The Impact of Servant Leadership on God Attachment in Survivors of Sexual Abuse by Clergy

by

Jennifer Jill Schwirzer

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

Liberty University

2021

The Impact of Servant Leadership on God Attachment in Survivors of Sexual Abuse by Clergy

by Jennifer Jill Schwirzer

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

Liberty University, Lynchburg, VA

2021

APPROVED BY:

Dr. Courtney Evans-Thompson, Ph.D., Committee Chair

Dr. Keena K. Cowsert, Ed.D., Committee Member

Abstract

Survivors of sexual abuse by religious leaders experience unique forms of trauma demanding unique forms of treatment. Using a nonequivalent control group pretest posttest design, this study examined the effectiveness of one such treatment. The *Abuse, Trauma, and Jesus* workshop was designed to impart psychoeducation, coping tools, and support to survivors of sexual abuse by clergy. The treatment group added a servant leadership psychoeducation element. Before and after the intervention the participants completed the Primary Care PTSD Screen and the Attachment to God (ATG) Inventory. The research questions asked whether trauma symptoms and avoidant/anxious styles of God attachment would be reduced after the workshop, and whether the treatment group effect would be greater. Paired sample t-tests were used to compare pre and posttest measures for both control and treatment groups. A difference-in-differences analysis was used to identify any different effect in the treatment group. Although none of the outcomes were statistically significant, there was a small but consistent reduction in anxious and avoidant styles of God attachment in the control group. It is believed that a combination of features of the workshop, including therapeutic recapitulation, myth-busting, emotional disclosure, social support, and tool-sharing, may have helped reduce avoidant and anxious God attachment styles. More research needs to be done to identify how to meet the unique therapeutic needs of survivors.

Keywords: sexual abuse by clergy, institutional betrayal, betrayal trauma, complex trauma, servant leadership, psychoeducation

Dedication

This work is dedicated to the scores of survivors I know, and the thousands of survivors I don’t. I join you in solidarity, not as an expert so much as a survivor myself in search the healing we all need. I will not stop until I find answers.

Acknowledgments

I wish to thank all the hard-working clinicians and researchers whose work helped me better understand abuse and its healing. Thank you, Michael Schwirzer, for believing my story of abuse so many years ago, and for parting with my company for so many hours as I worked on this paper. Thank you, Nick Miller, for suggesting this subject matter and for your undying support and expertise given in behalf of Project Safe Church. Thank you, Steven Grabiner, for your excellent work as a presenter and your authenticity as a servant leader. Thank you, Nicole Parker, Steve and Samantha Nelson, and others, for the work you have done and continue to do to right wrongs in the family of God.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

Servant Leadership (SL)

Sexual Abuse by Clergy (SAC)

Prolonged Exposure Therapy (PE)

Cognitive Processing Therapy (CPT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Eye Movement Desensitization and Reprocessing (EMDR)

Child Sexual Abuse (CSA)

Clergy-Perpetrated Sexual Abuse (CPSA)

Clergy Sexual Misconduct (CSM)

Clergy Sexual Misconduct Against Adults (CSMAA)

Complex Posttraumatic Stress Disorder (CPTSD)

Posttraumatic Stress Disorder (PTSD)

Posttraumatic Growth (PTG)

Abuse, Trauma, and Jesus Workshop (ATJ workshop)

Cognitive Behavioral Therapy (CBT)

Risk Reduction through Family Therapy (RRFT)

Acceptance and Commitment Therapy (ACT)

Health Insurance Portability and Accountability Act (HIPAA)

Attachment to God Inventory (ATG Inventory)

Chapter One: Introduction

Overview

Sexual abuse perpetrated by clergy may inflict deep wounds upon the psyche of survivors (Gavrielides, 2012; Farrell, et al., 2010). An abusive clergyperson profoundly misrepresents God, thus potentially creating spiritual confusion and pain for survivors of abuse (Rudolfsson & Tidefors, 2014). This pain may affect the families and churches of the survivor, who may not validate the survivor, thus causing more pain (Smith & Freyd, 2013). In some cases, survivors do begin to trust again, even growing from the experience (Wind, et al., 2008). However, this is not the case for all survivors of sexual abuse.

The pathway to healing for survivors of sexual abuse may be assisted through trauma interventions. For those survivors of sexual abuse perpetrated by clergy, such trauma interventions augmented by a component of servant leadership may be beneficial. Trauma psychoeducation that includes resiliency skill training, emphasizes recovery, is culturally sensitive, and helps participants know where to find additional help, has been shown to be effective when working with sexual abuse survivors (Bass, et al., 2016; Im, et al., 2018; Whitworth, 2016).

Servant leadership is a unique form of organizational leadership developed in recent years by Greenleaf (1970) and followed by others (Babakus, et al., 2011; Green, et al., 2016; Kool & Van Dierendonck, 2012; Peterson, et al., 2012; Savage-Austin & Honeycutt, 2011; Sendjaya & Pekerti, 2010; Spears, 2010; Waterman, 2011; Yoshida, et al., 2014). The distinctive character of servant leadership is first and foremost that it serves and builds the ones being led (van Dieredonck & Patterson, 2015). Although created as a leadership training, it has also been effective in increasing the resilience of individuals in subordinate positions (Eliot, 2020; de

Zulueta, 2016), but has rarely been studied as component of psychoeducation for trauma survivors.

A servant leadership component, when added to trauma interventions, could challenge the harmful messages given to survivors by corrupt clergy. This research investigates the *Abuse, Trauma, and Jesus* workshop for that purpose. It tests the effectiveness of two versions of trauma intervention: one with a servant leadership component, and one without.

Historical Overview

The Bible reports many instances of sexual misconduct on the part of spiritual leaders. The priest Eli's sons Hophni and Phinehas, "lay with the women who assembled at the door of the tabernacle of meeting" (1 Sam. 2:22). Since these women served as ministers in the sanctuary, it is speculated that the men may have potentially raped them, or at least intimidated them into sex (Davidson, 2007). The story of the Levite's concubine began with a priest engaging in egregious, although tolerated, sexual misconduct with a concubine (Judges 19-21). Davidson (2007) says that when Bathsheba stepped into the throne room of David, she knew that refusing him could bring the death penalty, so she suffered him taking advantage of her instead (2 Sam. 11). Evidenced by Jesus' comparison of his debt as 10 times greater, Simon the Pharisee very likely abused the *sinful woman* many believe to have been Mary Magdalene (Luke 7:36-50). The frankness of scripture on the sinful natures of men in spiritual leadership, and where that sinfulness can lead, stands in sharp contrast to the clergy abuse coverups so common in modern religious circles (Gavrielides, 2012).

The church age, with all its compromises and corruptions, most likely saw its share of abusive clergy; yet "the literature on professional sexual misconduct in general is recent, scant and mostly American" (Oliver, et al., 2017, p. 128). Hints of its existence in the codes of conduct

can be found: Farrell, et al. (2010) cites the "Didache of the Twelve Apostles," the oldest gospel commentary in existence, as saying, "Thou shall not seduce young boys." The Council of Elvira, Canon XVIII said that "clerics . . . who sexually abuse boys . . . are threatened with irrevocable exclusion." (p. 124).

Kleiven (2018) reports that anciently, secular law did not protect women, children, and lower-ranking clergy from the sexual exploits of the deviant, religious, and powerful. By suppressing normal sexual expression in marriage and giving clergy inordinate power over congregants, vows of celibacy, the practice of confessing sin to another human, and the practice of conferring divine status onto clergy all played their part in historically opening the floodgates to sexual abuse.

Doyle (2020) reports that the first public discussion of sexual abuse by priests took place at Notre Dame University in 1967. Speculations and accusations had occurred, but no formal process to address them had been put in place. All United States Catholic bishops were invited to the event. Scholarly work and interchurch communication took place in the decades following, until in 1993, when the Pope issued his first public statement on the matter (Doyle, 2020). An ad hoc committee published a three-part manual between 1994-1996. The 1994 *Catechism of the Catholic Church* addressed sexual abuse, citing its harmful effects to the survivors. The John Jay survey, published in 2004, revealed that since 1950 almost 4500 clergy perpetrators abused at least 10,000 victims (Doyle, 2020; John Jay College, 2004).

Abuse of Children

The years have not solved the problem. de Weger and Death (2017) report that the continuing prevalence of clergy-perpetrated sexual abuse (CPSA) rose to public notice in the United States in 2002 when the investigative journalism team of the Boston Globe uncovered a

dark labyrinth of abuse and coverup in the Boston Catholic archdiocese. Among Roman Catholic clergy, a group that takes vows of celibacy, 50% engage in sex of some kind, a fact that hints at duplicitous living and religious pretention on a mass scale (de Weger & Death, 2017). Ebisike (2020) reports that a 2018 Pennsylvania Grand Jury report, which only covered six of the eight Roman Catholic dioceses in Pennsylvania, said that over 300 priests sexually molested more than 1000 boys and girls for more than six decades. Additionally, the Philadelphia archdioceses grand jury report in 2005 outed over 60 priests involved in sexually abusing children. This number does not accurately represent the problem, as some survivors have since died and many never report. This means that the numbers, as shocking as they are, likely pale in comparison to the real problem, the extent of which, for the aforementioned reasons, is not known. The Catholic Church alone has spent over three billion dollars on abuse cases.

Abuse of Adults

The most scandalous exposes of clergy-perpetrated sexual abuse focus on cases involving underage victims (Ebisike, 2020). In contrast, clergy sexual misconduct against adults (CSMAA) is typically thought of as clergy having an “affair” (de Weger & Death, 2017). Considering the power differential of the clergy/congregant relationship, “affair” is not a correct or adequate term. CSMAA is not a fair fight. The Texas penal code seems to recognize this, as it defines clergy sex as nonconsensual “if the actor is a clergyman who causes the other person to submit or participate by exploiting the other person’s emotional dependency on the clergyman in the clergyman’s professional character as spiritual advisor” (Texas Penal Code Ch. 5, 22.011). Cooper-White (2012) reports that sex with congregants is also a crime in Arkansas, and is criminalized in 11 more states and the District of Columbia if it occurs within a pastoral counseling relationship.

The seeming consent of the adult congregant may be no more than abject terror or brainwashed compliance (Puls, 2018). In the strictest sense of the term abuse, CSMAA is at least an abuse of authority, and at most abuse of the congregant, most of whom lack the courage to cross a "man of God" (Kleiven, 2018). According to de Weger and Death (2017) "CSMAA becomes more evident and understandable when those clergy powers and adult vulnerabilities are clearly delineated as being both positional and personal realities" (p. 227). Jesus declared that one who causes a "little one" to stumble deserves death by drowning. "Little ones," from the Greek *micros,* refers to more than simply children. It refers to anyone of a smaller, weaker stature, physically, socially, or spiritually (Matthew 18:6).

Title IX prohibits sexual harassment in schools (Duchene, 2017); yet churches have no laws or statutes equivalent to Title IX. Unless the sexual contact between clergy and adult congregant is physically coercive and therefore criminal, survivors of CSMAA must, for the most part, depend upon civil suits and intrachurch courts to obtain justice. For reasons involving trauma, victims often lack the drive to do this, and require support in the form of advocacy (Gavrielides, 2012). Churches have been slow to form their own regulatory policies; as recently as 1993, virtually no religious organizations had policies dealing with CSM. Fortunately, this has changed as more and more denominations see the necessity (Gross-Schaefer, et al., 2011).

