life and then this other traumatic thing happened. And that was a mess. Somehow I finished my graduate program. You know basically it was like I didn’t want to
live anymore. I tried to kill myself a couple times…And the last time I tried to kill myself a friend of mine got a hold of me and kind of stopped me from following through. She actually took me to her counselor.

In recovery, Elizabeth learned to counter negative thoughts and practice techniques to build her self-esteem. She maintained those practices after completing the program. She talked about waiting to be able to see something good about herself in the mirror and one of the great changes she identified was:

[It was] believing that I was worth something at all; that I was beautiful. It was one of the points I never could see. I definitely have come a long way in that, but there are days when I still struggle… I have to remember that these are just feelings and they go away. Like they say; I still have to do work. I have to remind myself I am a beautiful daughter of the King. If I don’t I would go back there to [thinking] “I’m ugly, horrible and miserable.” It can come back easily.

When asked if these changes added to meaning and purpose in her life, she emphatically stated: “Yes. I want to live. Yes!”

Elizabeth’s story is typical of the changes from a very negative self-image to a more balanced perspective as described by these women. Erica also said, “I tried to commit suicide a few times.” She described herself and reasons she sought treatment:

I knew I had a problem with drinking, and I knew I had a problem with sex, and I knew I had a problem with just hating myself and not believing in anything.

She described her husband as verbally abusive, and said he called her “worthless, dumb, fat, and ugly” and she also thought of herself that way. After the program, she described a much better view of herself:

I am good. I am a good person, and I am good at a lot of things. I am smart. I am beautifully and wonderfully made. I got that part right out of the Bible! A few years ago I would have said beautifully and wonderfully made with what?
Tina stated that she had been diagnosed with depression before entering the program. She did not use the word suicidal, but described her previous life in the following words:

And I needed money and I wanted drugs and I started using needles at that point, shooting up prescription pain killers. My life was a mess. I had no hope for my future. You know I couldn’t get out of what I had dug myself into.

She described the way her newly found faith strengthened her self-esteem and improved her outlook on life:

Well, I definitely think I’m worth more than a piece of trash. Sometimes, you know, things will come up. Rejection issues: that’s what I really struggle with…No matter what they say to me or what they do to me, I have to stand on the word of God. I am made perfect in him. I am the apple of his eye…I must wash myself with these truths that God says about me. This is what keeps me strong and what protects me from what others may say about me.

Hope, who has been hospitalized several times, at least once for a suicide attempt, talked about self-image, self-esteem and self-hate:

I really have had none my whole life…just negative self-image… Not only did I not have any self-esteem but I hated myself sometimes. It’s getting better...It comes less and less these days. I would have this loathing for myself at times. I have always had that ever since I was young; wishing I was somebody else.

She went on to describe how her boyfriend corrects her and coaches her. He will contradict anything she says about herself that is negative:

He’ll jump on me when I’m like, “You dummy,” because I say that all the time. Or, “I’m so stupid or I’m so fat or so ugly.” He always says, “Stop ripping on my girlfriend. I’m gonna get really mad at you because I love her.” Isn’t that sweet? He’s been great for me. We’ve been trying to mature me because trauma has a way of causing you to stop maturing. And I had so much in my childhood. Like my dad held me over a gas stove when I was 16 months old. I really think my brain chemistry is screwed up. There are times when I just really feel like I’m not normal. I just can’t complete a thought or can’t complete a project. You know I hate myself...those things aren’t normal. I have been trying to mature and be a healthy woman.
As a young girl, Heather endured bullying along with her experiences of CSA. She started cutting in middle school and developed an eating disorder, both of which have been linked as common co-occurring presentations in the literature (Cabrera 2011).

She described her self-image in the following way:

My self-esteem was very low. I mean ever since I can remember I had very low self-esteem…When I was… in fifth grade the kids would pick on me and tell me I was fat and that really stuck with me. And then I’m sure some of the sexual abuse too…it just left me feeling dirty and so I felt very ugly and unwanted. Nothing I did was ever good enough; nothing I did was ever right. I was just a mistake. I was a failure. And so that’s why in middle school I wouldn’t eat… I was anorexic and bulimic, I guess. I mean I was never seen by a doctor or anything like that. But I wouldn’t eat and then when I did, I would make myself throw up. I wasn’t that healthy then… And by the time I came to the program I weighed about 90 pounds. I’m about 5’3” or 5’4”, and so 90 pounds was not good…I was like skin and bones.

Heather reported a very negative view of herself and her future before the program:

I didn’t see a future. I thought I was gonna live and die as a junkie. And that I would probably die from an overdose. I mean that’s what I thought was gonna happen. I wanted to die high, that was my goal. I didn’t see any future. I was positive I was going to die young. I wanted to die.

When Heather was asked about the most important changes she experienced, she said:

“That I don’t hate myself anymore.” She described a time in the program when she could look in the mirror and see something beautiful there. She added that she was still working on those issues and described a more realistic picture of herself after the program:

Before I felt that everything that happened to me was my fault, and that I was a horrible person and I must have done something wrong to deserve all of that. But now I know that it wasn’t my fault…I didn’t ask for it. It was nothing that I did, you know? It just happened.

Before entering the program, Leigh shared how she felt about herself:

But I got to a point where I couldn’t function and so we had to have someone to come in and care for my children. [I] just lay in bed [and] got very bad. I was just a wreck. I was very suicidal; I just didn’t want to live. I just really thought my
family would be better off without me….It [my self-esteem] was trashed when I got here. I had nothing when I got here. I mean as low as you can get in self-esteem; that’s where I was.

After completing the seven months in the program and going home with follow-up care in a special transition period, Leigh fell back into drinking. She described this time period in the following way:

After a couple more months of really trying hard to not just freak out I went to my husband one night and said if you don’t do something, if you don’t take me somewhere to a hospital… I don’t care where, if you don’t take me somewhere, I am gonna die…It was just a very frightening time for me to know the truth but to be constantly battling and attacked by suicidal thoughts...I ended up going to a psychiatric hospital under a suicide watch.

Leigh described her ongoing body-image issues, which seemed to contradict her statements about self-esteem:

And now my self-esteem is fine. I mean, I deal with the image of my body, of desiring certain things, cultural expectations, some…body hatred....I have to really fight that my reflection in the mirror does not define me…. What I see in the mirror does not define who I am; but who I am is defined by my heart and not my body. And as long as I am healthy and I am not damaging my body… I mean, I just ran 13 miles for crying out loud. I mean, come on! That’s crazy. That’s insane that I would have issues with it, but it’s just body image. But self-esteem; I feel great. I feel great.

Grace also has issues with self-hatred, and described her negative self-talk as an ongoing battle, very much connected with her eating disorder.

I just felt like… like I just hated myself and it was like every pound that I lost, the better I felt about myself. I just had a distorted image, and so every time I looked in the mirror… I saw something different from what everyone else saw.

Grace had multiple suicide attempts, beginning at age eight. She said, “I’ve been to the hospital like a million times.” She reported suicidal thoughts and feelings at the time of the interview, but instead of acting on them, as in the past, she is able to see them as
temporary, and part of her illness. When asked what helped her negative self-esteem improve, she said:

I still feel that way sometimes when I’m like really, really depressed. But part of it is from just reading different Scriptures that tell me different things. Part of it is also just having my husband telling me differently.

Although Grace was dealing with severe mental health symptoms, she said: “Overall, I’m a lot happier than I was before.”

Bella, who did not mention suicide, did talk about low self-esteem and about feeling unwanted as a child:

Now my mom and I have always had a tumultuous relationship; always, from the time I was a small child. I was the third child. I was not planned. I was an accident … they said they wanted a third child, but it was just not the timing that they intended. But I was a very clingy baby and my mom could not stand it. She just could not stand it. I always wanted her attention. She needed her space. I was the third child and she was tired. I think I always sought to have their acceptance; she and my dad, really. I wanted them to think I was the greatest thing. I tried academically, went to art… Anything I could think of I tried to do well in… There [were] three kids and a lot going on; you’re all the time feeling like there’s not enough [attention] to go around.

Bella expressed dismay that her parents never acknowledged the possible damage from the years of sexual abuse she endured at the hands of her sister. She constantly compared herself to this sister who she viewed as the favorite child in the family. But she did indicate some improvement in her self-image and self-esteem. She stated that it was helpful for her to learn she is a new person, and not just a recovering addict. She also declared, “I think that I know now that I’m worthy of more than what I was living before.”

Wanda stated that she used to fantasize about drinking herself to death, and she was hospitalized multiple times for suicide attempts. She described it this way: “All my
attempts at sobriety have been preceded by a suicide attempt. It’s sort of like of my M.O.” She was bullied and teased as a child, neglected and lied to by her mother, raped as a young girl, and felt rejected by the entire major metropolitan city where she grew up. She described some improvement in her self-esteem after the program, which was closely related to her relationship with God:

I didn’t know consciously that just because they said it didn’t make it true. So I just let everything they said get into my head and destroy me…People are going to have their opinions. But God’s opinion is what matters and I don’t have to prove anything to Him. I mean…He already knows!

Before entering the program, Ally said: “My self-esteem was gone. I just…I guess I kept thinking of how I was raised that I was not good enough.” She talked about internalizing other voices, particularly her critical step-father, and described being caught in a cycle of shame and remorsefulness while trying to stop drinking. Ally was using alcohol and drugs, and although she did not speak about suicide, she did talk about recognizing how dangerous her alcohol and drug use had become:

It was really bad, because I drank all the time and did pills. Yeah, it was pretty bad. I would have been dead in not too long… if I hadn’t come in here…It was almost like it wasn’t blood running through my veins, it was alcohol. And it was not even like I felt it. I couldn’t really handle it. I would be sick for days and days …if I didn’t start drinking the next morning … And I would be sick almost like alcohol poisoning. I would just lie in the bed not being able to move. I would get so sick. It was terrible.

Despite this level of illness, she had to be forced to enter treatment.

As their self-image and self-esteem began to improve, a few of these women literally began to see beauty in themselves. Elizabeth began to see it during the treatment program, as did Erica, Heather and Tina. Tina described the change:

I can remember in the program hearing them say, “Oh, I remember when I looked in the mirror and …[thought], “Wow, I look good!” And I remember thinking, “I
wonder what that feels like.” And then finally it started happening to me… I’d [say to myself], “My eyes look really pretty, or wow, I look really pretty in that picture.” And that had never really happened [before].

This section included vignettes from all ten women about their views of themselves before treatment, and improvements thereafter. In addition to the initial damage caused by the CSA, Bella and Wanda reported being retraumatized when they disclosed the abuse to their mothers. Hope shared how she wept and worried she could not find healing. She said: “Now I can see that you’re never too damaged that you’re not redeemable.”

Several program elements were connected with healing of the self. All the women talked about how love from God and feeling accepted by God helped them begin to accept and love themselves. Having a spiritual foundation was also identified as instrumental for their overall recovery. Six women described feeling personal responsibility for the CSA, and learned in treatment to properly attribute the blame to the predator. Several women spoke about how learning to forgive aided healing. Forgiving others helped to set them free from anger and bitterness as Tina described the process, and forgiving themselves was also a vital step that helped free at least one of them from guilt. Others, like Erica, expressed relief at finding similar wounded souls who endured the same abuse, which made them feel less “chronically unique.” Four women identified the individual counseling as an important program component, while others identified worship, being in a supportive environment, and the time necessary to “dig deep” to get at the root issue as critical parts of the healing process. Elizabeth described a form of Christian cognitive behavioral therapy that was utilized in her program and which helped her self-esteem and self-image improve:
We went through a very specific counseling module I guess, where they are all about healing for yourself and others… some of the things…what hurt you, how did it hurt you, how do you forgive people, how do you forgive yourself, and what are the lies you believed? That was one thing that was so vital for me. [We would] write everything down whether it is true or not; write what you believe about yourself, write everything. I had 12 pages. [I realized] this is all lies. Saying I was ugly and all... and so finding scripture that replaced that lie with truth [was powerful]. [We] read and believed the truth about who we are and pinpointed that this is a lie.