Most systematic research into the prevalence of sexual abuse in an institutional setting focuses on the Catholic Church, with less data available for the Protestant Church. This may be in part due to the hierarchal structure of Catholicism, something that may increase the likelihood of abuse, but ironically make it easier to track (Thoburn, et al., 2011). Rashid and Barron (2019) identify the main potential reasons as (a) the centralized nature of the Church; (b) anti-Catholic political and media bias in Protestant countries; (c) secular legal systems with access to powerful

lawyers looking to large organizations for compensation; (d) leaders marshalling institutional power to silence victims.

Abuse in Protestantism

Although less available, Protestantism offers its own scandalous facts on clergy-perpetrated sexual abuse in its ranks: Thoburn, et al., (2011) report that 10-14% of active pastors have sexual contact with a non-spouse; more than 30% of ministers engage in inappropriate sexual behavior; more than 15% of ministers are addicted to internet pornography; and the average congregation of 100-700 members has, in attendance, seven women survivors of clergy sexual misconduct (p. 109). Chaves and Garland (2010) report that 3.1% of women attending religious services at least monthly reported a sexual advance by clergy. For perspective, the rates of sexual misconduct by other professionals are lower. About 5-7% of mental health professionals and 10% of physicians acknowledge sex with clients/patients. Note as well that female perpetration of sexual abuse is nearly nonexistent at less than 1% (Thorburn, et al., 2011).

Denney, et al., (2018) cite the need for more exploration of abuse within Protestant churches in the US, given the estimated 314,000 churches and a member base of over 60 million people. Three faith-based insurance companies providing coverage for 165,000 mostly-Protestant churches, reported 7095 claims of church-related abuse between 1987 and 2007 (Denney, et al., 2018) and an average of 260 annual reports of children abused by Protestant ministers (Codone, 2019).

Because it is more congregational than denominational, Protestantism is difficult to study. This is becoming more the case; the number of Christians in the US who identify with a particular denomination went from 50% in 2000 to 30% in 2016 (Gallup, 2017). Some of this is due to a general reduction in religiosity, but some to a reduction in denominational affiliation

among Christians. Non-denominational churches represent the third-largest cluster in the United States, after the Roman Catholic Church and Southern Baptist Convention, with over 35,000 independent or nondenominational churches and more than 12 million adherents (Hartford Institute for Religious Research, 2015). These independent churches lack an accountability structure outside of themselves.

Until the emergence of the social sciences, and traumatology in particular, little focus was given to the effects of sexual abuse by clergy (SAC) on the survivors (Farrell, et al., 2010). But even anciently, the Bible acknowledged it. In the story of Amnon and Tamar, the prince raped his half-sister, after which she took refuge at her full-brother Absalom's house and lived out her life as a "ruined" woman (2 Samuel 13:20). What constituted this ruination? Could it have been that in addition to the trauma of the rape itself, the silence and inaction of Tamar's father David, who did not appropriately punish Amnon, deepened the wound? (2 Samuel 13). The unique features of the wounds caused by sexual abuse in a religious context need illumination.

Conceptual Background

DiMauro, et al., (2014) point out that sexual abuse trauma, along with combat, natural disaster, and life-threatening accidents, is one of the four most common causes of PTSD. Sexual abuse is defined as sexual contact that occurs without the explicit consent of the victim (DiMauro, et al., 2014). Sexual abuse has long been acknowledged as a source of trauma (Farrell, et al., 2010). For the purposes of this research, the term sexual abuse is used as an umbrella term which includes sexual harassment, sexual assault and other forms of sexual contact in which a power imbalance renders one party defenseless.

According to law, children, being underaged, cannot give consent, making all sexual contact with children sexual abuse. As previously discussed, adult survivors of sexual abuse may also be considered unable to give informed consent due to the clergy/congregant power differential (de Weger & Death, 2017). Farrell, et al. (2010) report that survivors of SAC experience many of the classic symptoms of PTSD, including fear, horror, re-experiencing, avoidance, and hyperarousal. In this regard, the trauma response resulting from child abuse and the trauma resulting from the abuse of adults with less positional power, such as is true in the case of sexual abuse by clergy, can be similar.

The unique clinical treatment of the survivors of SAC is the focus of this paper. Sexual abuse is often damaging (Ehring, et al., 2014), but sexual abuse by a religious leader may cause unique forms of damage, thus potentially requiring unique forms of treatment (de Weger & Death, 2017; Farrell, et al., 2010). The unique trauma resulting from SAC may involve the spiritual component. The clergyperson stands in the survivor's life as a representative of God, making perhaps the greatest areas of impact of SAC the God concept, God image, and God attachment of the survivor (de Weger & Death, 2017).

Zarzycka (2019) defines "God image" as the experimental, relational, emotional and implicit ideas of God. The God image construct originally appeared through Grosuch (1968) who developed an adjective checklist assessment of individual God image. Rizzuto (1979) built upon psychoanalytic and object relations theory, with its Freudian recognition of unconscious versus conscious beliefs. As a result, the largely-unconscious, emotionally-based God image was distinguished from the conscious, cognitively-based God-concept. To simplify: The God concept is who we think God to be, whereas the God image is who we feel God to be. Roof and Roof (1984) suggested that most individuals described God as a Father, then Nelsen, et al. (1985)

discovered that while individuals used the word “Father” as a descriptor, the God image aligned more fully with a feminine figure. Thus, the gap between God concept and image became more apparent. Kunkel, et al. (1999) focused on internal constructions of God, creating measurements utilizing two dimensions, anthropomorphic (having human characteristics) versus mystical, and punitive versus nurturant. Francis, et al. (2001) confirmed a positive relationship between self-worth and a loving and forgiving God image, and a negative relationship between self-worth and a cruel, punishing God image. Cheston, et al. (2003) established a link between positive, loving God image and personal growth.

Attachment theory as developed by Bowlby and Ainsworth (1991) provides a rich and enduring framework for research exploring the impact of God image on God attachment (Counted, 2015). Grimes (2008) reports that two primary hypotheses have dominated the literature: the compensatory hypothesis and the correspondence hypothesis. The compensatory hypothesis states that individuals attempt to obtain from their God attachment what they did not from their other attachments, and so imagine God to be what they need. The correspondence hypothesis states that individuals’ God image, which corresponds to their other interpersonal relationships, reflects what they have (Rasar, et al., 2013). Support for both of these hypotheses exists; in fact, God image and attachment are sufficiently complex to assume both the compensatory and the correspondence hypothesis can be true at the same time (Grimes, 2008).

Schaap-Jonker, et al. (2002) explored the relationship between personality disorders and God image, finding a two-way relationship in which the disorder appeared to influence the God image, and the God image appeared to feed the disorder. The link was the strongest with personality disorders in the A and C clusters. The presence of A-cluster symptoms was linked with God being experienced as detached and passive. The presence of C-cluster symptoms was

linked with God being experienced as a harsh judge. This association could be seen even after controlling for symptomology, suggesting that the link between symptoms and the God image may be mediated by personality pathology (Schaap-Jonker, et al., 2002).

A large body of literature exists on the relationship between abuse trauma, mental health, and religiosity (Brewer-Smith & Koenig, 2014; Maltby & Hall, 2012; Pressley & Spinazzola, 2015), but less has been done to establish linkages between clergy sexual misconduct/abuse, trauma, and mental health (Farrell, et al, 2010). The specificity of the type of trauma entailed in SAC bears unique factors that have not received much attention (Farrell, et al., 2010). However, the concept of institutional betrayal, common in clergy sexual misconduct/abuse, has received attention as potentially more harmful than the abuse itself (Holland & Barnes, 2019).

Not many treatments specifically designed for survivors of clergy sexual abuse/misconduct have been empirically validated (de Weger & Death, 2017; Farrell, et al., 2010). Much evidence exists that psychotherapy has general benefits on survivors of sexual trauma (Burrows, 2013; Danielson, et al., 2010 Ehring, et al., 2014; Farrell, et al., 2010; Hassija & Gray, 2011; Kim & Kim, 2020; Rasar, et al., 2013; Ringel, 2014; Suris, et al., 2013). God image has also been successfully treated in survivors of abuse (Cheston, et al., 2003; Tisdale et al., 1997). However, treatments effective in improving both mental health and God image/attachment for survivors of clergy sexual misconduct/abuse have not been studied specifically.

Servant Leadership

Servant leadership concepts have typically been communicated in the context of the training of leaders in an organizational context (Parris & Peachey, 2013; Sendjaya & Sarros, 2002; Shaw & Allen, 2009; van Dierendonck & Patterson, 2015). For example, the Robert K. Greenleaf Center for Servant Leadership, named after the man considered the author of modern servant leadership (Greenleaf, 1970; Green, et al., 2016), aims to "advance the awareness, understanding, and practice of servant leadership for individuals and organizations." (Greenleaf Center for Servant Leadership, 2016, para 1). Servant leadership trainings, unsurprisingly, train leaders.

The workshop that forms the basis of this research departed from the typical way servant leadership has been used (Beck, 2014; Parris & Peachey, 2013; van Dierendonck, 2011). Rather than train leaders, our workshop taught the principles of servant leadership to those who had been harmed by abusive leaders. In other words, this study observed the effect of servant leadership psychoeducation on those impacted by abusive leaders, versus the leaders themselves. The education was delivered by a leader holding a position similar to the position held by the leaders who abused the participants. The idea was to protest the harm done by abusive leaders by teaching and exemplifying what leadership should be. Thus, this study examined a new application of servant leadership.

Hints as to SL's therapeutic power exist in research. Servant leadership seems to foster mental health in an organizational context. It predicts resilience among subordinates (de Zulueta, 2016; Eliot, 2020), as well as general well-being and growth (Sendjaya & Sarros, 2002), pro-social behavior (Walumbwa, et al., 2010), creativity and team innovation (Yoshiida, et al., 2014),

employee optimism (Kool & van Dierendonck, 2012), and leader/subordinate trust levels (Sendjaya & Pekerti, 2010). It has never been examined as a stand-alone treatment component for abuse survivors, but Jit et al. (2017) report that servant leaders practice the process of "alleviating the emotional turmoil of employees" (p. 81). They go on to say, "The servant leaders in our study seem to play this role quite effectively as they help their subordinates come out of their shattered selves and be whole once again" (p. 91). This language hints at the therapeutic value of servant leadership, which may be more fully realized in a therapeutic, as opposed to an organizational, context.

Psychoeducation

This study uses a workshop utilizing psychoeducation as a form of treatment for trauma-related symptoms. Psychoeducation is a key component of trauma treatment (Bass, et al., 2016; Ford & Hawke, 2012; Im, et al., 2018; Kolaitis, 2017; Whitworth, 2016). Psychoeducational workshops have even been done by trained peers versus licensed professionals to meet great demand (Im, et al., 2018). Whitworth (2016) has studied psychoeducation as a stand-alone treatment, finding that interventions that focus solely on symptoms can actually increase them. In light of this, Whitworth recommends features such as an emphasis on recovery, fostering supportive relationships, using culturally-sensitive language, and referrals to other sources of help.