As evidence of a healthier self-image, five women reported choosing to be sexually abstinent for a period of time, which also reflected a respect for the self. Feeling loved was something new for any of these women, and that began by exploring Christianity.

The next theme to be addressed is changes in their relationship with God.

Changes in Relationship with God

Not every woman who entered treatment characterized herself as a Christian before entering the program and some were definitely hesitant about entering a religiously based treatment program. But during the interviews, all of them talked about their faith, and five identified love from God and two identified spiritual teachings as one of the most important changes they experienced while in treatment. Enduring misfortune of any type may lead a person to question the goodness of God, but going through a traumatic event like CSA has been noted to either block or change one’s spiritual outlook (Gall et al., 2007; Houg, 2008; Ryssel, 2010).

Elizabeth was a Christian before entering her program. Her relationship with God deepened during the time spent studying the Bible while in the program. Elizabeth found that by replacing lies she told herself with Scripture, she was able to resolve some issues, including her anger at God:
And so when I realized that I was angry, I saw that I was angry at God. When my dad left the family I think that hurt pretty deep. I was feeling like he must not love us to be gone. And so on. I didn’t know what to do with that information. So I thought if I am angry at my dad… I must be angry at God too. So I really had to separate my human emotions towards humans from my emotions toward God. And He was very gracious to me. I was not very nice.

Erica said that before she came to the program she believed in God, but did not have a spiritual life. When asked how she would describe her spiritual life now, she responded with a breaking voice:

It’s really good. I know I am loved, even if nobody else loves me. I know somebody loves me. . .It’s a happiness; it’s happiness, and I haven’t been happy in years.

Tina held a very negative view of God before entering the program. She attended a Catholic church as a child, but held a very toxic view of Him, which she described:

I always saw God as a punishing God. I went to CCD class when I was growing up. I made my communion, but that was it. I definitely did see God as a punishing God, and didn’t think that I was ever going to be good enough for God.

Despite this negative view at the entry to the program, in twenty pages of her transcribed interview, she mentioned God thirty times. When asked what made the difference in this program compared to the two other secular programs she attended, she replied:

[The difference is] my relationship with God and allowing the Holy Spirit to come into my life. Reading the Bible; reading the Word. Learning more about myself and how God sees me rather than how the world sees me…I have tried it other places and how to do it their way, and it didn’t work for me…Learning about God’s love was the pivotal point; that he has plans and a future for me. He knows me, the very number of hairs on my head; to be loved and accepted by God.

Hope talked a great deal about God both before the program and after it. She shared how her relationship with God was similar to the one she has with her adoptive parents:
I learned I didn’t have any information about God. Like I didn’t understand that we are to have a relationship with him. I didn’t understand that there was a Bible that I could read and apply things to my life. I always listened to God as a disciplinarian and I wasn’t doing a good enough job. Even though he would go out of his way to tell me he loves me. But because I wasn’t living my life the right way I felt like he really didn’t want anything to do with me in my daily life; if that makes any sense. Or he didn’t want a relationship with me. It’s just to love someone and not want a relationship with them. My parents have done that to me at times and I understood why. So, now I know that I can have a relationship with him every day and I can apply what’s in the Bible and I can understand it and that he loves me even when I don’t do the right thing. I think I understand a little bit more about grace. And actually I understand a little bit more about what forgiveness is.

Heather vaguely recalled going to Sunday School as a child, but described no other elements of a spiritual life. But after the program, she felt that having a secure relationship to God helped her view herself differently and it was the change that meant the most to her:

Before I was looking for love; I just wanted to be loved and I couldn’t find it. And I was so hurt and…I just hated myself because I thought I was unlovable and that I couldn’t be loved. So when I came here and I learned about Christ’s love I was like it’s just too good to be true, it just can’t be…And when I finally let myself open up to just how much he loved me, I realized that that was the love that I was looking for the whole time… It’s a love so strong and so pure [and] it’s despite anything that I have done. And that would be the biggest change that meant the most to me.

Leigh said she grew up in church and was saved as a young girl. She said she saw God as a father figure and then went on to describe her own father, who used anger as a way of control. She said that in the program, she realized, “I knew God but I don’t think I knew Jesus.” Realizing that she could go to God, just as she was and not after she got her life cleaned up was a pivotal revelation for her.

Grace described a period where she turned away from the Christian faith she was raised in. Her father was a church pastor, but she experienced “a life of hell.” Sexually
abused from the age of five until twenty, she developed an eating disorder, engaged in cutting, and made many suicide attempts, beginning at age 8. She said she turned away from God around the age of ten and described her negative thoughts at the time:

And I thought, “God, you obviously haven’t let me die yet, so you must not really care about me and what I want. And you’re letting all this stuff happen to me, so you must not really care about me. So I am just going to do whatever I want to do and not care about you.” …Then I pretty much got into a whole bunch of stuff that I really shouldn’t have gotten into. That’s when everything got worse…

Grace got involved in Wicca and forms of witchcraft that clashed with her Christian upbringing, and continued to attend church with her family while involved:

I hid it really well. It was like I was doing all this stuff on the side. I was going to church and acting like the perfect Christian girl. So … I felt super conflicted on the inside and that just made me feel a whole lot worse. Some of the people that were hurting me were people who were supposedly really Christians …. So that is one reason why I was so against it at the time.

She said she found healing and a renewed relationship with God through the treatment program. She still uses a form of Christian cognitive behavior therapy she learned there to help her battle against negative self-concept issues and just for encouragement.

Bella said she grew up going to church, but her view of God became more relational and active in her life after the program:

For one thing I do have hope… I know that God is watching out for me… I know that he is always wanting the best for me. He is never going to get me into something or put me through something that he’s not going to help me out of. That was something I never trusted before. I didn’t trust that God could get me out of some of the situations that I had gotten myself into.

Wanda considered herself deeply spiritual but not religious when she entered the program. She laughed, describing her expectations and her surprise at being immersed in the Bible. However, she found that everything being centered on God was helpful. She shared her thoughts on how her relationship to God changed:
Once I sort of got in touch that God is the most important thing to me, then other things fall away. Other things that seem so pressing and so important like other people’s opinions of me; they just don’t seem so pressing. Because I don’t put so much value on what they think, because I know what God thinks, and God trumps everybody.

Reading the Bible was a new experience for Wanda, and she shared her thoughts on how this aided her perspective of life:

The Bible reading helped. It helped a lot because it established in my mind that the world doesn’t revolve around me because I am nowhere in there. So how much consequence could I really be? …I find it very comforting to tell myself [that]. Because that means I can make as many mistakes as I need to make. It’s not gonna throw the earth off its orbit and axis and send it spinning out into oblivion just because Wanda gets a speeding ticket.

Ally had fallen away from her faith when she and her husband experienced a break with their former church. Ally said that she did not want to come to the program, despite the fact that she was a Christian. Describing her expectations, she said: “Oh gosh, they were going to be Bible thumpers. And they were and I loved it!” She said God is an important part of her life now and described why she feels that way: “Just knowing how much he loves me and that I am his daughter and he is my father and that he loves me, just as I am.” When asked about her father’s death, she blended both her biological father and her heavenly father in the same response:

My father passed away my birthday weekend. We had a relationship. I don’t know if he was that one that abused me as a child, but that was then. But I know the Lord loves me unconditionally.

This section demonstrated how significant these women felt having a relationship with a loving God became for them. It helped them begin to love and accept themselves. All of the women talked about the Bible studies and the teachings on spiritual truths as important program elements. Having a relationship with God is also part of the discourse
on attachment theory (Beck & McDonald, 2004; Clinton & Straub, 2010; Fujikawa, 2010; Morúa, 2008; Proctor et al., 2009; Salerno et al., 2010), and has been shown to either compensate for a lack of close relationships in real life, or correspond to relationships with others (Hall et al., 2009; Reinert & Edwards, 2009). For these women, having a negative view of God may have corresponded to the negative father figures or male abusers in their lives, or, as Elizabeth and Grace described it, they were angry at God for the negative events they experienced. Spiritual integration is an important part of mainstream therapy and a variety of ways that religion and spiritual beliefs and practices impact health have been explored (Gall, 2006; Gall et al., 2007; Ganje-Fling & McCarthy, 1996; Houg, 2008; Knapik, Martsolf, & Draucker, 2008; Reinert & Edwards, 2009; Reinert, Edwards, & Hendrix, 2009; Worthington & Sandage, 2001). A positive view of God can enhance one’s spiritual coping and changing one’s view of God from distant or punishing to loving enables one to utilize those skills (Murray-Swank, 2003; Murray-Swank & Pargament, 2005; Pargament, 2007).

The next theme to be addressed emerged in conjunction with the former three. The practice of forgiveness was connected to these women’s view of themselves, of others, and how they understood God.

Forgiveness as a Catalyst for Change

Forgiveness has always been a central theological tenet of Christianity, but it has also entered the clinical literature in recent years. According to Bash (2007), “forgiveness is a moral response to wrongdoing,” (p. 166) and must remain grounded in ethics. It is an interpersonal response, with much complexity, and may or may not involve
reconciliation.” For these women, reconciliation is not necessarily a healthy response to every relationship. It is difficult to isolate forgiveness from the restoration of relationships with self, others, and God, but it is an important thread that ran through the stories of these women. Bash further comments on and clarifies forgiveness:

One also has to [recognize] the limited extent of human forgiveness. Human forgiveness does not – and cannot – undo the past or free people both from the consequences of what they have done and from what Arendt calls ‘the predicament of irreversibility’. Human forgiveness and the process of which it is part do not exculpate the wrongdoer (Bash, 2007, p. 168).

Most of the women talked about forgiveness as part of their process of healing. Some found it very helpful in both their relationships with others and in their relationships with themselves. Elizabeth summarized the importance that forgiveness held for many of the research participants in the following statement: “Learning to forgive was huge, huge, huge!” Not surprisingly, she identified forgiveness as one of the three most important changes she experienced.

Erica described the key role forgiveness played in her relationship with her mother and her joy at their reunion. Tina also described how central forgiveness toward her father was to her recovery process and believed it to be one of the most important changes that occurred in her life. She stated:

Getting a revelation of simple truths, such as He loves me with an everlasting love, and He forgives me, no matter what, were the eye openers for my healing process to begin. [I could] accept myself because Jesus accepts me. For me, knowing the truth about Jesus, and who He is, helps me the most. He can relate to me, through every situation. The best part is that Jesus knows what I went through; he knows what I’m going through. Jesus felt the same things I felt: [such as] not being able to speak when I couldn’t defend myself. He knows what it was like to be ridiculed and humiliated by strangers. I really meditated on it, you know? I just felt this freedom to no longer hold onto these situations that happened to me. To experience the presence and love of God is what truly set me free.
Hope is just learning about forgiveness now, two years after completing the program. She described her feelings on the subject:

I am learning how to forgive and I’m learning how to restore my mother. But I don’t believe with all the damage that’s been done [to me]; that that’s gonna be done in one day. It’s gonna take a little while. Starting small, with like people cutting me off on a road; I can do that. And people who I might work with who might do me wrong. Or Guy—he makes mistakes. It’s gonna take a while for people who abused me or assaulted me in any way.

Heather, like the rest of the women in this study, dealt with a lot of negative self-image and self-hatred. When asked if that change had anything to do with forgiveness, she responded:

Oh, yeah totally. It was really hard. It was really hard. It was a process. I had to forgive myself over and over. And then new stuff came and I had to forgive myself for that. And then I would forget that I forgave myself and I had to forgive myself for that. A lot of that had to do with knowing that I am not that same person. I am a new person; I don’t have to carry that guilt and that weight any more.

When asked to identify three important changes, Heather emphasized forgiveness:

Learning how to forgive those that have hurt me, sexual abuse issues, how to forgive my mother, forgive myself, to forgive my father to a degree for not being there all the time; learning how to forgive. It helped me get rid of all that anger, bitterness and rage I had inside.

Wanda did not mention the word forgiveness, but she did say she was less distrustful of people in general, and believes that improvement had to do with putting her mother and others who have hurt her into a better perspective. She described it this way:

I just don’t feel that way anymore. I think that’s the biggest difference. I just don’t feel that way now. I know that she [mother] was the exception, not the rule. A big old exception! A big old exception! If someone hurts me it’s not the end of the world and it doesn’t mean it’s happening to me all over again. It doesn’t mean anything; it means they are a jerk and the world goes on.
Of the ten participants, nine mentioned forgiveness; six vignettes were included above. Forgiveness was identified by three women as one of the most important changes they experienced in recovery. Forgiveness was not one of the items on the Semi-Structured Interview Protocol (see Appendix D), yet emerged as a common theme through analysis of the interviews.

The Bible teachings in every program addressed forgiveness. In Tina and Heather’s program, forgiveness was part of individual study packets as well. Elizabeth and Grace described forgiveness as part of the counseling process they underwent. For Elizabeth, Tina, and Heather, forgiving themselves began the process of improving their self-image, removing self-hatred and suicidal thinking, and in self-harm practices such as bulimia, anorexia, and substance use. Forgiving others played a role in the restoration of relationships for eight women. And five women mentioned it in conjunction with the development of new relationships. Forgiveness was mentioned in conjunction with spiritual practices and love for God by five women. Three reported less negative affect related to anger, bitterness, and guilt because of the practice of forgiveness. Table 4.6 displays the frequency that forgiveness was mentioned in relationship to self, others, God and spirituality, and negative affect. Under each of these headings, the table indicates the improvements in these realms reported by each individual, if specifically mentioned in connection to forgiveness.
Table 4.6

_The Role of Forgiveness in Recovery_

<table>
<thead>
<tr>
<th></th>
<th>Elizabeth</th>
<th>Erica</th>
<th>Tina</th>
<th>Hope</th>
<th>Heather</th>
<th>Leigh</th>
<th>Grace</th>
<th>Bella</th>
<th>Wanda</th>
<th>Ally</th>
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<tbody>
<tr>
<td>Forgiving self</td>
<td>X</td>
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<td>Improved self-image</td>
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<td>Lack of self-hatred</td>
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<td>Lack of self-harm</td>
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<td>Feeling beautiful</td>
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<td>No longer suicidal</td>
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<tr>
<td>Forgiving others</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>Restoration</td>
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<td>New relationships</td>
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<tr>
<td>Forgiving God</td>
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<td>X</td>
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<tr>
<td>Less negative affect</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Anger</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Bitterness</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Guilt</td>
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</table>

This section described changes in how the women in this study felt about and regarded themselves, changes about how they interacted with others, and changes in their relationship with God. Additionally, participants described forgiveness and how it played a role in all of these changes. These themes address the research question “What changes do participants recognize as part of healing or recovery?” by exploring those changes interpersonally, intrapersonally, and spiritually. Table 4.7 summarizes this research question, and indicates when forgiveness was mentioned as a method or approach to those changes. The final research question seeks to understand how the women in this study believe they have been able to maintain the changes they described after leaving the residential program.
Table 4.7

Summary of Changes Reported by Participants

<table>
<thead>
<tr>
<th>Changes reported</th>
<th>Mediated by forgiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes in relationship to others</strong></td>
<td></td>
</tr>
<tr>
<td>Separating from toxic individuals</td>
<td></td>
</tr>
<tr>
<td>Developing new healthy relationships</td>
<td>X</td>
</tr>
<tr>
<td>Restoration of broken relationships</td>
<td>X</td>
</tr>
</tbody>
</table>

| Changes in relationship to self        |                         |
| Negative self-image became more positive |                         |
| Appropriate attribution of blame       |                         |
| Forgave self                           | X                       |
| Began to accept self and love self     | X                       |
| Began to see beauty in self            |                         |
| Lack of self-harm                      | X                       |
| Lack of suicidal ideation              | X                       |
| Less negative affect                   |                         |
| Cessation of risky behaviors           |                         |
| Abstinence from addictive behaviors    |                         |

| Changes in relationship to God         |                         |
| From distant to close                   |                         |
| From punishing to loving               |                         |
| From anger to forgiveness              | X                       |

Research Question Three

The last research question was, “How Are Graduates of This Program Functioning Post Treatment?” Recovery maintenance is an area of research that was birthed out of addiction studies, but is applicable to all therapeutic gains (Friedrich, 2003). Relapse prevention is an area of research that is critical when dealing with chronic behaviors such as eating disorders (Sosin, 2008) or addictions (Brandon, Vidrine, & Litvin, 2007); all the participants either had one or both of these conditions. Participants were asked to describe how they are doing and what they are involved in as far as maintaining the gains they have found. Six women reported that they continued with
counseling or psychiatric care after completing the program; three are in leadership of recovery programs and have access to pastoral counseling and materials on a daily basis. Two reported going for marriage counseling after the program. Five either lead or attend 12-step groups. Nine reported some type of self-imposed barrier to avoid temptation toward relapse. All women reported continuing to attend church, reading their Bibles, and praying. One attended another residential program after the one in this study, and two lived in a halfway house. All reported how important having healthy relationships are. And lastly, four described how sharing the story is an important phase of recovery. Table 4.8 summarizes their responses. The following themes emerged through analysis of their interviews: Self-imposed Barriers, Spiritual Practices, Participation in Recovery Groups, Continuing Mental Health Care, Sharing the Story, and Connections Instead of Isolation.

Table 4.8

<table>
<thead>
<tr>
<th>Recovery Maintenance Practices</th>
<th>Elizabeth</th>
<th>Erica</th>
<th>Tina</th>
<th>Hope</th>
<th>Heather</th>
<th>Leigh</th>
<th>Grace</th>
<th>Bella</th>
<th>Wanda</th>
<th>Ally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
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Self-imposed Barriers

Self-imposed barriers are those chosen voluntarily: in this case, these barriers are meant to help the participants resist regressing to old dysfunctional patterns of behavior. Examples of these barriers included avoiding people, places, or things that may lead to temptation, along with self-monitoring. For example, several women mentioned avoiding certain friends who might lead them to relapse, and avoiding places where they had gone in the past when they were actively involved in substance use. Wanda and Erica are living in a halfway house by choice, and this is an effective barrier which provides structure and is recommended by many treatment programs. Wanda specifically did not want to make too many changes at once; she had recently begun college and knew that too many changes could trigger emotional stress. Erica enrolled in a program to help her get an apartment on her own, but worried that living alone might lead to depression as it had in the past.

Self-monitoring was practiced by Bella, who said she paid attention when she reacted to a situation in a healthier way than in the past; this encouraged her and reminded her of her personal growth. Elizabeth also was engaged in self-monitoring. She described pain in her back that she believed was triggered by stress; it alerts her to slow down. Elizabeth also monitored herself after dealing with an eating disorder that lasted 20 years:

I don’t feel that I have an eating disorder anymore. I’m not starving myself or purging what I eat, but there are certainly times when I am tempted to do that….Exercise may be the one area I have to watch myself more.

Another way they practiced setting barriers was limiting their exposure to certain media, especially television and movies that contained violence. Watching television that
contained alcohol or drugs can act as a trigger. Heather was very excited when she shared
the following evidence of how far she had come in her sobriety:

Just yesterday … or the day before, I was watching TV with one of the other
interns; one of my sisters here. And there was someone with a needle getting ready to shoot up. And she looked at me and… [said] “Does that bother you?”
And I was like: “What?” And I had to think about it for a second and then I
realized she was referring to the needle…. I got so excited … because my mind
didn’t even go there…That was huge…that was huge. I mean it was a big deal!

Bella had two years of sobriety from her abuse of pain pills and her pelvic
complaints had ended. She also talked about limiting her exposure to temptation. At first,
she avoided drugstores and going to doctors because in the past she had lied to medical
personnel and forged prescriptions to get medication she was addicted to. When asked if
she still experienced cravings, she shared the following:

No, it really is incredible. That’s not to say there aren’t times I wish I could numb
my pain with something else. Food or…relationships can be like that. That’s
something I have to watch out for. There’s always that void, and you try to fill it
up with something. It can’t be a guy or drugs.

The women in this study already had gained sobriety or freedom from an eating
disorder for at least a year before the interviews took place. They were determined to
maintain the gains they had made, and all of them mentioned ways they were monitoring
themselves, and avoiding people, places, or things in their environment that might trigger
a relapse.

**Spiritual Practices**

All of the women reported attending church, and engaging in prayer, worship,
and Bible reading as ongoing practices they are involved in and attributed these practices
to supporting recovery maintenance. Most of them described a growing sense of self-
acceptance which replaced their very negative self-image and related this improvement to finding love and acceptance from God. Reading Scripture supported that belief and helped Heather, Tina, Grace, Elizabeth, and Ally as they worked on maintaining positive self-esteem after graduating from their respective programs. Krause’s research bolsters this finding (2009). Church attendance and involvement were also reported as methods of developing friendships and connections with others.

Tina stated that her work keeps her connected with the Bible and God, as well as her involvement with a local church. As for the future, she talked about the treatment program itself as a resource:

When I leave here and I’m not working here anymore, I can still call here and get help. This is my spiritual home. Just like someone would call their pastor or somebody from church, I could call here and ask for help.

Since most of the women felt that the spiritual teachings and their own gains in recovery were based on some aspect of their faith (being loved by God or practicing forgiveness), remaining active in their faith was important to them. Hope was planning on joining a church as soon as she and Guy got settled in their new surroundings.

Participation in Recovery Groups

Grace, Wanda, and Erica reported attending recovery groups after graduating from their programs. Wanda and Erica attended 12-step groups that were the same ones utilized by the program they attended, and the format and teaching was a continuation of what they had already experienced. For Grace, the recovery program she attended was not based on the 12 steps, but contained a variety of classes, and was a way of connecting to continuing support when she needed it. Leigh leads a 12-step group, and talked about
being encouraged by hearing other’s stories, and by seeing other people move toward health. She shared how being in leadership also helps prevent temptation and relapse:

I would like to have a glass of wine like all these normal people and he [God] just says, “Too bad, so sad, I’m using you for different stuff and you can’t have it. You don’t need a glass of wine.” He just took that obsession from me.

Tina, Heather, and Ally were involved in recovery groups not only as a means of recovery maintenance, but as a vocational calling.

Recovery from substance abuse, as portrayed in the working definition created by SAMHSA (2012), is: “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential,” (p.1). These women understood that recovery is a process, and those who continued to take advantage of community support groups were engaging in self-care and safeguarding their own well-being.

**Continuing Mental Health Care**

Eight women reported using some form of mental health services or ongoing psychopharmacological intervention after graduating from their program. Grace attended another residential program after the one included in this study. She had been hospitalized after overdosing on drugs after leaving the program and believed she needed more structure and support. Grace was still seeing a psychiatrist at the time of the interview to help her deal with auditory hallucinations, depression, and suicidal ideation.