The *Abuse, Trauma and Jesus* workshop was offered as an educational, versus therapeutic event. However, appropriate referrals were made to participants who needed additional help, and participants' status was monitored throughout through in-workshop session chat option. The Whitworth (2016) recommendations of avoiding a negative, symptom-focused approach and the addition of the helpful components cited above was followed.

Problem Statement

The global lifetime prevalence rate of sexual abuse is 18% for girls and 7.6% for boys, and while this abuse most frequently occurs in families, the second most common context in which sexual abuse occurs is institutions. Sexual abuse has both short and long-term consequences for most survivors (Bell, 2016; Dorahy, et al., 2013; Ringel, 2014). The younger the child at the time of the abuse, the more potentially severe the effects (Drebing, et al., 2019).

Treatments for sexual abuse trauma have been studied but not standardized (Burrows, 2013; Danielson, et al., 2010; Gorg, et al., 2017; Hassija & Gray, 2011; Ringel, 2014; Steil, et al., 2018; Suris, et al., 2013). Empirically-supported treatments include emotional regulation strategies, narrative therapy, cognitive restructuring, anxiety and stress management, interpersonal therapy, psychodynamic approaches, family therapy, cognitive processing therapy and acceptance and commitment therapy (Burrows, 2013; Cloitre, et al., 2011; Ringel, 2014; Suris, et al., 2013). However, literature suggests that research on therapeutic approaches aimed at working with survivors of sexual abuse is "inconclusive, conflicting, and contradictory" (Narang, et al., 2019, p. 1). The research on treatment for survivors of SAC may be even more so. Research by Farrell, et al. (2010) has shown that SAC trauma presents unique features demanding unique treatment. Beyond this study, there is a paucity of research on treatments for victims of sexual abuse by clergy.

Potentially due to the high regard with which congregants hold religious leaders, very few survivors of SAC report the abuse (de Weger & Death, 2017). This often results in isolation, inviting depression and other secondary effects (Smith & Freyd, 2014). Beyond this, the survivor's faith in the church and even God, is often shaken. Gavrielides (2012) lists problems arising from sexual abuse by clergy as: difficulty praying, discomfort with religion, inner

emptiness, conflict with God, inability to engage in religious exercises, and political anger. These problems, unique to SAC, must be addressed if interventions are to be effective.

Given that servant leadership (SL) effectively "heals" organizations through such means as building trust, helping relationships, instilling morality (Sendjaya & Pekerti, 2010), and given its healing effect on individuals in an organizational context, it may have a healing effect on individuals in a therapeutic context (Jit, et al., 2017). Counted (2015) called a spiritual leader who helps a survivor heal, a "hermeneutical figure" (p. 7). Through appropriate empathy with the survivor, this figure has the potential of accomplishing a therapeutic recapitulation of negative events with religious leaders (Counted, 2015). In order to explore the potential for this therapeutic effect, an SL element was included in the *Abuse, Trauma, and Jesus* workshop.

Purpose Statement

The purpose of this study was to examine the effectiveness of the *Abuse, Trauma, and Jesus* workshop in treating survivors of sexual abuse by clergy. The treatment integrated several interventions that had been empirically validated in treating abuse trauma, including elements of prolonged exposure therapy (PE), cognitive processing therapy (CPT) (Lopez-Zeron & Blow, 2015), psychoeducation (Whitworth, 2016), and sensory motor therapy (Buckley, et al., 2018). In order to target the unique features of trauma acquired from SAC, the method incorporated data about institutional betrayal, which occurs when the institution employing the perpetrator of abuse invalidates, ignores, or blames the survivor in order to remain loyal to the institution (Holland, & Barnes, 2019; Smith, & Freyd, 2013), God image (Testoni et al., 2016), and God attachment (Counted, 2015). More specifically, since the individual's grasp of the servant leader heart of God may be confused by a harmful encounter with an exploitive individual seen as proxy for God (Kusner & Pargament, 2012), the treatment group included a servant leadership

psychoeducational component in one of the two test groups. In an organizational context, servant leaders help resolve the emotional turmoil of followers by using the tools of effective listening, calming and comforting techniques, and assisting in problem-solving, a process called “healing a broken spirit” (Jit, et al., 2017). This study tested whether SL can be brought into a therapeutic psychoeducation workshop with a similar effect.

The workshop used two groups, one with the servant leadership component (the treatment group) and one without (the control group). This pretest-posttest, experimental design measures a dependent variable before (pretest) and after (posttest) a treatment, and that same dependent variable pretest and posttest in another nonequivalent group.

The design was experimental because random assignment was used. The names of participants were written on pieces of paper, shaken in a jar, and drawn out to distribute them into the two groups. The design allowed for comparison between the treatment group and the control group to assess if the treatment had any additional benefit. General effectiveness of both groups was also assessed through the pretest and posttest.

Survivors of SAC need specific, targeted treatment for their very unique wounds (Astbury, 2013; Farrell, et al., 2010). This study tested both a general approach and a more-targeted approach to begin the process of focusing on the unique treatment needs of survivors of SAC.

Significance of the Study

This study added to the existing literature on trauma treatments generally, and treatments for sexual abuse and institutional betrayal, specifically. Many helpful methods of treating trauma exist. Ehring, et al. (2014) identify several with strong empirical backing: prolonged exposure therapy (PE), trauma-focused cognitive behavioral therapy (TF-CBT), eye movement

desensitization and reprocessing (EMDR), emotion-focused therapy, and interpersonal therapy. This study combined elements of these treatments that could be done appropriately in a Zoom-mediated psychoeducational group workshop.

It also opened an arena in which psychoeducation on servant leadership could potentially provide a healing influence. Servant leadership as conceptualized by Sendjaya, et al. (2019) deeply reflects biblical principles such as using power to serve, freedom to question leadership, respect of individuality, moral influence, encouraging meaning-making, and contributing to professional and personal growth. The work of Sendjaya, et al. (2019) was used as a basis for the servant leadership component of the treatment group of the workshop. The effect of servant leadership on organizations has been studied extensively; its healing effect on individuals, particularly individuals who had experienced SAC, has not.

This study contributed to the larger body of literature of several domains. Specific treatments for trauma stemming from SAC was sparse in the literature (Farrell, et al., 2010), and this study helped made an addition. Clinicians encountering this research will be better equipped to address the unique aspects of SAC trauma. Additionally, this study enriches the understanding of the broadness of the applicability of the principles of servant leadership, which has been examined mostly in the context of the workplace (Sendjaya, et al., 2019). The study expanded clinical methods of addressing God image, concept and attachment therapeutically through psychoeducation. Finally, it added to the existing literature on institutional betrayal, its effects, and clinical approaches to its treatment, as institutional betrayal is often overlooked as a factor in trauma (Smith & Freyd, 2014).

Research Question(s)

The research questions of this study asked two things. One was if a six-session, videoconferencing *Abuse, Trauma and Jesus* workshop would help survivors of church-related sexual abuse improve in the domains of God attachment and PTSD symptoms. These domains were measured using empirically validated assessments: The Attachment to God Inventory (Beck & McDonald, 2004) and the Primary Care PTSD Screen for the DSM-V (Prins, et al., 2016). The assessments were administered before and after the workshop.

The second question was if the addition of a servant leader psychoeducation component would bring about further improvement. The treatment group was the same workshop as the control group, but with the added component, delivered by a male clergyperson. The participants completed the same assessments pre and posttest.

RQ1: Will participation in a six-session, videoconferencing, *Abuse Trauma, and Jesus* workshop improve measures of God attachment in survivors of sexual abuse by clergy?

RQ2: Will participation in a six-session, videoconferencing, *Abuse Trauma, and Jesus* workshop improve measures of PTSD in survivors of sexual abuse by clergy?

RQ3: Will participation in a six-session, videoconferencing, *Abuse Trauma, and Jesus* workshop with the added component of servant leadership psychoeducation more significantly improve measures of God attachment in survivors of sexual abuse by clergy than the stand-alone workshop?

RQ4: Will participation in a six-session, videoconferencing, *Abuse Trauma, and Jesus* workshop with the added component of servant leadership psychoeducation more significantly improve measures of PTSD in survivors of sexual abuse by clergy than the stand-alone workshop?

Definitions

1. *Betrayal Trauma* – This type of trauma occurs when survivors expect protective, benevolent treatment from sources that instead deliver harmful treatment and abuse. Often the survivor dissociates from the truth for coping purposes (Kaehler & Freyd, 2012).
2. *Child Sexual Abuse (CSA)* – CSA is involving a child in sexual activity, either through contact abuse such as fondling or rape, or non-contact abuse such as forced involvement in pornography or modeling of sexual behavior. Because underaged persons lack the ability to comprehend and give informed consent to sexual activity, all CSA is considered non-consensual (Astbury, 2013).
3. *Clergy* – Refers to ordained pastors, priests, chaplains and other ministers, but in principle includes any who hold an office of spiritual leadership, including informal contexts such as lay-led ministries and teachers in religious schools (Death, 2014: Gross-Shaefer, et al., 2011; Kleiven, 2018).
4. *Clergy-Perpetrated Sexual Abuse (CPSA)* – CPSA refers to clergy exploiting their power advantage and spiritual office to pleasure themselves at the expense of their congregants. Most often CPSA refers to clergy abuse of children (de Weger & Death, 2017), and is sometimes termed clergy perpetrated child sexual abuse (CPCSA) (Astbury, 2013).
5. *Clergy Sexual Misconduct (CSM)* – In most usage, CSM refers to clergy pursing sexual contact with adult congregants, distinct from the sexual abuse of children by clergy (de Weger & Death, 2017; Oliver, et al., 2017).

6. *Clergy Sexual Misconduct Against Adults (CSMAA)* – The term CSMAA is more precise than CSMAA, specifying that the survivor is not underage, but still vulnerable as designated by the word "against." (de Weger & Death, 2017).
7. *Cognitive Processing Therapy (CPT)* – This cognitive-behavioral-based therapy utilizes exposure through narration of traumatic events to give opportunity for reframing and rethinking (Lamp et al., 2019).
8. *Complex Post Traumatic Stress Disorder (CPTSD)* – This diagnosis has been validated in research but has not yet been included in the diagnostic manual of the American Psychiatric Association (2013). It is characterized by many of the same symptoms as PTSD, but tends to relate more to repeated childhood abuse or chaos rather than an isolated life-threatening situation (Tummala-Narra, et al., 2012).
9. *Eye Movement Desensitization and Reprocessing (EMDR)* – This therapy, originally developed by Francis Shapiro, utilizes many of the same components of other trauma therapies with the addition of eye movements to facilitate a brain condition thought conducive to memory processing (Oren & Solomon, 2012).
10. *God Attachment* – This term refers to the ability of the individual to feel a secure bond with the divine (Counted, 2015; Kézdy, et al., 2013; Krause & Ironson, 2017).
11. *God Concept* – This term refers to an individual's intellectual and conscious concept of God (Gardner, 2013).
12. *God Image* – This term refers to an individual's emotional and unconscious sense of God (Testoni et al., 2016).