Wanda has been on disability for a while due to her anxiety, depression, and insomnia. These have improved to the point that her doctor has taken her off all medication for three months, to determine what medication, if any, she needs. She
reported that she did great for the first two months, but lately she said she has been:
“crying about weird stuff and really moody. I’ve decided that I’m certainly not like I was
when I was 14, but I really do need to be back on medication I think.” Erica also
continued on with her medication regimen, possibly due to the bipolar diagnosis she
reported.

Leigh and Ally went to marriage counseling with their husbands. Hope relapsed
and returned to the program for assistance, as did Leigh. Leigh relapsed, became suicidal,
and entered a psychiatric hospital for a few days. She began a regimen of
psychopharmacological interventions and returned to the residential program for two
more weeks. Since that final period of care, she has maintained sobriety.

Elizabeth continued with counseling for two years after leaving the program to
help her deal with flashbacks and memories of the sexual abuse. Tina and Heather stated
that they no longer felt the need for counseling, but could go and speak with their
program manager or pastoral counselor when necessary. Similarly, Ally reported having
immediate access to support, and may find it through casual conversation rather than a
structured counseling session.

Maintaining connections to support from mental health professionals is an aspect
of recovery that these women found necessary. After leaving a structured environment,
with 24-hour support available, the transition to independent living was not always
immediately successful (especially for Hope, Leigh, and Elizabeth). However, by
utilizing these services as needed, and perhaps viewing this as a way of stepping out of
residential care with continued support, most of these women did gradually decrease their
use of mental health services.
**Sharing the Story**

Most of the women in this study stated that sharing what they have been through and their restoration and recovery added meaning and purpose to their lives and continues to help them make sense of the trauma they endured. For example, Hope wants to teach teen girls the dangers of drinking, despite her relapse. Erica volunteered to be a speaker at a recovery group. Faith, Tina, Ally, and Leigh are actively leading programs. Leigh summed up this aspect of recovery best:

The reason I have this story is because it’s gonna help somebody else. I mean that’s God’s way of saying I’m gonna show how powerful I am to remove your story and then because of your experience you’re gonna share it with others and they’re gonna get better. And it’s all just sharing experience with people and it’s just such a ripple effect and it just keeps going and going and going. And even if just one person hears something and you connect with them and they think there’s something to this…. I think that our absolute purpose in life is to love God first, and then to love other people. There’s nothing else in life but that.

Finding meaning and purpose after enduring CSA and its sequelae by using their experiences to help others was beneficial for these women in several ways. First, it helped them reconcile the evil they experienced with a loving God. By using their pain as a way of encouraging others, they felt that God used their situation for good. In fact, all the women in this study wanted to be part of it in order to help someone else. Using their story was also empowering, and this differed quite a bit from viewing themselves as victims. Bella, who had worked in the human services field in the past, felt that she could reach more people with her story now. She shared how this aspect of recovery encouraged her:

That’s probably the biggest difference in how I feel about myself… I definitely feel like I can help people change their lives; that God can use me that way.
Connections Instead of Isolation

Each woman talked about a period in her life before entering the program when they felt alone or began to recognize that the relationships they had were unhealthy and the way they were living had to change. Bella was living with a violently abusive alcoholic and said:

I was the kind of person who did well to keep a few good friends and I did in college. But I got married right after my third year in college. In a relationship that’s very controlled there’s not room for other people... I wouldn’t say...that my husband necessarily wouldn’t allow me to have other relationships. I just felt like there just wasn’t room for that. And we had three children very fast.

Some of them realized it when they were facing legal sanctions (Erica, Tina, and Hope). Others, like Wanda, wanted to break their isolation, and establish connections. Ally and Leigh were living with family, but isolated in their addictions without close relationships with other adults. Learning how to open up and build trusting relationships was an aspect of residential care that many women mentioned. They were taught how to be more assertive and how to handle conflict because they were in a “laboratory” where conflict had to be addressed. Ally described these changes:

I was an isolator. You know I still am to some degree. I love my house and I love being home with my cats and you know, just piddling and stuff. But I learned a lot about relationships here, living with 19 other women...It was quite an experience. We learned how to deal with conflicts in a healthy way. I learned a lot. I think it helped my relationships.

Tina, Heather, and Bella talked about the process of “care-fronting,” where one used biblical principles when dealing with conflict. In her role as an administrator, Heather described how the women learn to change:

People don’t just change; they need that help to change. So it’s very intense and very strict here, but that’s what works. You know, you just don’t change out of
your lifestyle at the drop of a dime. You have to work at it. It’s our job to point [things] out to people [by saying], “Hey, that wasn’t right… this is how you would do that.” Or…“Hey, you broke a rule.” Or help them to solve conflict and learn how to communicate with each other.

All of the women talked about relationships within the program, and many maintained contact after graduating. Erica had no close friends or family before the program, but reconnected with her mother. Erica was living in a halfway house at the time of the interview and expressed her fear about moving to an apartment to live alone:

Every month you call in and find out what number you are. When you get to [number] one, it is time to move out and live by yourself. I think that is a deadly combination. I think when my ex-husband divorced me, I went from being every day with him and [my daughter] to [being] with nobody. I got depressed real quick.

These women all described how much relationships in their lives had improved and become closer. Tina described relationship building in her program: “…They teach you Christian relationship skills, you know how to forgive each other; how to correct each other in a loving way.” At the time of the interviews, each woman was very involved with work or school, church, and recovery programs. All were living with family or living in a transitional living arrangement with others. All of them felt this need for connection and pleasure at having found it.

Before I was miserable, I was so miserable I was so hopeless but now I’m happy now…I don’t like that word happy because it’s so sensitive to your situation; but I have joy. You know? Joy in knowing that it’s going to be all right.

While each participant’s story differed, all described a spiritual renewal and remains connected to support resources. Maintaining sobriety and freedom from eating disorders are goals that were much discussed, along with the improved self-image and relationships they have gained through recovery. All of these treatment programs recommended after-care or provided resources to graduates of their programs. Heather is
currently working with the treatment program as an intern and when she talks about recovery, described it is an ongoing process. Despite failing in two other treatment programs, she found recovery through this faith based program, and said:

It’s not magic, like snap your fingers and it’s gone. I’m still getting freedom. I’m still dealing with things that happened in my past. The main difference is that I know I can fix it; well God can fix it.

Summary

This chapter presented findings in the voices of the participants along with other descriptive data. In order to understand the experience of recovery in a faith based residential treatment center, the programs were described and compared, and the participants were described along with their symptoms. The three research questions were answered through the process of interpretive phenomenology analysis, resulting in 15 themes. The first research question was, “What is the experience of recovery from the sequelae of CSA, including alcohol or substance abuse, in a faith based treatment center?” Five themes emerged to help answer this question. They were: Re-education, Bonding, Most Helpful Program Elements, Least Favorite Program Elements, and Graduation. The second research question was: “What changes do participants recognize as part of healing or recovery?” Four themes emerged in this section and they were: Changes in Relationship to Others, Changes in Relationship to Self, Changes in Relationship to God, and Forgiveness as a Catalyst of Change. The last research question was: “How are graduates of these programs doing post treatment?” Six themes emerged, and these were: Spiritual Practices, Self-Imposed Barriers, Participation in Recovery.
Groups, Counseling and Psychiatric Care, Sharing the Story, and Connections Instead of Isolation. The research questions and resultant themes are displayed in Table 4.9.

**Table 4.9**

**Summary of Research Questions and Resultant Themes**

<table>
<thead>
<tr>
<th>What is the experience of recovery from the sequelae of CSA, including alcohol or substance abuse, in a faith based residential treatment center?</th>
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<tbody>
<tr>
<td><strong>Themes:</strong></td>
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<tr>
<td>Re-education</td>
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<td>Bonding</td>
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<td>Most Helpful Program Elements</td>
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<td>Least Favorite Program Elements</td>
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<td>Graduation</td>
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<tr>
<th>What changes do participants recognize as part of healing or recovery?</th>
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<tr>
<td><strong>Themes:</strong></td>
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<tr>
<td>Changes in Relationship to Others</td>
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<td>Changes in Relationship to Self</td>
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<tr>
<td>Changes in Relationship to God</td>
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<tr>
<td>Forgiveness as a Catalyst for Change</td>
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<tr>
<th>How are graduates of these programs functioning post treatment?</th>
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<tr>
<td><strong>Themes:</strong></td>
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<tr>
<td>Spiritual Practices</td>
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<tr>
<td>Self-Imposed Barriers</td>
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<tr>
<td>Participation in Recovery Groups</td>
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<tr>
<td>Counseling and Psychiatric Care</td>
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<td>Sharing the Story</td>
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<td>Connections Instead of Isolation</td>
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**Final Summary**

This chapter presented the findings of this study through the themes that emerged during the phenomenological exploration of these women’s journeys. Each one of these women shared different experiences related to their history of CSA, along with a plethora
of symptoms that have been found in the literature. In the words of these women, they went from hating themselves and engaging in suicidal and risky behaviors to finding love for themselves and establishing healthy relationships with others. They also spoke about how they would maintain these positive changes in their lives. The next and final chapter will include conclusions, implications, and recommendations based on these findings.
CHAPTER FIVE: DISCUSSION

Overview

The purpose of this study was to explore recovery from the sequelae of childhood sexual abuse (CSA) in women who completed a faith based residential treatment program. Interviews with 10 participants, conversations with administrators of these programs, review of some of the curriculum used, and visits to two programs were part of the investigation. The findings from the research process were presented in Chapter Four. This chapter will present the significance of those findings, the implications for treatment, and suggestions for further research, strengths and limitations of this research, as well as the location of the researcher in relationship to the study. First, the significance of the findings in this exploratory study are presented. Topics covered in this section include: a) a comparison of presenting psychological, social, and spiritual symptoms with the literature, b) a comparison of the program structure to the standard of care, in which a composite model of the treatment programs was developed, and c) a comparison of symptom improvements with the literature. Next, the implications of the findings and how they inform diagnosis and treatment planning with this population are presented. These topics include a) the treatment of co-occurring disorders, b) an intrapersonal focus c) and interpersonal focus d) the need for recovery maintenance planning, e) spiritual integration, and f) forgiveness. Recommendations for further research are discussed thereafter. These recommendations include a) more qualitative and quantitative studies on this population, b) more program evaluation for faith based residential programs, c) more research on eating disorders as sequelae of CSA, and d) prospective rather than
retrospective research. The subsequent section addresses strengths of the research, and is followed by a section noting its limitations. Lastly, the chapter concludes with a section presenting the location of the researcher in relation to these findings.

Significance of the Research Findings

This section will compare and contrast findings from this study with the literature review in Chapter Two. First, symptoms and conditions of interest reported by participants will be compared to the previously cited research. These include biological, psychological, social, and spiritual symptoms that were similar to findings in other research, and this will be followed by a section noting the differences between this study and the literature. Next, program elements will be compared with the literature. These include: structure and design, composite program elements, and a comparison with evidence based practices. Lastly, improvements reported by participants will be compared with treatment recommendations.

Symptoms and Conditions of Interest

The women in this study described a plethora of symptoms and conditions that reflect those described in the literature. The prevalence rates of these bio-psycho-social-spiritual conditions were also compared with the literature, when available. First, similarities are examined. Lastly, differences will be noted.
**Biological Symptoms**

Migraines were reported by two women, genital problems including surgery were reported by two women, two women had back problems, and overall, 80% reported a variety of physical illnesses, which reflects the high incidence of physical illness reported in the literature (Sachs-Ericsson et al., 2005; Wilson, 2010).