13. *Institutional Betrayal* – This type of betrayal occurs when the institution or organization behind a perpetrator of abuse disbelieves and/or discredits the survivor (Holland, & Barnes, 2019; Smith, & Freyd, 2013).
14. *Posttraumatic Stress Disorder (PTSD)* – This diagnosis, found in the Diagnostic Manual of the American Psychiatric Association (2013), is characterized by several symptoms signaling unprocessed traumatic memories.
15. *Post Traumatic Growth (PTG)* – This concept refers to positive character growth following traumatic life events. The research on PTG was pioneered by Richard Tedeschi and Lawrence Calhoun (Tedeschi & Calhoun, 1996).
16. *Prolonged Exposure Therapy (PE)* – PE therapy is an empirically-validated, manualized, structured approach to treating PTSD involving gradual exposure to triggers (Foa, Hembree, & Rothbaum, 2007; Thompson & Waltz, 2010).
17. *Servant Leadership (SL)* – Servant leadership distinguishes itself from the militaristic or corporate models of leadership in one central regard—that the leader uplifts, helps, and builds their followers rather than their own power over their followers (Beck, et al., 2018; van Dierendonck, 2011; Sendjaya, et al., 2019).
18. *Sexual Abuse*- Sexual abuse is an umbrella term including sexual harassment, sexual assault and other forms of sexual contact in which a power imbalance renders one party defenseless, creating what Kleiven (2018) calls a “power theoretical framework” (p. 277).
19. *Sexual Abuse by Clergy (SAC)* – This umbrella term describes any form of sexual abuse perpetrated by any type of spiritual leader (Death, 2015).
20. *Sexual Assault* – Sexual assault is defined by sexual contact that occurs without the explicit consent of the victim (DiMauro, 2014).

21. *Title IX* – Title IX is a US civil rights law passed as part of the Education Amendments of 1972 preventing discrimination based on sex, which includes prohibitions against sexual harassment and abuse in the workplace and educational institutions (Duchene, 2017).
22. *Trauma-Focused CBT (TF-CBT)* – TF-CBT is an evidenced-based trauma treatment delivered primarily to children and adolescents and their parents, typically focusing on complex trauma involving multiple events (Ehring, et al., 2014).
23. *Survivor* – An individual who has been violated by another. Survivor, as opposed to victim, is the preferred term for the sake of the self-concept of the survivor (Papendick & Bohner, 2017).

Summary

Few evidence-based treatment approaches for survivors of sexual abuse by clergy (SAC) exist; yet the unique features of SAC demand unique treatment (Astbury, 2013; Farrell, et al., 2010). The perpetrator of SAC has violated the trust of the survivor in ways even the survivor may not fully comprehend (Smith & Freyd, 2014). Betrayal trauma factors enter the picture as the survivor struggles with the perceptual shift from the clergy being a benevolent figure to the realization of the malevolence required to take advantage of the survivor's trust (Kaehler & Freyd, 2012). Complex institutional betrayal factors present themselves as the families and churches of survivors either believe, validate, and support, or disbelieve, invalidate, and abandon the survivor (Death, 2015). This can predict certain effects: the loss of faithful supporters due to the fracturing of the faith community may plunge the survivor into isolation; the general mental health of the survivor may suffer due to trauma-related anxiety and depression; due to the representative role of the clergyperson, the God image of the survivor takes on distortions that

impact God attachment, which can also suffer a withering blow as the result of SAC (Smith & Freyd, 2014).

Many therapies have helped survivors of sexual abuse (Burrows, 2013; Danielson, et al., 2010; Hassija, 2011; Kaehler & Freyd, 2012; Ringel, 2014; Suris, et al., 2013). This study utilized a combination of the most appropriate aspects of those therapies in a six-session, Zoom-mediated psychoeducational group called the *Abuse, Trauma, and Jesus* workshop (ATJ workshop). The treatment group in the study introduced one new therapeutic factor, that of a servant leadership psychoeducation component.

The effect of servant leadership upon organizational functioning has been studied extensively (Kool & van Dierendonck, 2012; Parris & Peachey, 2013; Savage-Austin & Honeycutt, 2011; Sendjaya & Pekerti, 2010; Sendjaya & Sarros, 2002; Walumbwa, et al., 2010; Yoshida, et al., 2014), but no research exists on its ability to heal individuals of the effects of abuse trauma. This study will test its effectiveness as well as the general effectiveness of the ATJ workshop. More and effective treatments are needed for those who suffer in the unique ways of survivors of SAC (Astbury, 2013; Smith & Freyd, 2014).

Chapter Two: Literature Review

Overview

Sexual abuse by clergy (SAC) and clergy sexual misconduct (CSM) refer broadly to the phenomenon of pastors, priests, and other spiritual leaders using their power advantage obtain sexual access to those they lead (Astbury, 2013; de Weger & Death, 2017; John Jay College, 2004; Oliver, et al., 2017). The effect of such abuse, whether physically forced or not, can be profound, especially when compounded by the secondary trauma of institutional betrayal in which the survivor is disbelieved, invalidated, and even shunned by the organization represented by the clergyperson (Holland & Barnes, 2019; Smith & Freyd, 2014). Some survivors will develop PTSD, but more will develop a subtype of complex posttraumatic stress disorder (CPTSD) with features of betrayal trauma (Farrell, et al., 2010). This bears a similarity to the betrayal trauma of caregiver-abused children who may deny the abuse while seeing the abuser as a source of good will (Maltby & Hall, 2012; Tummala-Narra, et al., 2012).

All of this profoundly impacts the survivor's God image, and the implicit, emotional sense of God's character (Testoni, et al., 2016). Along with the effect on the God image, God attachment—the ability to attach to God—is affected as well (Counted, 2015; Kézdy, et al., 2013; Krause & Ironson, 2017). These changes can take place even with a stable, positive God concept, the conscious, cognitive belief about God. This may lead to incongruity between a distorted God image and an accurate God concept (Gardner, 2013). A distorted God image can also lead to changes in the God concept, as in cases where the individual becomes atheistic due to an overwhelming sense that God was not present during the abuse (Kusner & Pargament, 2012).

Therapists have power to help revise the God image of abused clients through therapeutic recapitulation and trust-building (Counted, 2015). Survivors may also be helped by evidence-based treatments for PTSD, even enjoying the effects of posttraumatic growth (Tedeschi & Calhoun, 1996; Triplett, et al., 2012). In combination with these treatments, the principles and practice of servant leadership may have therapeutic power (Kool & van Dierendonck, 2012; Sendjaya & Pekerti, 2010). However, the role it could play in the rebuilding of the God image of survivors of sexual abuse by clergy has not been considered or tested. More research is needed to understand its potential.

Keywords: betrayal trauma, child sexual abuse, sexual abuse by clergy, clergy sexual misconduct, posttraumatic stress disorder, complex posttraumatic stress disorder, betrayal trauma, institutional betrayal, God concept, God image, God attachment, posttraumatic growth, servant leadership.

The research presented in this literature review examines various aspects of sexual abuse by clergy, including its prevalence, effect, effective therapies, and potential long-term outcomes including posttraumatic growth. It identifies the gap in the literature, which this study addresses. That gap is treatments for survivors of SAC. Specifically, it is the potential therapeutic benefit of psychoeducation about servant leadership upon the individual whose trust in clergy, in self, in others, and in God has been violated by SAC.

Theoretical Framework

Much research has been conducted on various aspects of this study. The relationship between God concept, God image, and God attachment has been explored (Counted, 2015; Gardner, 2013; Kézdy, et al., 2013; Krause & Ironson, 2017; Testoni, et al., 2016). Sexual abuse in a church context has been studied along with its ancillaries of institutional betrayal, betrayal

trauma, and complex trauma (Edwards, et al., 2012; Gobin, & Freyd, 2014; Holland, & Barnes, 2019; Smith, & Freyd, 2013; Yeater & O'Donohue, 1999). In addition, PTSD and CPTSD have large bodies of literature (American Psychiatric Association, 2013; Cooper-White, 2012; Death, 2015; Dinenberg, et al., 2014; John Jay College, 2004; Kezelman & Stravropoulos, 2012; Kliethermes, et al., 2014; Tummala-Narra, et al., 2012) as do their treatments (Arkowitz & Lilienfeld, 2016; Bass, et al., 2016; Burrows, 2013; Danielson, et al., 2010; Farrell, et al., 2010; Fisher, 2019; Foa, et al., 2013; Ford & Hawke, 2012; Hassija & Gray, 2011; Im, et al., 2018; Kaehler & Freyd, 2012; Kolaitis, 2017; Lamp, et al., 2019; Lopez-Zeron & Blow, 2015; Narang, et al., 2019; Oren & Solomon, 2012; Pressley & Spinazzola, 2015; Ringel, 2014; Shapiro & Forrest, 2016; Suris, et al., 2013; Thompson & Waltz, 2010; Ullman et al., 2014; van Minnen, et al., 2012; Watts, et al., 2013; Whitworth, 2016). Yet, little research exists either on treatments effective for the unique aspects of trauma stemming from SAC, or on the therapeutic impact of psychoeducation on servant leadership on survivors of sexual trauma perpetrated by clergy.

There is extraordinarily high potential for sexual abuse by clergy to cause damaging traumatic responses, especially to the individual's religious faith and God concept, image, and attachment (Arkowitz & Lilienfeld, 2012; Astbury, 2013; Bass, et al., 2016; Farrell, et al., 2010; Fisher, 2019; Foa, et al., 2007; Ford & Hawke, 2012; Gurda, 2015; Im, et al., 2018; Kolaitis, 2017; Lamp, et al., 2019; Lopez-Zeron & Blow, 2015; Menon, et al., 2010; Narang, et al., 2019; Pressley & Spinazzola, 2015; Salas, et al., 2020; Smith & Freyd, 2014; Watts, et al., 2013; Whitworth, 2016). This study asked whether psychoeducation on servant leadership improves God attachment and trauma symptoms in survivors of sexual abuse by clergy who participate in a six-session video conferencing *Abuse, Trauma, and Jesus* workshop.

Related Literature

The topics reviewed relate to the test in multiple ways essential to studying the relationship between God and trauma, including aspects of the effect of trauma on God concept, God image, and God attachment, which interconnect on many levels. The topics of clergy sexual misconduct and sexual abuse in a church context are also reviewed, giving some space to sexual abuse prevention and response efforts that various organizations, including churches, have made. A review of typical sexual abuse perpetrator psychology explores the source of the complex trauma our participants experienced. Complex trauma, including betrayal trauma, and the institutional betrayal that often occurs when an individual suffers sexual abuse by clergy are also reviewed. Finally. effectiveness of trauma treatments used in the ATJ workshop, and the principles of servant leadership utilized in the treatment group, are reviewed.

God and Trauma

God Concept and God Image

The test that provided the basis of this study examined whether a certain treatment for survivors of sexual abuse by clergy produced a measurable effect in two domains: God attachment and trauma symptoms. Trauma impacts God attachment (Rudolfsson & Tidefors, 2014). In order to better understand how this takes place and how it can be addressed therapeutically, we must understand God attachment and its ancillary issues.