**Psychological Symptoms.**

Depression has been noted as the most common outcome from CSA, and all women in this study reported being depressed before entering treatment (Chunis, 2009; Fergusson et al., 2008; Lundqvist et al., 2004; Sachs-Ericsson et al., 2011; Zink et al., 2009). Anxiety is also a common presenting symptom, and in this study, 80% of the women reported it as an issue (Cougle et al., 2010). Sixty percent reported insomnia as problematic, which is less than the prevalence rate reported by Pigeon, May, Perlis, Ward, Lu, and Talbot (2009). Body image issues were remarked upon by 70% of the sample (Van Gerko et al., 2005). Two women (20%) reported having flashbacks, which is one feature of traumatic injury (Briere & Runtz, 1989). Forty percent reported an eating disorder: four women reported anorexia and three were bulimic (Carter et al., 2006; Fischer et al., 2010; Holzer et al., 2008; Welch & Fairburn, 1996). Ninety percent reported alcohol and/or drug abuse or dependence, which is also a common presentation with this history (Draucker & Martsolf, 2006; Fergusson et al., 2008; Finkelhor, 1991; Sartor, et al., 2008; Zink et al., 2009). Borderline personality disorder has also been suggested as a disorder common to this population; one woman, or 10% of the participants reported being diagnosed with this (Briere & Scott, 2006; Minzenberg et al., 2008). All presented with a very negative self-concept (Briere, 2002; Cook et al., 2005).
In addition, Elizabeth, Leigh, and Heather talked about bearing guilt because of the CSA (Whiffen & MacIntosh, 2005).

**Social Symptoms**

All women presented with relationship disruptions (Rumstein-McKean & Hunsley, 2001; Walker et. al, 2011). Although it is impossible from retrospective accounts to determine whether any of the participants had an attachment disruption, they did display characteristics of insecure attachment (Cook et al., 2005; Fonagy & Bateman, 2007; Muller, Sicoli, & Lemieux, 2000; Whiffen & MacIntosh, 2005). Two women described themselves as prostitutes, and along with four others, were involved in early sexual contact and promiscuous behavior (Testa et al., 2005; Wilson & Widom, 2008). Ninety percent were re-victimized as adults, and at least one experienced ongoing abuse from more than one adult as a child (Barnes et al., 2009; Ericksen, 2010). Forty percent of the participants had a history of incarceration, which falls within the range of a 10-70% prevalence rate described by Johnson and Lynch (2013).

**Spiritual Symptoms**

Lastly, nine women had a negative view of God before entering their program of choice. This reflects the spiritual integration literature which indicates CSA can lead to a spiritual disruption (Crisp, 2007; Gall et al., 2007; Ganje-Fling and McCarthy, 1996; Houg, 2008; Ryssel, 2010).

The following table summarizes the percentage of participants reporting symptoms in the biological, psychological, social, and spiritual categories. Table 5.1 also includes references to the other research studies which reported similar findings in their samples.
Table 5.1

**Similarities of symptoms between the sample and the literature**

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Percentage</th>
<th>Literature</th>
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<tbody>
<tr>
<td><strong>Biological symptoms</strong></td>
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<tr>
<td>Illnesses &amp; surgeries</td>
<td>80%</td>
<td>Sachs-Ericsson et al., 2005; Wilson, 2010</td>
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<tr>
<td><strong>Psychological Symptoms</strong></td>
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<td></td>
</tr>
<tr>
<td>Depression</td>
<td>100%</td>
<td>Chunis, 2009; Fergusson et al., 2008; Lundqvist et al., 2004; Sachs-Ericsson et al., 2011; Zink et al., 2009</td>
</tr>
<tr>
<td>Anxiety</td>
<td>80%</td>
<td>Cougle et al., 2010</td>
</tr>
<tr>
<td>Insomnia</td>
<td>60%</td>
<td>Pigeon et al., 2009</td>
</tr>
<tr>
<td>Body image issues</td>
<td>70%</td>
<td>Van Gerko et al., 2005</td>
</tr>
<tr>
<td>Flashbacks</td>
<td>20%</td>
<td>Briere and Runtz, 1989</td>
</tr>
<tr>
<td>Anorexia</td>
<td>40%</td>
<td>Carter et al., 2006; Fischer et al., 2010; Holzer et al., 2008; Welch &amp; Fairburn, 1996</td>
</tr>
<tr>
<td>Bulimia</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Alcohol or drug abuse</td>
<td>90%</td>
<td>Draucker &amp; Marsoff, 2006; (Fergusson et al., 2008; Finkelhor, 1991; Sartor, et al., 2008; Zink et al., 2009</td>
</tr>
<tr>
<td>Borderline personality diagnosis</td>
<td>10%</td>
<td>Briere &amp; Scott, 2006; Minzenberg et al., 2008)</td>
</tr>
<tr>
<td>Negative self-concept</td>
<td>100%</td>
<td>Briere, 2002; Cook et al., 2005; Whiffen &amp; MacIntosh, 2005</td>
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<tr>
<td>Guilt</td>
<td>30%</td>
<td>Whiffen &amp; MacIntosh, 2005</td>
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<tr>
<td><strong>Social symptoms</strong></td>
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<tr>
<td>Relationship dysfunctions</td>
<td>100%</td>
<td>Rumstein-Mckean &amp; Hunsley, 2001; Walker et al., 2011</td>
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<tr>
<td>Characteristics of insecure attachment</td>
<td>100%</td>
<td>Cook et al., 2005; Fonagy &amp; Bateman, 2007; Muller, Sicoli, and Lemieux,2000</td>
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<tr>
<td>Promiscuity</td>
<td>60%</td>
<td>Testa et al., 2005; Wilson &amp; Widom, 2008</td>
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<tr>
<td>Re-victimization</td>
<td>90%</td>
<td>Barnes et al., 2009; Ericksen, 2010</td>
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<tr>
<td>History of incarceration</td>
<td>40%</td>
<td>Johnson &amp; Lynch, 2013 (10-70%)</td>
</tr>
<tr>
<td><strong>Spiritual symptoms</strong></td>
<td></td>
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</tr>
<tr>
<td>Negative view of God</td>
<td>90%</td>
<td>Crisp, 2007; Gall et al., 2007; Ganje-Fling and McCarthy, 1996; Houg, 2008; Ryssel, 2010</td>
</tr>
</tbody>
</table>
Differences Between the Participants and the Literature

In contrast to findings by Arnow, Hart, Scott, Dea, O'Connell (1999), who found no greater use of inpatient services for distressed women with a history of CSA compared to other groups within an HMO organization; in this sample, 50% of the women reported at least one inpatient mental hospitalization. In contrast to the study by Noll et al. (2003), in which 32.2% of a sample engaged in self-injurious behavior, 60% of this group reported suicide attempts and 20% reported cutting in the past. If one classifies severe alcoholism, intravenous drug use, or engaging in risky sexual encounters and risky lifestyles as self-injurious behavior, other participants could also be included in that percentage. Only one participant reported an aversion to sexual contact, which conflicts with the findings of Leonard and Follette (2002), who found that this was the most common response to CSA. These differences are displayed in Table 5.2.

Table 5.2

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Percentage of Sample</th>
<th>Relevant Literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospitalizations</td>
<td>50%</td>
<td>Arnow et al., 1999</td>
</tr>
<tr>
<td>Self-harm</td>
<td>60%</td>
<td>Noll et al., 2003</td>
</tr>
<tr>
<td>Sexual aversion</td>
<td>10%</td>
<td>Leonard &amp; Follette, 2002</td>
</tr>
</tbody>
</table>

Overall, the participants in this study presented symptoms comparable to those reported by other studies, although more prior hospitalizations, suicidal ideation, and
suicide attempts and less aversion to sexual contact were reported. The group of participants in this sample may have differed somewhat from those in the great majority of research on this population, which were based on outpatient treatment approaches. It is likely that the symptoms in this group were more severe from those used by other studies, since they sought residential treatment rather than outpatient care. This is significant to note, both as part of the exploration of recovery and for purposes of comparing this treatment approach with others. The next section will explore how these program elements compare to evidence based practices.

Comparison of Programs to the Literature

There are no evidence based practices for this population in a residential setting that incorporate Christian spirituality. However, these programs did address substance abuse, eating disorders, and underlying trauma in ways that did not conflict with the literature. Some comparisons will be made in the following subsections.

Program Structure and Design

Although these five programs were unique they shared some common characteristics in structure. These included: 1) Residential care was for females only. 2) The programs were highly structured, and included hourly schedules for clients. These schedules included times for classes, counseling, groups, homework/study, household duties, 12 step group times, and times for attending programs and activities outside of the treatment program itself. 3) Limited contact between clients and family and friends during an initial period after entering the program. 4) Limited or banned discussions of personal issues between clients, although it still occurred. The purpose of limiting
discussions between clients was to eliminate “war stories” and comparisons, as well as keeping each woman focused on her own recovery. 5) Fees for these programs varied. Some programs involved no fees at all if accepted. Fees varied greatly between programs, but most were not able to accept insurance reimbursement.

In addition to the program structure, teaching, counseling, and psychoeducation were accomplished through a variety of modes: as classes, as group or individual counseling, and as individual study. Clients were also required to turn in “homework” based on assignments from classes or counselors. In addition, time was structured in a way that allowed for individual spiritual practices as well as time devoted to corporate spiritual practices, such as church attendance. These are summarized in Table 5.3.

Table 5.3

Composite Program Structure and Design

<table>
<thead>
<tr>
<th>Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Care for Females only</td>
</tr>
<tr>
<td>Strict Time Management: Hourly Schedules Printed for Clients</td>
</tr>
<tr>
<td>Limited Outside Contact During Initial Period</td>
</tr>
<tr>
<td>No Discussion of Personal Issues Between Clients</td>
</tr>
<tr>
<td>Fees varied from $0 and Upward</td>
</tr>
</tbody>
</table>

Mode of delivery

Classes
Group Counseling
Individual Counseling
Individual Study and/or Homework
Individual and Corporate Spiritual Practices
The structure and modes of delivery are significant to note when comparing this treatment approach to evidence based practices. According to the findings from the meta-analysis of 44 studies on women with a history of CSA conducted by Taylor and Harvey (2010), the greatest effect size was found in studies that incorporated homework and utilized individual therapy. The programs in this study all included both of these elements.

**Program Elements**

Program elements included assessment, and although these programs were not designed to treat CSA, they did assess for it in at least two of the programs. Elizabeth and Grace’s program had a waiting list, so in addition to assessment procedures, they offered pre-entry support materials.

All programs utilized a substance abuse curriculum and some form of 12-step groups. Each offered material on healthy relationships. Each incorporated some general life skill training, such as finances, home management, and job training. Nutrition and health education were necessary parts of the programs for people in substance dependency and those with eating disorders. Based on the descriptions of changes the women experienced, there was some use of at least a psychoeducational approach to trauma; during the interviews, most of the women linked their history of CSA to troubling symptoms in the present. Family education on addictions and for marriage counseling was advised. All programs taught the importance of the practice of forgiveness. A version of Christian CBT was mentioned as being helpful by at least two participants. All programs were grounded in Christianity and incorporated Bible study, worship, prayer, and church attendance as core components. In addition to the
aforementioned, all treatment programs had structure or support in place for after care, which is also recommended in the relapse prevention literature (for an overview of relapse models, see Brandon et al., 2007). Figure 5.1 displays a composite model of the treatment program components.

Figure 5.1

*Composite Model of Faith Based Treatment Programs*

![Composite Model of Faith Based Treatment Programs](image)

This composite model is a significant aspect of the findings, because this was the pathway to recovery from addictions and mental health symptoms arising from a history of CSA. Explorations of alternate pathways were recommended by both IRETA (2009) and SAMHSA (2011). One program stated that they utilized best practices from the mental health field combined with biblical teachings in their counseling model.

*Comparison with Evidence Based Practices*

There were three evidence based practices for women with this history listed on SAMHSA’s National Registry of Evidence Based Programs and Practices. They include the Trauma Recovery and Empowerment Model (TREM (Harris, 1998)), the Boston...
Consortium Model: Trauma-Informed Substance Abuse Treatment for Women (Amaro et al., 2005), and Seeking Safety (Najavits, 2007). TREM uses a group format, and has been used in a variety of settings. It emphasizes psycho-educational focus and skill-building, empowerment, and peer support, boundary maintenance, and self-soothing techniques.

The Boston Consortium Model was adapted from TREM, and includes a focus on regaining custody of children and parenting skills. The Seeking Safety model was designed for the initial stages of recovery from trauma, and addresses the issue of safety after trauma in relationships, thinking, behavior, and emotions. It has also been used in a variety of settings, both in group and individual formats. These evidence based practices are summarized briefly in Table 5.4. The table indicates the number of sessions, style recommended for administering the material, and the topics by category.

Table 5.4

<table>
<thead>
<tr>
<th>Evidence Based Practice Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Boston Consortium Model</strong></td>
</tr>
<tr>
<td><strong>Program Design</strong></td>
</tr>
<tr>
<td>Group Format, 33 Sessions</td>
</tr>
<tr>
<td><strong>Program Components &amp; Number of Sessions</strong></td>
</tr>
<tr>
<td>(3) Women’s Leadership</td>
</tr>
<tr>
<td>(8) Economic Success</td>
</tr>
<tr>
<td>(10) Family Reunification</td>
</tr>
<tr>
<td>(12) Nurturing for Families in SUD Treatment</td>
</tr>
</tbody>
</table>
A comparison of program topics and modes of delivery between these models and the composite program model yields some similarities. These are a focus on relationships, the inner person of the client, and substance abuse. A psychoeducational focus is apparent in all models, along with a significant period of time necessary for the implementation of treatment. And the influence of peer support in a group setting is another commonality between the programs in this study and evidence based practices. The next section will compare symptom improvements reported by participants to areas addressed by other research studies.

Symptom Improvements

In Chapter Four, Table 4.4 displayed the improvements described by the women in this study. These included attainment of sobriety, less depression, anxiety, and insomnia, improvements in physical health, less use of psychopharmacological interventions overall, a cessation of suicidal ideation, anorexia, and bulimia. These problems areas have been addressed for women with a history of CSA in the literature (Draucker et al., 2009; Taylor & Harvey, 2010; Whiffen and MacIntosh, 2005).

In addition, many women chose to become sexually abstinent for a period of time, and to avoid re-engaging in unhealthy relationships with men, while others married. The qualitative meta-analysis performed by Draucker (2009) included a great emphasis on relational healing, which was also reflected by this study. The women in this study described changes in self-concept and self-esteem, interpersonal functioning, and overall improvement in a multitude of symptoms, which mirrors the findings of this study. In a
review of the literature, Whiffen and MacIntosh (2005) also found that shame or self-blame, interpersonal problems including attachment insecurity and negative coping techniques all could be factors linking CSA to adult emotional distress. The women in this study talked about feeling guilty, and all had relationships problems, and they described themselves using characteristics of insecure attachment styles. They also talked about using alcohol or drugs for various reasons, as well as using eating disorders and cutting as methods of coping. Without pre-and post-testing, as in a quantitative study, there is no way to measure the degree of change reported by the women in this study. However, the women graduated from the treatment programs and reported between six months and almost four years of sobriety and/or less problematic mental health symptoms, which is indicative of successful recovery. Comparing symptoms before and after treatment, and to those addressed in the literature is one way of indicating that the programs were at least successful to some degree in the cases of the women in this study.

In addition to the evidence based practices cited above, these programs incorporated spiritual teachings as a core component of recovery. One possible way this may have been effective is to view spiritual practices as coping techniques. Coping techniques for dealing with negative affect include substance abuse. Anorexia has also been identified as a method of coping (Sosin, 2008). The women in this study, who previously engaged in these practices, were introduced to positive spiritual coping skills instead. Ano and Vasconcelles (2005) conducted a meta-analysis of 49 studies that examined the relationships between religious coping skills and stress. They found that “positive religious coping served some adaptive functions and led to some relatively
long-term improvements in mental health among patients and their significant others.” (p. 477). In addition, they found that positive religious coping strategies were inversely related to negative psychological adjustment. They also found that negative religious coping styles were related to negative psychological symptoms. The findings from Ano and Vasconcelles (2005) along with the findings in this study further highlight the need for spiritual assessment as part of the overall approach to counseling, and the value of positive spiritual coping skills.

Summary

All participants in this study described improvement in some of the symptoms presented in Table 5.1. A picture of global improvement emerged in the group as a whole, as described in Chapter Four. The women in this study presented symptoms compatible with the extant body of literature related to CSA. The treatment programs integrated elements, along with religious teaching, from the standard of care for this population. A composite picture of the program elements was developed, which were compared to evidence based practice. Symptom reduction was reported by all participants, including abstinence from substance abuse and eating disorders, and these were compared to findings from other research studies. Comparing these elements to the standard of care for this population is significant, in that the study was exploratory in nature, and these comparisons help illuminate this alternate path to recovery. The next section focuses on how this information may inform treatment planning for women with a history of CSA.
Implications for Treatment

This section will describe how the findings may inform therapists treating women with a history of CSA and its sequelae. These implications include the need to address co-occurring disorders, with a focus on intrapersonal and interpersonal issues, the importance of maintenance recovery practices, and the role of Christian spirituality and forgiveness.

Treating Co-Occurring Disorders

According to SAMHSA (Office of Applied Studies, 2004), co-occurring mental health problems and substance abuse issues are usually treated as individual disorders. In 2002, there were 14 million Americans with a serious mental illness and 23% of those (4 million) had a co-occurring substance use or dependence disorder. Of those, less than half received any treatment whatsoever. Evidence based practices in the new field of co-occurring disorders are still being developed and there is a focus on research for trauma and substance abuse in the programs for women (Center for Substance Abuse Treatment, 2005). A correlation between a history of CSA and substance use has been established (Brems, Johns, Neal, & Freemon, 2004; Gottfried, 2004; Kendler et al., 2000; Khoury et al, 2010; Sartor et al., 2008; Spatz Widom et al., 2006; Zlotnick et al., 2006). According to these researchers, assessing for trauma is vital and, in fact, empirically supported treatment, as reported in the literature, should always include thorough bio-psycho-social-spiritual pre-treatment evaluation, including in-depth history taking, as part of effective practice (Hersen & Rosqvist, 2008). In this study, at least some of the programs did
assess for a history of sexual abuse, which is an important element for treatment planning because of the long-reaching effects of abuse.

The programs in this study did not intentionally list the trauma component as part of their approach to treatment, but the issues were addressed as part of the overall recovery process. For clients with a history of CSA and sequelae requiring residential care, a therapist needs to locate a program that can address the underlying trauma history as well as the presenting substance abuse along with other bio-psycho-social-spiritual problems. The integration of empirically supported treatments specific to trauma recovery is recommended (Wampold et al., 2010).

**Intrapersonal Focus**

All of these women had very negative self-images and self-esteem; most reporting self-hatred. Addressing this issue was central to the women in this study, since negative affective states have been connected to this negative self-concept (Darity, 2008). In addition to spirituality, the women spoke about properly attributing blame for the CSA as one of the helpful aspects of therapy, which has been noted in the literature (Gold, 1986; Valle & Silovsky, 2002; Weiss, Longhurts, & Mazure, 1999; Whiffen & MacIntosh, 2005). Once blame was placed appropriately, self-forgiveness played a role in recovery. Several women spoke about being perfectionists and how this added to the negative view they had of themselves, which has been connected to self-esteem, attachment, and negative affect (Dunkley, Berg, & Zuroff, 2012). Shame and guilt, and loss of personal identity were described by participants and are also recommended targets for therapy (Draucker & Martsolf, 2006). For example, Leigh described herself as a chameleon,
becoming whatever others expected her to be. Wanda talked about how important it was to learn that she could be herself all the time and not act differently around different people, and Elizabeth described a search for the “real me.” Elizabeth also learned how to process emotions rather than turning to an unhealthy disorder like bingeing or purging. Bella also talked about how she learned to express herself rather than holding negative feelings inside. Treatments that address emotional expression rather than avoidant coping methods are recommended in the literature (Whiffen & MacIntosh, 2005). While these programs did not specifically identify treatment targeting these issues, the women reported improvement in all these areas. Some of these issues may have been addressed in individual counseling sessions or through individual study assignments.

The women identified the intrapersonal changes they experienced as one of the most important changes they recognized. They were released from self-hatred and began to view themselves in a more positive light through the course of therapy. In attachment terms, their “inner working model” was at least partially modified. Therapists working with similar clients might utilize support and/or recovery groups in addition to individual therapy, and use workbooks to replicate the individual study used in these programs.

As in any therapy, treatment should begin with a thorough biological, psychological, social, and spiritual assessment, case conceptualization, multi-axial diagnosis, treatment planning, treatment monitoring, and development of an aftercare plan. Because these women have co-occurring disorders, using a workbook such as the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2010) is suggested. The Treatments that Work series also includes many workbooks addressing single areas of distress that affected these women, such as depression, anxiety,
and trauma that could also be utilized. For the women in this study, most believed that feeling loved by God was the most important element in changing their negative view of themselves. For therapists without religious training, referral to a religious organization or therapist with experience in Christian spiritual integration may be helpful in similar cases.

**Interpersonal Focus**

Research indicates that insecure attachment styles influence the outcome of CSA (Dimitrova et al., 2010; Gottfried, 2004; Morúa, 2011) as well as future relationships as adults and in therapy (Shorey & Snyder, 2006). Substance abuse has also been connected to insecure attachment styles (Kassel et al., 2007; Molnar et al., 2009; Schindler et al., 2005; Smith & Tonigan, 2009). Therefore, treatment approaches that enhance secure attachment are recommended for this population. These programs addressed interpersonal skills and women had a chance to practice healthy conflict resolution practices and setting boundaries while in the ‘laboratory’ of residential living. They received information about codependency and lived in a structured environment where they had to learn to obey authority. In addition, they learned about forgiveness in relationships and for themselves (Dixon & McConnell, 2012) which is also part of a robust clinical literature (Freedman & Enright, 1996; Jacinto & Edwards, 2011). Residential treatment offers an opportunity to practice these skills and may be one way to help people develop more secure attachments.

These women talked about particular elements in the way they changed relationship styles, involving being real (Elizabeth), open (Tina), forgiving (Heather),
assertive (Grace), and not afraid of confrontation (Ally). These were major changes from the way they described themselves previously, which included such things as “wearing masks” (Tina) being “people pleasers” (Ally), and fearing the way people thought of them (Wanda) or talked about them (Heather, Erica). And most of them felt that developing close relationships with the other residents in their program was a helpful part of their recovery.

Summary

Because of the importance of relational healing to these women, the use of support groups and recovery groups is reiterated; they were used by women in this study. These can be helpful for clients who need to find social connections as well as additional therapeutic venues for addictions and/or eating disorders or other CSA sequelae. Interpersonal Therapy (IPT) may be helpful (Scherstuhl, 2013). Most of the women really enjoyed the teachings on relationships and the workbooks on codependency they used, which could also be used in outpatient therapy. For women who wish to work on their spiritual growth as part of recovery, church attendance is another way they may be able to develop healthy supportive relationships.