Human beings in general and trauma survivors in particular struggle to understand evil alongside the Biblical teaching of a loving God fully invested in human well-being. Theodicy, the vindication of divine goodness in view of the existence of evil, has grown over the centuries into a massive a cross-disciplinary field of study (Peckham, 2018). Taking theodicy within the scope of this study, the impact of individual experience with God upon human well-being

becomes clear (Beck & McDonald, 2004; Bradshaw, et al., 2010; Kézdy, et al., 2013; Leman, et al., 2018; Maltby & Hall, 2012). This experience involves God concept, which entails cognitive and explicit theological beliefs (Gardner, 2013), God image, which entails emotional and implicit perceptions (Testoni, et al., 2016), and God attachment, which is how humans connect with God on a relational level (Counted, 2015; Kézdy, et al., 2013; Krause & Ironson, 2017), and which has been shown to be predicted by God image (Gardner, 2013). Trauma has the potential of impacting all three of these, particularly when the source of trauma is a religious figure claiming to represent God (Kucharska, 2018).

The God concept plays an important self-regulatory role in the human experience (Counted, 2015). God image is more implicit and emotionally-centered, but it can influence the God concept and vice versa (Counted, 2015). Kucharska (2018) found that both religious and non-religious women with a history of sexual trauma had higher self-blame if they had a "strict God" concept. In the same study, religiosity and the God concept moderated the relationship between the type of trauma, posttraumatic cognitions, and mental health. Individuals holding a traditional concept of God as male are much less favorable toward same-sex unions than those who do not view God as masculine (Whitehead, 2014). When God image was measured through an implicit testing technique, those with an image of God as a supportive and compassionate Father predicted lower anxiety and fewer avoidance strategies (Testoni, et al., 2016).

Krause and Ironson (2017) reporting on a national survey, found little difference between the God image of Hispanics and Whites, but did find differences between Blacks and both Hispanics and Whites. Blacks had a more positive God image, and were more likely to have strong positive emotions toward God. This suggests that a positive God image predicts God

attachment in the form of positive emotions toward God, versus avoidant or anxious emotions (Krause & Ironson, 2017).

Kézdy, et al. (2013) studied God image in relationship to work addiction, finding direct associations between the two when there was a controlling God image. The same study showed a positive association between anxiety about being abandoned by God and work addiction risk (Kézdy, et al, 2013). A negative image of God was positively correlated with depression in cancer patients, as was pathological guilt (Alavi, et al., 2013). A positive image of God has also been associated with lower anxiety and depression in college students (Koohsar & Bonab, 2011).

Internal working models have been well-understood in psychodynamic psychology. These are mental representations of our relationship with primary caregivers and other early relations that become templates for future relationships (Beck & McDonald, 2004). Granqvist (2012) reports that through these early experiences and their resulting representations, attachment information becomes encoded in the nervous system and trust-building capacity of the individual. Granqvist also found support for the correspondence hypothesis that working models created in childhood tend to generalize to other relationships, including God. They found that individuals generalized avoidant attachment styles formed in the parent-child relationship to their relationship with God, and the same was true for anxious attachment styles. Parent-child attachment has been associated with religious and spiritual struggle; a distant God image mediated the relationship between avoidant attachment to parents and religious doubt, and a cruel God image mediated the relationship between avoidant attachment to parents and interpersonal struggle (Zarzycka, 2019).

Trauma, whether incremental as is typical in CPTSD, or sudden and overwhelming as in PTSD, has the potential of disrupting our internal working model of God, or God image

(Pressley & Spnazzola, 2015). Maltby and Hall (2012) report that stress hormones needed to cope with crises work well in the moment, but compromise brain regions such as the amygdala and hippocampus so needed in bonding. Maltby and Hall also advise that when working with traumatized individuals, we should expect a greater distance between explicit and implicit knowing, be prepared for transference enactments, understand the spiritual significance of trauma, support survivors' efforts to share their story with their spiritual community, and help spiritual leaders become trauma-informed (Maltby & Hall, 2012).

God Attachment

Attachment styles tend to form in the first three years of life between the primary caregiver (typically mother) and child, carrying over into the individual attachment to God (Granqvist, et al., 2012). Secure attachment to God has been inversely associated with distress, whereas both anxious attachment to God and stressful life events are positively related to distress (Bradshaw, et al., 2010). Anxious attachment to God has been found to mediate the relationship between parental care and negative religious coping, whereas levels of avoidant attachment to God and positive religious coping were independent of perceived parental care (Láng, 2016).

The therapeutic process has the potential to improve intimacy with God by altering neural networks associated with internal objects of authority figures, reformatting the brain to experience God in a new way (Gardner, 2013). Counted (2015) has called a spiritual leader who strives to heal attachment-impacting trauma a "hermeneutical figure." By entering the experience of, and empathizing with, the pain of the survivor, this figure assists the trauma survivor in re-interpreting reality. Counted (2015) says that especially when a religious leader caused the trauma in the first place does this hermeneutical figure have the potential of healing recapitulation through empathy with the survivor.

Leman, et al., (2018) showed that secure attachment to God characterized by lower avoidance and anxiety features and religious service attendance predicted self-reported emotional well-being, and that even after religious service attendance, prayer, and demographic variables were controlled, secure God attachment predicted the same benefit. The authors summarized by saying that "perceived relationship with God appears to be an important factor in the connection between religiousness and psychological health" (Leman, 2018, p. 162).

Hernandez, et al. (2010) reported that feelings of God abandonment led to self-directing the religious coping style (p. 97), and that this predicted more alcohol use in college students than either a secure or an anxious-ambivalent relationship with God. Students who felt securely attached to God used alcohol significantly less than all groups (Hernandez, et al., 2010). In a nationwide sample study, secure attachment to God was inversely related with psychological distress (Bradshaw, et al., 2010).

Trauma has been found to impact God attachment. Relevantly, Rudolfsson and Tidefors (2014) found that sexual abuse led to religious struggles and feelings of having been betrayed by God and excluded from fellowship even if the perpetrator was not a clergy person. Since clergy abuse survivors' families of origin often revere the clergy, the impact on relationships within the family can be devastating (Wind, et al., 2008). Survivors may not only feel betrayed by the church, but the family; they may also feel that the clergy person betrayed their family (Wind, et al., 2008). If an abuse survivor's experience with God has been grounded in family and church, and the family and church "side" with the perpetrator, the foundation of the survivor's attachment to God is effectively removed (Smith & Freyd, (2014).

Religion, Trauma, and Mental Health

In a study by ter Kuile and Ehring (2014), nearly half of the sample of trauma survivors who filled out the questionnaire reported changes in religious beliefs and activities as the result of the trauma. A significant factor in this is the shattering of the belief that the world is a safe, predictable, and fair place (ter Kuile & Ehring, 2014). Stone (2013) points out that while the existing research links religion and mental health positively, popular literature contains many books on spiritual and religious abuse, and that this disparity may show that the literature does not adequately reflect the sometimes harmful effects of spirituality and religion.

Stone (2013) points out that one of the chief concerns regarding the effect of faith on mental health is the practice of using it to bypass problems, feelings and needs. The typical religious clichés used to shut down emotions and processing come to mind: "It must be God's will" would prevent a religious person from questioning why a disaster occurred. "Pray about it" would stop a sufferer from complaining for fear of seeming unprayerful. The bypassing effect heightens when the source of trauma is clergy, as clergy represent God (Stone, 2013).

Various God images have been linked directly to specific disorders. For example, punishing God reappraisal has been linked to PTSD symptoms, while reappraisal of the event to evil forces was not linked (Wortmann, et al., 2011). Attributing a traumatic event to evil forces becomes very difficult when the source of the trauma represents God, such as in the case of clergy. This interfaces with institutional betrayal, to be developed later in this review.

Pressley and Spinazzola (2015) say that one of the effects of complex trauma is the disruption of systems of meaning. Reconstructing that meaning is difficult, arduous work, especially when it involves religion and spirituality. Survivors grapple mightily with their losses, particularly in that they were not loved and protected by those they had reason to assume would

love and protect them (Pressley & Spinazzola, 2015). Moreover, God allowed the abuse to happen. The inaction creates a blank screen onto which a negative narrative can be easily projected (Rudolftsson & Tidefors, 2014).

Bomyea, et al. (2013) report that pre-trauma individual differences can increase vulnerability to PTSD, including gene variations, neuroendocrine factors, and cognitive factors. Bomyea, et al. (2013) found several cognitive vulnerabilities predicted the acquisition of PTSD, including lower intelligence, low executive function, poor performance on neuropsychological tests, and cognitive biases that increase one's subjective sense of threat.

Brewer-Smyth and Koenig (2014) posit that, "While spirituality and religion can be related to guilt, neurotic, and psychotic disorders, they also can be powerful sources of hope, meaning, peace, comfort, and forgiveness for the self and others" (p. 251). They identify several mediating factors including the promotion of forgiveness, opportunity for emotional catharsis, and social support, which can be both intrinsic in the form of a connection to the divine, and extrinsic in the form of human connection (Brewer-Smith & Koenig, 2014). The authors point out that these dynamics bring about actual change in survivors' neurobiological condition. For example, levels of hormones in response to hypothalamus-pituitary-adrenal (HPA) axis activation are considered biomarkers of resilience. Women reporting religious activity had biomarkers consistent with resilience, whereas the opposite was true for women with low religiosity. The authors linked weekly religious service attendance with lower overall stress, and lower hostility levels. They also report a link between religion and lower suicidality (Brewer-Smyth & Koenig, 2014).

However, faith-based groups can vary greatly, with some emphasizing forgiveness, trust, prayer, and social support and others emphasizing wrath and punishment. The latter may have

the opposite of the desired effect (Brewer-Smyth & Koenig, 2014). Tausch, et al., (2011) report that positive religious coping methods include support from other believers, emotional reassurance, intimacy with God and others, and the perception of a loving, sovereign God. Discontent with the congregation and with God and negative reframing, as seeing traumatic events as punishments from God, are negative forms of religious coping (Tausch, et al., 2011). These studies make it clear that religion can go either way in its effect on trauma survivors.

Church-Related Sexual Abuse and Misconduct

In this study we examined individuals who experienced trauma of a specific kind in a specific context—sexual abuse trauma experienced in a church context. Sexual trauma perpetrated by clergy generates unique trauma features not accounted for within the existing PTSD conceptual frameworks. These unique features stem from the spiritual and religious crises bound up in the experience Farrell, et al. (2010) identify these unique features as: theological conflict, silencing strategies used by abusers, spiritual identity, existentialist questions about free will, political anger, and re-traumatization by the church (p. 127).

The problem of sexual abuse by clergy can be separated into two broad categories: The abuse of children, called clergy-perpetrated sexual abuse or clergy-perpetrated child sexual abuse (CPSA, CPCSA) and the sexual exploitation of adult congregants, most often called clergy sexual misconduct (CSM) (Astbury, 2013; de Weger & Death, 2017; Oliver, et al., 2017). The umbrella term used in this study is sexual abuse by clergy (SAC).