Recovery Maintenance Practices

All programs had plans or recommendations for after care. Each woman was asked to identify the ways she had been and would continue working on her personal and spiritual growth, and maintain recovery. Six practices emerged from their narratives: Self-imposed Barriers, Spiritual Practices, Participation in Recovery Groups, Continuing Mental Health Care, Sharing the Story, and Connections Instead of Isolation. Figure 5.2
displays these elements of recovery maintenance. Consistent with other qualitative studies with this population and the existential literature in general, sharing their stories in order to help others added meaning and purpose to their lives. Six of the ten women were volunteering or leading in recovery programs, while others talked about the value of sharing their story in a more private setting. They all viewed recovery as an ongoing process.

Figure 5.2

*Recovery Maintenance Practices*

*Summary.* Recovery maintenance, or relapse prevention is an important aspect of therapy, both for addictions and other mental health problems (Brandon et al., 2007). A therapist needs to work with the client and plan how the client is going to maintain gains made in therapy, and what they will do if they begin to relapse. Returning to counseling
is an option included in the model derived from this study, and therapists can suggest “check-ups” either through visits or phone calls to add support to their client’s recovery maintenance plan.

**Spiritual Integration**

Spirituality is an important aspect of life and impacts mental health (Plante, 2009). For these women, it was not a generic spirituality that mattered, but one founded on Christian teachings. Cognitive Behavioral Therapy (CBT) is an approach that has been shown to be effective with depression, anxiety, and low self-esteem (Fennell, 2005). Elizabeth described the process of writing and comparing beliefs to biblical truths as very helpful, and others related how they continued to use this technique to bolster their self-image and self-concept. For programs that incorporate spirituality, this is an approach to CBT that could be beneficial when working with Christian women. For Christian counselors working with Christian women, Lauderdale-Akhigbe’s (2010) book may guide practitioners who wish to integrate faith principles into empirically supported cognitive behavioral approaches for the treatment of depression, anxiety, and low self-esteem.

The women in this study indicated what had helped them the most through the process of recovery was finding the love and acceptance of God. Before the program, most felt God was negative or indifferent to their plight. A negative view of God has been linked to anxiety and depressed mood (Exline, Yali, & Lobel, 1999). Spiritual assessments should be an important part of any treatment protocol because, according to Gallup (Newport, 2011), more than 90% of Americans believe in God, and 77% identify
themselves as Christians (Newport, 2012). Based on the findings in this study, when doing a spiritual assessment, a therapist should ask whether the client believes God is for her, against her, or indifferent. Having a negative view of God or believing that one’s problems are God’s punishment can affect hedonic experiences and subjective well-being (Wiegand & Weiss, 2006). One’s relationship with God can be understood in terms of attachment theory (Beck & McDonald, 2004; Clinton & Straub, 2010; Fujikawa, 2010; Hall et al., 2009; Morúa, 2008; Proctor et al., 2009; Salerno et al., 2010). A number of studies suggest that one’s relationship with God mirrors adult relationships (Fujikawa, 2010). In this study, nine out of ten women viewed God negatively, themselves negatively, and had broken relationships, perhaps helping to support this contention.

Spiritual integration is part of mainstream therapy and a variety of ways that religion and spiritual beliefs and practices impact health have been explored (Gall, 2006; Gall et al., 2007; Ganje-Fling & McCarthy, 1996; Houg, 2008; Knapik et al., 2008; Murray-Swank, 2003; Pargament, 2007; Sosin, 2007; Worthington & Sandage, 2001). Teachings about Christian spirituality were the background of each of these programs, and all women were involved in learning about their faith, and participated in spiritual practices such as prayer, Bible reading and memorization, worship, and church attendance. Women in this study remained engaged in the practice of Christian spirituality as part of their recovery maintenance plans. Implications for therapists include encouraging women to explore their faith while recognizing that healthy spirituality can bolster and help maintain recovery.
Forgiveness

Forgiveness emerged as a theme in this study, and although it is a Christian spiritual practice, it has been researched regarding its role in recovery from a variety of mental health issues (Bash, 2007). Research studies indicate that forgiveness can play a role in ameliorating distressing symptoms for the victim and is an aid in the recovery process (Beckenbach, 2002; Helm, Cook, Berecz, 2005; O'Leary, 2007; Snyder & Heinze, 2005). Worthington’s (2006) REACH model is an evidence based application that may be used to address this issue, and it is founded on a Christian perspective.

Summary of Implications for Treatment

The implications for treatment listed above include doing a through bio-psycho-social-spiritual assessment of the client. The clinician needs to assess for a history of childhood sexual abuse, while also realizing that some women may not disclose this initially. Symptoms presenting for treatment in this study included depression, anxiety, addictions, eating disorders, suicidal ideation, relationship issues, negative spirituality, and a variety of PTSD symptoms. One diagnosis of borderline personality disorder was also found within the group of ten participants. Multiple health problems were reported, along with a range of relationships issues. For some of these women, safety was a concern, and they needed to be separated from violent or abusive men in their lives; clinicians need to address safety in current relationships as part of assessment.

Summary

When planning treatment, the therapist should review evidence based approaches for treating co-occurring disorders. Attention should be paid to the time span when
treating this population based on models in the literature. Therapists may consider employing group therapy and/or recovery groups along with individual therapy and the use of homework assignments based on program structure in this study. Interpersonal therapy and a psychoeducational approach to trauma and healthy relationships may be helpful. Forgiveness therapy is indicated for women with this history, and spiritual integration may be helpful for therapists and clients who agree to this approach. Therapists may also refer to a religious organization to encourage the client to develop spirituality as an additional avenue to recovery. A summary of areas to be addressed in diagnosis as indicated by this research study are presented in Table 5.5. Issues of concern for treatment planning are indicated in Table 5.6. The following section addresses suggestions for future research.

Table 5.5

**Summary of Implications for Diagnosis**

**MULTI-AXIAL DIAGNOSIS**

Axis I: Clinical disorders may include:
- Suicidal ideation
- Addictions
- Eating disorders
- Depression
- Anxiety
- PTSD symptoms
- Religious or spiritual problems

Axis II: Personality disorders
- Borderline personality disorder

Axis III: Medical conditions likely to be present

Axis IV: Psychosocial and Environmental Problems
- Relationship dysfunctions and isolation may be problematic
- Safety in relationships may need to be addressed
Table 5.6

Summary of Implications for Treatment Planning

<table>
<thead>
<tr>
<th>TREATMENT PLANNING SHOULD INCLUDE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods to address co-occurring disorders</td>
</tr>
<tr>
<td>Attention to time of proposed treatment plan</td>
</tr>
<tr>
<td>Individual therapy, group therapy, recovery groups, and homework</td>
</tr>
<tr>
<td>Psychoeducational approach to trauma</td>
</tr>
<tr>
<td>Forgiveness Therapy</td>
</tr>
<tr>
<td>Interpersonal Therapy</td>
</tr>
<tr>
<td>Spiritual integration or referral</td>
</tr>
<tr>
<td>Recovery maintenance planning</td>
</tr>
</tbody>
</table>

Suggestions for Further Research

This study illuminated the need for additional research on childhood sexual abuse, which will be addressed in this section. More research from both quantitative and qualitative perspectives is needed. More program evaluation, especially for faith based residential programs in this study are necessary. Research on treatment for eating disorders as sequelae of CSA is indicated. Finally, prospective rather than retrospective research would also be helpful.

More Qualitative and Quantitative Research on This Population

This study was a phenomenological exploration of recovery, and more qualitative studies on this population and the process of recovery may further illuminate the mechanisms of change, explore why women drop out of residential programs, or evaluate other factors that are helpful in the process of treatment. There is a need for further research on the best way to treat adults with a history of CSA, according to Martsolf and
Draucker (2005), and both quantitative and qualitative approaches are needed in this endeavor. Most of the research cited in this study referred to studies of women with this history; more studies including men need to be conducted (Gold, Ketchman, Zucker, Cott, & Sellers, 2008). Case studies on both males and females with this history may help inform therapists and treatment planning. In addition, research addressing ways to help prevent the occurrence of childhood sexual abuse would be invaluable (Wilson, 2010).

Program Evaluation for Faith Based Residential Care

A variety of treatment approaches and models have been recommended for women dealing with the issue of CSA (Taylor & Harvey, 2010), but the great majority of approaches to treatment in those research studies were for outpatient services. For those who require inpatient treatment, faith based residential treatment centers offer an alternative approach and there has been little research on outcomes for this population in residential care of any type, and none specifically targeting adults with this history who attended a residential program that integrated spirituality. In addition, research on the integration of spirituality with empirically supported treatment models for this population may help inform therapists interested in this approach. Models such as Murray-Swank and Pargament’s approach (2005) can add to the literature on spiritual integration when treating women with a history of CSA.

Eating Disorders as CSA Sequelae

According to Draucker and Martsolf (2006), there are no empirically validated models of treatment for women with a history of CSA with sufficient research, possibly
due to the unique ways people struggle with the large variety of possible ramifications of such experiences. Most of the women in this study went to residential care for substance abuse, not directly because of the CSA. Elizabeth did not have a substance abuse disorder, but did have an eating disorder, which is also commonly associated with CSA (Carter et al., 2006; Fischer et al., 2010; Holzer et al., 2008; Welch & Fairburn, 1996), and there is a great need for research on effective treatment models for that population as well (Ghaderi, 2010; Maine, Davis, & Shure, 2009; Sosin, 2008). More research on recovery from eating disorders in a program such as the one Grace and Elizabeth attended may inform therapists working with this population. Remuda Ranch is an example of a residential program engaged in best practices. Remuda Ranch treats eating disorders as a specialty, and is involved with program evaluation and has developed a model for treatment that incorporates spirituality (Bennett, 2009; Eberly, Wall, & Cabrera, 2003). Two of the programs in this study have no program evaluation or research on their programs yet.

*Prospective Rather Than Retrospective Research*

It would be helpful to have measurable data to quantify changes in symptom severity in participants in addition to retrospective reports. Having women complete assessment instruments upon entry and at departure in a residential program might demonstrate measurable improvements in depression levels, anxiety levels, trauma symptoms, attachment styles, God attachment, and substance abuse assessments. Therapists engaged in best practices should assess throughout treatment to determine effectiveness of approaches and techniques, just as therapy sites should conduct overall
assessments in order to improve services for their clients (Lambert, 2010; Miller & Hubble, 2011).

**Summary**

The development of treatment models to address the plethora of symptoms reported by adult men and women with a history of CSA is needed, and there are multiple ways research can assist in evaluating treatment models, from both quantitative and qualitative perspectives. More program evaluation is needed, especially for the residential treatment centers in this study who integrate spirituality in their model, from both a prospective as well as retrospective viewpoints. The need for further research on eating disorders was indicated by this study. In addition to the items mentioned above, further research on the pathways to recovery, including those that incorporate spirituality, are needed to address recovery from addictions (IRETA, 2009; SAMHSA, 2011). The following section will address the strengths and limitations of this study.

**Strengths of the Present Research**

Phenomenological research involves rich, thick descriptions and analyses of personal experiences which can add to the body of research on this subject by indicating the kinds of questions and areas of concern to be measured by structured instruments. Illuminating the pathways to recovery is an endeavor that is best undertaken from the viewpoint of those who have made that journey. In addition to the value of taking this approach, the subject of recovery from the sequelae of CSA through residential programs that integrated Christian spirituality has not been examined before, through either a qualitative or quantitative approach. The women in this study may have provided
information for future measurement and assessment of this particular treatment model. This study may help inform future researchers interested in recovery of CSA through this type of residential care.