Kusner and Pargament (2012) mention clergy perpetrated sexual abuse (CPSA) as part of the category of spiritual trauma, explaining that, “Traumas become spiritual when they are appraised as threatening or damaging to aspects of life that the individual holds sacred” (p. 212). CPSA may be appraised as a sacred loss, a loss of faith and perceived connection to God, even

the loss of a worldview. Clergy may be seen as proxies for God possessing such authority that they must be obeyed without question (Kusner & Pargament, 2012).

Clergy-Perpetrated Child Sexual Abuse

In that it occurs within a religious "family" clergy-perpetrated child sexual abuse (CPCSA) resembles incestuous child abuse in several features, including:

- Relatedness- Survivors are closely allied to their church family;
- Length of time- Abuse tend to occur over an extended period;
- Adults' disbelief- Adults frequently do not believe reports of abuse;
- Scandal avoidance- Church leaders attempt to silence survivors;
- Nondisclosure in childhood- Many survivors do not report till adulthood (Astbury, 2013).

The effects of CPCSA track with typical trauma symptoms such as substance abuse, affective lability, and relational conflicts, but then fan out into unique features such as alterations in spirituality and religious practices and a deep sense of having been betrayed by both the clergyperson and the church (John Jay College, 2004). Perpetrators often invoke the name and person of God as a silencing strategy (Astbury, 2013).

Due to these impediments, CPCSA survivors often report long after the event. In the John Jay Report (John Jay College, 2004), less than 13% of the allegations were made during the year when the abuse began, and more than 25% were made more than 30 years later. The abuse often extends for a long period; more than 10% lasted five to nine years (John Jay College, 2004). The keeping of secrets weighs heavily on survivors. When the abuser and the institution demand this secrecy, the survivor may fearfully comply with the sources of harm, adding the guilt of compliance to the already overwhelming load of psychological injuries (Death, 2015).

Clergy Sexual Misconduct Toward Adults

As a result of raised awareness regarding the unique and devastating ways sexual abuse by clergy can damage and harm, at least 36 denominations now have policies that state that sexual relationships between clergy and adult congregants are misconduct (termed "clergy sexual misconduct, or CSM) subject to discipline (Garland & Argueta, 2010). Some take the matter even further; de Weger and Death (2017) point out that it is doubtful whether congregant consent even exists in a clergy/congregant sexual encounter, but that even if did, sexual contact with a congregant is abuse on the part of the clergy. The power imbalance and "God factor" leads to a suspension of defenses on the part of the congregant, who may consent physically to the sexual contact, but is so overpowered psychologically that the physical consent means nothing (de Weger & Death, 2017). Even some states, namely Arkansas and Texas, have laws criminalizing clergy sexual contact with an adult congregant (Cooper-White, 2012; Texas Penal Code Ch. 5, 22.011).

Kleiven (2018) addresses the perception of CSM being consensual by saying that the lens through which we see it must change. Viewing it through the lens of a sexual act, we see two adults enjoying a sexual liaison, but viewing it through the lens of power, we see one human being taking advantage of another. The former lens "accuses both parties involved in cases of sexual misconduct by downplaying abusive behavior and ignoring the vulnerability of the abused" (Kleiven, 2018, p. 287). Conceptualizing sexual misconduct primarily as an act of sexuality creates a framework of reciprocity, leading survivors to be regarded as consenting participants. However, conceptualizing clergy sexual misconduct as primarily an abuse of power allows for more recognition of power imbalance-related compliance (Kleiven, 2018).

Perpetrator Psychology

In order to better understand the specific type of trauma experienced by the participants of the study, it was necessary to understand the individuals who engaged in the traumatizing acts. Specifically, since part of the trauma involved aspects of both the personality of the perpetrator and the dynamics and relationship that developed out of that personality, it was necessary to understand the clergy who perpetrate sexual abuse.

Perhaps the most comprehensive effort to document the problem of sexually abusive clergy in the Catholic Church came from the Church itself in a report commissioned by a review board that arose out of the General Meeting of Catholic Bishops in 2002 (Perillo, et al., 2008). The board engaged John Jay College of Criminal Justice, who conducted the research and published a summary in the John Jay Report. The report examined 10,677 individuals' allegations. Just over half of abusive priests allegedly abused only one victim, 27% alleged two or three, and 14% alleged more than four. The 3.5% of priests who allegedly abused 10 or more victims were allegedly responsible for 25% of the total allegations (John Jay College, 2004). Perpetrators can vary in how prolifically they abuse. More research is needed on whether this feature is innate or develops over time and with repeat offending.

Prior sexual abuse is a strong predictor of sexual recidivism, defined by repeat offending even after legal and therapeutic intervention (Ozkan, et al., 2020; Perillo, et al., 2008). This suggests the compulsion to abuse builds upon itself. Perillo, et al. (2008) identify risk factors for repeat offending as: prior convictions for sexual abuse, young age onset of abusing, having male and extrafamilial victims, antisocial personality traits, and emotional identification with children. Sexual interest in children as measured by phallometric testing also predicted repeat offending

(Perillo, et al., 2008). Ozkan, et al. (2020) add adverse childhood experiences (ACEs) as a recidivism risk. Ford and Hawke (2012) report the benefits of trauma-focused programs in reducing recidivism rates.

Sexually abusive clergy have been conceptualized as falling into three basic typologies: the wanderer, who wanders across boundaries due to overwhelming crisis or life transition, the lover, who simply falls in love with someone who happens to be a member of his congregation, and the predator who intentionally seeks victims and is lacking in conscience (Garland, 2006). Cooper-White (2012) explains that most churches optimistically see abusive pastors as non-predators, when in fact at least half of them fall into the latter category.

Cooper-White (2012) states that factors leading clergy to sexually abuse must never excuse behavior nor remove responsibility, then offers the following contributing factors: educational gaps, specifically, a lack of training on professional boundaries; situational stresses such as marital discord, workaholism, and social isolation; and characterological factors involving personality traits, particularly narcissism.

Situational crime prevention (SCP) studies how situations can become conducive to criminal acts, and how criminals then use these environments to their advantage. Criminals will be less likely to commit acts of abuse if the acts present too much risk, require too much effort, or offer too little reward (Terry & Freilich, 2012). In the case of sexual abuse by clergy, the "situation" of the local church's administrative structure can deter or encourage crime. Catholicism is a sacramental culture where the ordination of a man to the priesthood makes him "alter Christus" or "another Christ" (Astbury, 2013). In Protestantism the special status of clergy, though not as heavily doctrinally inculcated, thrives still (Denney, et al., 2018). Cooper-White (2012) describes the power imbalance in a clergy/congregant relationship:

> He is often physically stronger and more imposing. He may also be an employer. He may also assume a teaching or mentor role, which encourages her to listen to his advice and correction and sets her up for a particularly virulent form of psychological abuse. Often, he also functions as her counselor, with all the transference inherent in such a relationship. Parallels to incest pertain within the church "family" and can hold similar traumatic consequences for victims as in cases of intrafamilial abuse (p. 153).

Notably, the victims of child sexual abuse by Catholic clergy are 81% male, most of them falling in the 10-15 years old category (John Jay College, 2004; Astbury, 2013). In contrast, Rashid and Barron (2019) note that this contrasts with the general population in which most victims of sexual abuse are female. Rashid and Barron also mention the paucity of research on SAC victim characteristics in Protestantism, attributing it to the less-centralized nature of Protestantism. However, Kaiser (1996) reported that victims of SAC within Protestantism are more often female. Phallometric testing is a strong predictor of repeat sexual offending, especially for pedophilic sexual interest, possibly suggesting a compulsive aspect of pedophilia (Perillo, et al., 2008). Explanations of the differences between victim profiles in Catholicism and Protestantism deserve more study.

Ebisike (2020) argues that the majority of sexually abusive Catholic priests suffer from psychiatric and psychological disorders, substance abuse problems, endocrine disorders, and/or were survivors of abuse themselves, rendering the psychological/psychiatric evaluations of applicants into seminaries woefully inadequate. Better evaluation procedures of seminary applicants would make it easier to identify potentially abusive individuals (Ebisike, 2020).

Using a sample of digital news articles from 1982 to 2014 of 2240 abuse allegations, Denney, et al. (2018) looked at sexually abusive clergy within Protestant churches. Similar to the

John Jay Report (John Jay College, 2004) and other sources examining perpetrators within the Catholic tradition, the majority of Protestant offenders were White, male, middle aged, and engaged in contact offenses. They report that sexually abusive clergy suffer from high levels of narcissism and sexual compulsivity (Denney, et al., 2018). Aspects of the clergy role that may contribute to the cultivation of narcissism include idealization, hiding the self, stress, overfunctioning, unboundaried influence, and unrealistic expectations (Ruffing et al., 2018).

"The Dark Triad," a 91-item measure of the triad traits of narcissism, psychopathy, and Machiavellianism often seen in perpetrators of abuse, was inefficient for researchers to use, leading Jonason and Webster (2010) to develop "The Dirty Dozen," a 12-item measure that has reasonable psychometric properties and retained its core features of disagreeableness, short-term mating, and aggressiveness (see Appendix A). By this measure, the 10 traits of a narcissism are expressed in such traits as manipulativeness, deceitfulness, use of flattery, exploitation, lack of remorse and concern for morality, callousness, cynicism, need for admiration, attention-seeking, desire for prestige, and entitlement (Jonason & Webster, 2010).

Cooper-White (2012) presents narcissism as beginning in childhood when abusive attachment figures deliver a withering blow to the selfhood of the child, resulting in outsized insecurities with compensatory self-centeredness and entitlement following soon after. Thoburn (2011) calls the instant status of clergy the "pedestal effect," in which they are not only afforded trust and influence, but expected to be nearly invulnerable. Cooper-White (2012) points out that this aspect of the ministry attracts those looking for a quick fix to their broken selfhood, and that often such individuals lack the ability to suspend competitiveness long enough to build healthy collegial friendships, becoming "lone rangers," accountable to, and in need of, no one.

Dunaetz, et al. (2018) points out that the larger-than-life persona a narcissistic clergyperson has become skilled in projecting may actually appeal to church constituency, who perceive it as true leadership. Members of large churches have been shown to have a higher tolerance for pastors with narcissistic traits, even though they are more likely to cause damage in the long run, especially to those with whom they work closely (Dunaetz, et al., 2018).

Complex Trauma and PTSD

The participants of the workshop that formed the basis of this paper experienced sexual abuse trauma of a unique sort. In order to better understand the unique form of trauma, this review first establishes the two main trauma presentations, PTSD and CPTSD, and then relates it to some of the unique features of sexual abuse by clergy.

PTSD

Posttraumatic stress disorder (PTSD) develops after exposure to a dangerous, horrifying, and/or potentially life-threatening event that exceeds present coping resources. In order to qualify for a diagnosis, there must be (a) an actual threat of death, serious injury, or sexual violence and the individual must have either directly experienced it or learned that it occurred to a close family member or close friend; (b) intrusive memories, flashbacks, trigger reactions, or dissociation; (c) a pattern of avoidance of internal or external stimuli associated with the traumatic event; (d) negative changes in thought and emotion, including distorted cognitions regarding the trauma, a persistently negative emotional state, diminished interest in things that previously brought pleasure, feelings of estrangement, and the inability to experience positive emotions; and/or (e) hyperarousal in the form of symptoms such as irritable or reckless behavior, hypervigilance, exaggerated startle response, problems with concentration and sleep disturbance

difficulties with concentration, sleep disturbance, and easy startle reflex (American Psychiatric Association, 2013).

Key to the diagnosis of PTSD is an encounter with extreme danger. In many cases of sexual abuse by clergy, victims may be groomed or manipulated into compliance rather than physically forced into sex (John Jay College, 2004). The John Jay Report (2004) reports that over 18% of victims of Catholic priests were given a gift as one means of grooming. The abuse that follows such seductive, coaxing efforts on the part of the abuser may not be violent or forced, but would be very traumatic nonetheless. Due to the fact that grooming is not physically violent, an individual coaxed into sex may not qualify for PTSD. For them, complex posttraumatic stress disorder, or CPTSD, may be a more appropriate description (McGraw, et al., 2019).

Complex Trauma

Complex trauma involves chronic or multiple traumas during vulnerable periods of the developmental process, most often occurring during childhood and adolescence, disrupting early attachment relationships and brain development, and resulting in somatic, behavioral, and cognitive difficulties and dysregulation (Kliethermes, et al., 2014). Having evolved as a concept over the past 25 years, complex trauma has yet to arrive at a consensus definition (Kliethermes, et al., 2014).

The term complex trauma may also refer to unique symptomology, including deficits in relationship and attachments, behavioral and emotional dysregulation, cognitive deficits, and even biological changes affecting health (Kliethermes, et al., 2014). Complex trauma events occur at a high prevalence; one study reported that almost 66% of the sample had been exposed

to at least one victimization. Complex trauma outcomes are more difficult to measure, but research suggests them to be dose-specific (Kliethermes, et al., 2014).

The CPTSD diagnosis has not yet been recognized by the DSM (American Psychiatric Association, 2013). The traumatic experiences of CPTSD typically accumulate over a long period of time, often playing out more in the psychological, relational, and emotional realms than the physical. Herman (2012) speaks of CPTSD as a distinct entity which is highly prevalent, is present in all cultures, and appears in survivors of prolonged, repeated trauma. If the APA in revising the DSM had recognized it as part of the spectrum of traumatic disorders, better treatments would be developed and more people would be helped (Herman, 1997).

Farrell, et al. (2010) point out that the unique features of trauma caused by clergy abuse may place it out of the existing PTSD framework. Kezelman and Stavropoulos (2012) conceptualize the trauma caused by sexual abuse by clergy as complex trauma. Given that the church is the "household of God" (Ephesians 2:19), and the clergy often a paternal figure, sexual abuse by clergy bears similarities to sexual abuse within the family. CPTSD typically develops in a family context, and in the context of conflicted caregiver roles where the caregiver alternates between acting as a source of pain and a source of comfort (Edwards, et al., 2012).

Social support is key to human thriving. Dinenberg, et al. (2014) measured the predictive value of social support on trauma symptoms across three subscales, tangible, appraisal, and belonging. Tangible social support entails actually meeting unmet material and other needs. Appraisal social support is a matter of seeing and noticing a person's needs. Belonging social support means that the supported person has a sense of being part of a group. All types predicted lower trauma symptoms, the most predictive subscales being tangible and belonging (Dinenberg, et al., 2014). When an individual reports sexual abuse by an honored and loved clergy, they often

lose their social support system overnight, increasing vulnerability to primary and secondary trauma symptoms (Death, 2015). Cooper-White (2012) associates the traumatic response to sexual abuse by clergy with intimate partner violence.

The psychological lives of survivors of CPTSD are often characterized by feelings of shame, self-blame, and powerlessness, which contribute to challenges in self-care and positive relating with others (Tummala-Narra, et al., 2012). Similarly, these symptoms impact survivor of SAC (Farrell, et al., 2010). For these reasons, CPTSD is the best diagnosis for most victims of non-violent SAC experiencing trauma symptoms.

Betrayal Trauma

Betrayal Trauma Theory posits that survivors of interpersonal trauma may remain unaware of betrayal in order to maintain a necessary attachment (Kaehler & Freyd, 2012). This dissociation can be adaptive when trauma occurs at the hands of a caregiver, but ultimately leads to poor mental health outcomes (Edwards, et al., 2012). Women develop PTSD at roughly twice the rate as men, and betrayal trauma may also play a role in this (Tang & Freyd, 2012). High betrayal (HB) abuse survivors were found to have poorer functional and mental health than low betrayal (LB) abuse survivors (Edwards et al., 2012).

Smith and Freyd (2014) report that the most severe outcomes of betrayal trauma seem due to the coping strategy that this type of trauma elicits: suppression of awareness of the betrayal, and even the loss of ability to remember the betrayal. This compensatory strategy allows for the maintenance of necessary relationships, even abusive ones, in a way that supports attachment behaviors. Unfortunately, it also continues the exposure to abuse, leading to more severe psychological difficulties (Smith, & Freyd, 2014).

In betrayal trauma theory, survivors of complex trauma have a higher risk of making inaccurate trust decisions in interpersonal contexts, thus impeding intimacy and elevating risk for revictimization. Survivors of HB trauma were found to be less trusting of people in general and also less trusting of romantic partners (Gobin, & Freyd, 2014). At the same time, they tend to miss danger cues, leading to over-trusting when distrust would be more appropriate; the inability to perceive risk predicts revictimization (Bockers, et al., 2014; Yeater & O'Donohue, 1999).

Institutional Betrayal

Death (2015) reports that perpetrators of sexual abuse representing institutions often receive the support of those institutions when accused. Death also says that the use of institutional power and privilege to facilitate cover-up of sexual abuse by clergy should be understood and discussed as institutional abuse versus loyalty or other virtuous construction. The response of the institution can have a significant effect on the survivor's well-being, exceeding even the effect of the abuse itself (Holland, & Barnes, 2019).

The phenomena of the institution supporting the perpetrator is called institutional betrayal (Smith & Freyd, 2013). Survivors of institutional betrayal reported increased levels of anxiety, trauma-specific sexual symptoms, dissociation, and problematic sexual functioning. The betrayal of the institution supporting the perpetrator of SAC adds an additional layer of trauma (Smith, & Freyd, 2013).

Harsey and Freyd (2020) identified a common strategy of abusers as deny, attack, reverse victim and offender, or DARVO. In one study, participants exposed to DARVO perceived the victim as less believable, and more likely responsible for the abuse, and perceived the perpetrator as less abusive and responsible for the abuse. However, the researchers showed that the effect of DARVO could be partly mitigated by education on the phenomenon (Harsey & Freyd, 2020).

Cooper-White (2012) associates the institutional betrayal experienced by the survivor of SAC with the betrayal of primary caregivers in childhood, explaining that the requisite dissociation and denial gives way to broken trust and disillusionment, then ultimately produces bad mental health outcomes. In reporting on her work with survivors of sexual abuse by clergy, she says:

> I have witnessed the lasting devastation and anguish that these women have experienced, some for many years. Through this work, the many parallels between sexual abuse by clergy and incest and intimate-partner violence have become increasingly clear to me. Such parallels are particularly apt, because the church is so often portrayed as family (p. 151).

Trauma Treatments

The workshop that forms the basis of this research presents a unique form of treatment for survivors of SAC. An understanding of the treatments for general trauma have helped guide the development of this treatment. In addition, an understanding of the unique features of trauma resulting from SAC have contributed as well.

Treatments for sexual abuse trauma have been studied but not standardized (Burrows, 2013; Danielson, et al., 2010; Gorg, et al., 2017; Hassija & Gray, 2011; Ringel, 2014; Steil, et al., 2018; Suris, et al., 2013). In an expert clinician survey on best practices for treatment of complex trauma, Cloitre, et al., (2011) report that 84% of the experts agreed with phase-based or sequenced approach with interventions targeted on specific symptom sets. They report large consensus on the efficacy of emotional regulation strategies, narration of trauma memory, cognitive restructuring, anxiety and stress management, and interpersonal skills. Cloitre, et al.

(2011) also found that experts agreed that meditation and mindfulness interventions were effective as second-line approaches.

Psychodynamic approaches (Ringel, 2014) and family therapy approaches (Danielson, et al., 2010) have also been found effective. Finally, cognitive processing therapy (CPT) has been found more effective than present-centered therapy (PCT) for veteran sexual assault survivors (Suris, et al., 2013) and acceptance and commitment therapy (ACT) has been found effective in reducing avoidance symptoms (Burrows, 2013). Telehealth sessions using classic approaches such as cognitive processing therapy (CPT) and prolonged exposure (PE) have shown evidence of reduction in PTSD symptoms and depression (Hassija & Gray, 2011).

Pressley and Spinazzola (2015) suggest that trauma treatment in a Christian context involves four components: (a) relationship, (b) regulation, (c) parts work, and (d) narrative. Relationship entails therapeutic recapitulation of negative relational patterns through building of a warm, empathic alliance with the therapist. Regulation assists the individual in learning self-regulation, as abuse impacts the autonomic nervous system (ANS) and affect-regulating brain systems. Parts work involves the integration of "parts" of self that have been dissociated in an effort to cope with trauma. Narrative processing is telling the story of the trauma, grieving the losses, and finally meaning-making. All of the empirically-validated trauma treatments touch on most of these domains (Pressley & Spinazzola, 2015).

Exposure therapy, such as prolonged exposure (PE), cognitive processing therapy (CPT), and eye movement desensitization and reprocessing (EMDR) are the three most empirically-validated therapies for PTSD (Lopez-Zeron & Blow, 2015). A meta-analysis of PTSD treatment effectiveness showed effective psychotherapies to include cognitive therapy, exposure therapy, EMDR, and pharmacotherapies (Watts et al., 2013).

Prolonged Exposure Therapy

PE Therapy is a manualized, structured approach used often with military veterans. Experiential avoidance predicts PTSD symptom severity, but gradual and prolonged exposure to those triggers gives the body time to habituate, reducing its own stress response, forming a new association between the trigger and autonomic nervous system calm (Thompson & Waltz, 2010). PE treatment utilizes subjective reporting of distress, called "subjective units of distress," (sometimes called "subjective units of discomfort") or SUDS, in vivo exposure, imaginal exposure, and homework (Foa, et al., 2007). In one study of adolescent girls with sexual abuse-related PTSD, PE yielded greater benefit than supportive counseling, even when delivered by a therapist who normally provided supportive counseling (Foa, et al., 2013).

van Minnen, et al., (2012) tested the claims that PE was contraindicated when dissociation, borderline personality disorder, psychosis, suicidal behavior, self-injury, substance abuse, and major depression comorbidities were present. van Minnen (2012) concluded that PE could be used safely in the presence of those comorbidities, but the authors recommended providing integrated or concurrent treatment to help manage the comorbid symptoms, if severe.