Limitations of the Research

The women in this study reported a great number of symptoms that led to residential care which may differ from women who have a similar trauma history. This was a small sample and 90% were Caucasian women, and for those reasons, findings may not generalize to all populations, which is normative for most qualitative studies.

Finding enough women who completed the same treatment program would have made comparisons easier. More in-depth description of treatment models could have been provided. Reflecting on experience is part of phenomenological approaches, but accuracy of recall is an inherent issue of such exploration.

Having participants with a longer time span after treatment might be more informative for insight into relapse prevention. Additionally, if a checklist of symptoms had been utilized in this study, more symptoms might have been reported by each individual. More emphasis could have been directed at further exploring the mechanisms of change in the process of recovery.

The strengths of this study as well as the limitations of the research are important to note when working with clients with this history. These elements can also be informative when planning other research studies. The next section addresses the location of the researcher in relation to the findings of this study.
Locating the Researcher in Relation to the Findings

Because of my unfamiliarity with this treatment model, this research study introduced me to some facilities I would recommend to clients in need of residential care. Despite the fact that I am doing a research study, I had some faulty concepts associated with faith based treatment programs, which have been put to rest through the time spent in this research. The facilities themselves were impressive, and the people who operate and lead the programs typically have been through similar situations and have compassion and understanding for those enrolled.

This study helped me clarify my understanding of how faith can play a role in healing and recovery from a traumatic event such as CSA. These programs do not focus on simply praying and waiting for a miracle, but on centering the self in light of a loving God, who provides acceptance and care that some of these women have never experienced from earthly parents or the men in their lives. Their stories involved some significant mental health issues, including anorexia, bulimia, complex PTSD, bipolar disorder, substance abuse issues, and borderline personality disorder, along with previous suicide attempts. These treatment centers have dealt with some very complex issues with an intense focus on spiritual teachings. I was corrected when I made a comment that their spiritual focus must be like attending seminary. The women in this study let me know that it was not about dogma or theology, but about a relationship with God.

Being immersed in their stories has influenced me again of the value of constructivism as a way of understanding other people’s realities. These women were caught in such a negative view of themselves and the world and believed it; and they acted upon those beliefs, entering into risky behaviors and practices, some of which led to
suicide attempts. By going through a long term residential program, they began learning what healthy relationships were like, and how people, including themselves, should be treated. Although I am not a fan of Timothy Leary, I just discovered his term, “reality tunnel.” I think these women were living in a tunnel, but not much of it was based on reality, and even less on truth.

Summary

This chapter presented the significance and implications of the findings in this study, followed by suggestions for further research, strengths and limitations of the study, and lastly located the researcher in relation to the findings. First the significance of the findings were presented in this order: a) participant’s symptoms were compared to the literature, b) program structure and design were examined c) a composite picture of program elements was developed d) the composite model was compared to evidence based practices, and e) symptom improvements were compared with the standard of care. Next, the implications for treatment were addressed, which included the following topics: a) treating co-occurring disorders, b) a focus on intrapersonal and interpersonal issues in diagnosis and treatment planning c) the need for recovery maintenance planning, d) spiritual integration and e) forgiveness. Suggestions for further research were then listed. Finally the location of the researcher in relation to the findings was presented.
Final Summary

This study was a phenomenological exploration of the process of recovery and recovery maintenance for women with a history of CSA who completed a residential faith based treatment program. First, the purpose of the study, the research questions, definitions, and a description of the researcher were presented. A review of the literature followed. Afterward, the research method of phenomenology was presented, along with an explanation of the data collection and analysis procedures. The case was defined, the research questions were presented, and trustworthiness was addressed. Next, the research findings were presented, including a comparison of the treatment programs, the symptoms before and changes before and after treatment, and descriptions of each participant and her journey of recovery. Themes that developed from the phenomenological exploration were presented. Lastly, a discussion of the findings were presented, including their significance, implications for treatment, suggestions for further research, and the location of the researcher in relationship to the findings was presented. It is hoped that this exploration will add to the literature on recovery from CSA, and how spiritually integrated residential treatment centers may play a role in that recovery.
REFERENCES


Küpers, W. M. (2009). The status and relevance of phenomenology for integral research: or why phenomenology is more and different than an “upper left” or “zone #1” affair. *Integral Review, 5*(1), 51-95.


APPENDIX A

ABSTRACT

AN EXPLORATORY STUDY OF RECOVERY AND RECOVERY MAINTENANCE FOR VICTIMS OF CHILDHOOD SEXUAL ABUSE WHO COMPLETED FAITH-BASED RESIDENTIAL TREATMENT PROGRAMS

Ann Marie Kerlin

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This interpretive phenomenological analysis of the experience of recovery and recovery maintenance for women with a history of childhood sexual abuse and its sequelae included interviews and a non-standard questionnaire. Ten women with this history who had completed a faith based treatment program for substance abuse and/or eating disorders described recovery. Themes that emerged related to the process of change included: Changes in Relationships with Others, to Self, to God, and lastly, Forgiveness as a Catalyst for Change. Six practices emerged in the exploration of maintenance recovery. This research highlighted the need for thorough bio-psycho-social-spiritual assessment and areas of concern for treatment, and illuminated an alternative path to recovery that involved a spiritually integrated treatment approach to recovery.
APPENDIX B
Consent Form

AN EXPLORATORY STUDY OF RECOVERY AND RECOVERY MAINTENANCE FOR VICTIMS OF CHILDHOOD SEXUAL ABUSE WHO COMPLETED FAITH-BASED RESIDENTIAL TREATMENT PROGRAMS

Ann Marie Kerlin, Principal Investigator
Liberty University
Department of Counseling and Family Studies

You are invited to be in a research study of an exploration of former faith-based residential treatment participants. You were selected as a possible participant because you have completed the program between six months and three years ago. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Ann Marie Kerlin, a student in the Department of Counseling and Family Studies at Liberty University.

Background Information

The purpose of this study is to explore the process of recovery through a residential treatment program that incorporates Christianity and recovery maintenance after treatment.

Procedures:

If you agree to be in this study, please do the following things:

1. Complete a questionnaire, which you may examine before agreeing to participate
2. Participate in an interview, which is expected to take 1½ to 2 hours to complete
Risks and Benefits of being in the Study

This study has several risks: First, recalling such information may cause psychological distress. Second, you may reveal information that would require me to report child abuse, child neglect, elder abuse, or intent to harm self or others. Otherwise, the risks are no more than what you may encounter in everyday life. If you feel psychological distress after completing this study, a referral to a professional counselor will be available.

The benefits to participation are: You may be helping others on their journey of recovery by assisting researchers and therapists to provide informed care. You may also find that reflecting on your experiences is beneficial to you personally.

Compensation:

You will receive payment of $25.00 for your time in helping with this research project after completion of the steps outlined below.

Confidentiality:

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be stored securely and only researchers will have access to the records.

The original documents will be coded in such a way that no identifying information is revealed. The audiotapes will be reviewed and identifying names or information will be removed immediately. The tapes will be transcribed and coded in a way that does not reveal identifying information. Original materials will be stored in a locked cabinet.
The researcher will store transcribed audiotapes and scanned documents on her personal computer with password protection until completion of the study. This data will then be stored on a remote storage device for ten years, with the possible use of the material in future studies. This device will be kept in a locked cabinet. The original documents and audiotapes will be destroyed after the study is completed. You will be given the option to review and/or withdraw the audiotape from the research study upon completion of the interview.

**Voluntary Nature of the Study:**

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the Liberty University or your former treatment program. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

**Contacts and Questions:**

The researcher conducting this study is: Ann Marie Kerlin. You may ask any questions you have now. If you have questions later, you are encouraged to contact the researcher at (770) 254-1300, or amkerlin@liberty.edu. The faculty advisor for this project is Dr. Lisa Sosin, Ph.D., L.L.P., L.P.C., Associate Director of the Department of Counseling and Family Studies. You may reach her at (434) 592-4042, or at lssosin@liberty.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), you are encouraged to contact the Institutional Review Board, Dr. Fernando Garzon, Chair, 1971 University Blvd, Suite 1582, Lynchburg, VA 24502 or email at fgarzon@liberty.edu.
You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study. I am over 18 years of age.

Signature: ___________________________ Date: ______________

Signature of Investigator: ___________________________ Date: ______________
APPENDIX C

Questionnaire

Please answer the following questions.

When did you participate in and graduate from the treatment program?

Entrance date_____________ Exit date_______________

Your date of birth is ___________________?

Have you ever experienced sexual abuse in your childhood?

a. Yes
b. No

Have you ever experienced sexual abuse as an adult?

a. Yes
b. No

Your race is:

a. Caucasian
b. Hispanic
c. African-American
d. Asian
e. Other

Your highest level of education is:

a. GED
b. High school diploma
c. Technical degree
d. Bachelor’s degree  
e. Master’s degree  
f. None of the above

Have you ever participated in any treatment program or counseling before entering the program?

a. No  
b. Individual counseling  
c. Another residential program  
d. Pastoral counseling  
e. Other

Have you ever participated in any treatment program or counseling program after treatment?

a. No  
b. Individual counseling  
c. Another residential program  
d. Pastoral counseling  
e. Other

Have you in the past or are you now using any psychotropic medication? Please write the name of any you have or are taking:

<table>
<thead>
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<th>Present</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>Anti-Anxiety medication</td>
<td>Anti-Anxiety medication</td>
</tr>
<tr>
<td>Sleeping pills</td>
<td>Sleeping pills</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>
APPENDIX D
SEMI-STRUCTURED INTERVIEW

1. Thinking back to before the time you entered the program, can you tell me
   a) What was happening in your life?
   b) What circumstances led you to enter the program?
   c) What was the quality or nature of your relationships with people?
      (Romantic, family, friendships, etc.; prompt for descriptions of closeness,
      trust issues, etc.)
   d) How would you have described your spiritual life? Your relationship with
      God? Your relationship with males or authority figures? How about
      church?
   e) How would you have described your overall physical health (headaches,
      backaches, stomach problems, etc.)?
   f) How about your mental health (any anxiety, depression, problems with
      stress)?
   g) How would you have described your self-image? How about self-esteem?
   h) How would you describe your substance abuse problems before the
      program (whatever she indicated on the questionnaire)? Can you explain
      why you used the substance when you think back (to handle negative
      affect, part of social life, just a habit, etc.)?

2. Thinking about now, after completion of the program, how would you describe
   the same elements in your life?
a) How would you describe the nature and quality of your relationships with people? With romantic partners? With family? With friends?

b) Can you describe your circumstances now (employment, living arrangements)?

c) How would you describe your spiritual life? Your relationship with God? Your relationship with males or authority figures? How about church?

d) How would you have described your overall physical health (headaches, backaches, stomach problems, etc.)?

e) How about your mental health (any anxiety, depression, problems with stress)?

f) How would you describe your self-image and self-esteem?

g) How would you describe your substance abuse problems now (whatever she indicated on the questionnaire)? Can you explain what, if anything, you do to maintain sobriety now?

3. Comparing these descriptions of the time between before the program and now, can you describe what you think may have lead to these differences?

4. What are the three most important changes for you during your experience in the program? How have these changes affected your sense of meaningfulness in life?

5. For the future, what are your plans to maintain the growth you have obtained (if any)? What, if anything, do you do to grow spiritually now? What about personally?
6. Which program element(s) did you find most beneficial in your journey of recovery? (Prompts: Group sessions, individual therapy sessions, enhanced spirituality, personal interactions with other clients, etc.).