Cognitive Processing Therapy

In speaking of CPT**,** Lamp, et al. (2019) conceptualize PTSD as a disorder of non-recovery, in which, distorted beliefs produce strong emotions which overwhelm brain systems and make accurate processing impossible. Lamp explains that the first phase of CPT, also a manualized treatment, is psychoeducation and rapport-building, the second moves into trauma processing, and the third recaps the skills and lessons learned. CPT utilizes exposure, but in narrative form with the client writing down their story. It is thought that writing allows for some emotional distance from distressing events. This trauma account is coupled with ongoing

cognitive techniques similar to conventional cognitive behavioral therapy (CBT). CPT has predicted greater outcomes when delivered in individual counseling versus a group format (Lamp et al., 2019).

Eye Movement Desensitization and Reprocessing

EMDR was discovered by Francis Shapiro as she walked through a park thinking about a distressing memory. Shapiro realized that the memory felt less distressing when she moved her eyes back and forth across the field of vision. This led her to develop an in-office method of producing brain bilateralization, which is thought to be the effective element of the treatment (Shapiro & Forrest, 2016). EMDR includes exposure and cognitive processing features. It has been found effective in treating PTSD and some of its related disorders, but the mechanism of action needs more study (Oren & Solomon, 2012). Some believe that the eye movements unique to EMDR do not contribute to its effectiveness, but rather the cognitive and exposure components, which are common to other empirically-validated therapies (Arkowitz & Lilienfeld, 2016).

EMDR utilizes eight phases: client history and treatment planning, preparation and teaching grounding techniques, identifying the target memory and salient associated message, evaluation of distressing event, strengthening of positive cognition, checking for somatic responses, utilization of grounding/self-control techniques, and reevaluation and review (Menon, et al., 2010). Farrell, et al. (2010) tested EMDR with survivors of sexual abuse perpetrated by Roman Catholic clergy, finding it generally effective. However, the researchers submit that: “During Desensitization (Phase 4) when processing becomes blocked, the integration of creative cognitive interweaves around themes such as theology, existentialism, spirituality, and political anger may need to be utilized” (p. 132).

Psychoeducation

Kolaitis (2017) cites the key components of trauma treatment as psychoeducation, exposure and habituation, and coping skills training. Using the acronym TARGET for Trauma Affect Regulation Guide for Education and Therapy, a manualized psychoeducation group in juvenile detention facilities, reductions in risk behaviors, fewer disciplinary measures, and potential reduction in recidivism were found (Ford & Hawke, 2012).

A trauma-informed support, skills, and psychoeducation intervention used with survivors of torture and related trauma in Kurdistan showed positive effect on depression and anxiety symptoms (Bass, et al., 2016). A 12-session trauma-informed, culturally-relevant psychoeducation intervention used on Somali refugees in Nairobi, Kenya, tested pre- and post-intervention, made positive impact on PTSD symptoms, particularly if they were high at baseline (Im, et al., 2018). In the latter intervention, Im, et al. (2018) says trained peers versus licensed professionals conducted the sessions in order to meet the great demand for interventions.

Whitworth (2016) reports that while most empirically-validated treatments for trauma include psychoeducation, little research has been done on the effects of psychoeducation as a stand-alone treatment. The results of the studies that have been done are mixed, some finding a beneficial outcome, and some not. In specific, treatments that merely list the effects of trauma can actually increase the reporting of trauma symptoms by sensitizing individuals to them. In light of these things, Whitworth (2016) recommends that psychoeducation for trauma treatment include the following components:

- Emphasize resiliency and recovery, normalizing symptoms and giving hope for recovery while offering empathy for current struggles.

- Offer it in the context of a supportive relationship, which can be done in one-on-0one sessions or small groups.
- Provide it early and often, as trauma psychoeducation prevents individuals forming distorted narratives about the traumatic incident. Different from premature debriefing, which has been found unhelpful, early psychoeducation can have a positive impact;
- Conduct it in a culturally-sensitive and client-centered manner, as psychoeducation can apply the facts of trauma in a way that can be easily accepted by the recipient;
- Deliver it along with information for seeking additional support and help, as psychoeducation for trauma can be a first phase of what for some will be a longer journey (pp. 445-446).

Whitworth (2016) also recommends including the following components in trauma psychoeducation: a definition of trauma, common myths about trauma, trauma's effect on brains and bodies, common trauma reactions and symptoms, coping and resiliency skills, sources of additional help.

Pharmacotherapies

In a meta-analysis of effective trauma treatments, Watts, et al. (2013) reported that paroxetine, sertraline, fluoxetine, risperidone, topiramate, and venlafaxine have been found effective. However, studies with more women showed larger effects and studies with more veterans showed smaller effects. Selective serotonin reuptake inhibitor (SSRI) drugs and venlafaxine, a selective serotonin and norepinephrine inhibitor (SNRI) drug were found the most effective (Watts, et al., 2013). An additional factor involved in treating PTSD pharmacologically is adherence; antidepressant medication adherence is higher in those whose symptoms improve, but low overall (Salas et al., 2020).

Other Treatments

Gurda (2015) reports that emerging trauma treatment approaches such as energy psychology, yoga, and brainspotting have yet to produce a body of support in the literature. However, preliminary studies and meta-analyses have overwhelmingly found that yoga as an adjunctive intervention can boost the effectiveness of treatment (Gurda, 2015).

Survivors of trauma, particularly if the trauma was acquired early in life, may experience impairments in sensorimotor function, including a hypersensitivity to physical contact, somatization, and increased general medical problems (Bell, 2016). Sensorimotor psychotherapy may address these and other problems. Sensorimotor therapy purposely activates prediction, which is the somatic response to triggers based on past experience, in order to interrupt it, working toward a healthier, more flexible response to present day life (Buckley, et al., 2018).

Fisher (2019) reports the limitations of the more often-used treatments: traditional therapeutic modalities such as cognitive behavioral therapy (CBT) address distorted cognitions but not emotional processing; supportive and expressive therapies focus on emotional expression but not processing, and exposure therapies often fail to improve autonomic dysregulation problems. In contrast, sensorimotor psychotherapy, as a somatically-oriented talking therapy, approaches affect dysregulation as a subcortical physiological issue central to the treatment of traumatic stress (Fisher, 2019).

Narang, et al. (2019) note the conflicting data on interventions for child and adolescent survivors of child sexual abuse (CSA). They suggest that the number of therapeutic approaches that have demonstrated symptom improvement may indicate that symptom remission is not entirely dependent upon the type of intervention used. They note an absence of culturally-

specific, clear guides to as to the best therapies for CSA survivors. More research is needed to identify the best interventions for child and adolescent survivors of CSA (Narang, et al., 2019).

Treatments Specific to Sexual Abuse Trauma

Hassija and Gray (2011) studied the effectiveness of telehealth-based sessions delivered by Masters level clinicians trained in trauma-focused therapies such as prolonged exposure and cognitive processing therapy. In four sessions, participants gave evidence of large reductions in PTSD and depression symptoms. Additionally, participants' level of satisfaction with teletherapy as a delivery system was high.

Recognizing that trauma has been linked to insecure attachment styles (Kaehler & Freyd, 2012), Ringel (2014) drew from three conceptual models: (a) developmental/attachment, (b) a sensory/affective model based on neuroscience research, and, (c) EMDR to access traumatic memories. The integration of standard trauma treatments with a psychodynamic and intersubjective approach was thought to better address trauma vulnerabilities that arise from attachment problems, and to, in the intersubjective facet of treatment utilizing transference and countertransference, give opportunity for corrective recapitulation (Ringel, 2014).

Sexual assault history is associated with higher risk of substance abuse in women (Ullman, et al., 2014). Risk Reduction through Family Therapy (RRFT) was used with success on small sample (N=10) of adolescent sexual assault survivors to effect risk reduction for substance abuse and trauma-related psychopathology such as depression and PTSD. RRFT combines multisystem therapy (MST) and trauma-focused cognitive behavioral therapy (TF-CBT), and is delivered to the family (Danielson, et al., 2010).

In a randomized clinical trial, Suris, et al. (2013) studied cognitive processing therapy (CPT) for veterans with military sexual trauma-acquired PTSD. Twelve sessions of either CPT

or present-centered therapy (PCT) were given to a sample of 86 veterans. Veterans who received CPT had significantly greater reduction in self-reported PTSD symptoms (Suris, et al., 2013).

Experiential avoidance has been shown to mediate the relationship between sexual assault and adverse long-term effects. Acceptance and commitment therapy (ACT) has been found effective in reducing avoidance, thought suppression, and trauma symptomology, and increasing quality of life (Burrows, 2013).

Treatments Specific to SAC Trauma

As previously mentioned, little work has been done to develop and test treatments addressing the aspects of sexual abuse trauma specific to SAC for individuals, families, and churches. It is assumed that general trauma treatments will provide benefit, but targeted treatment will provide more. Restorative justice and institutional support may be components of this more-targeted treatment approach.

Restorative Justice

Gavrielides (2012) presents a means of healing both the individuals and relationships involved in SAC through restorative justice, beginning with a delineation of existential and spiritual problems specific to SAC. Existential problems include: dissonance in accepting inner freedom and direction within life, fear of death and/or dying, being robbed of an important philosophy of life, generalized uncertainty surrounding the purpose of life itself, and the conflating of omnipotence, collusion, powerlessness, and significance. Spiritual problems include: difficulty praying, discomfort with religion, assuming ownership of the spirit, generalized sense of inner emptiness, locked into continual conflict with God, inability to engage in any of the sacraments, and political anger. Themes specific to survivors of clergy child sexual

abuse include: theological conflict, idiosyncratic silencing strategies, spiritual identity, existentialism, political anger, and retraumitization by the church.

Gavrielides (2012) also reports that what survivors want from the justice process differs from what churches want. The former desire such commonsense things as full disclosure, remorse from offender and offender's institution, a voice on the justice process, assurance of prevention measures, reasonable monetary compensation, and restoration of their faith in the church and God. The latter tends to be more concerned with the financial burden involved and to restore public image (Gavrielides, 2012). The success of any justice process would therefore involve closing the gap between the disparate agendas. This in itself requires patient efforts at education and persuasion. Many a church is very institution-loyal versus individual-loyal, which sharply contrasts with the principle of servant leadership where the focus is upon empowering the weak (Gavrielides, 2012). A restorative justice dialog can potentially lead to reparations such as appropriate apologies, financial compensation, counseling and medical service coverage, and a commitment by participants to work toward eradication of abuse (Gavrielides, 2012).

Institutional Support

Smith and Freyd (2014) suggest that effective intervention with survivors of sexual abuse by clergy will include a thorough understanding of institutional betrayal which often accompanies it. They mention the risk of additional harm when clinicians associated with the betraying institution are not trauma-informed. Indeed, they themselves may add to the trauma. However:

> Clinicians who are embedded in the same institutions in which a client's betrayal occurred may have a unique opportunity to repair institutional betrayal by acting as a source of healing rather than further betrayal . . . individuals who experience institutional

> betrayal around an unwanted sexual experience may be more likely to seek out institutional sources of support . . . this implies that there may be a natural opportunity for clinicians to begin alleviating or even protecting against some of the distressed caused by institutional betrayal (p. 585).

Sexual abuse by clergy should be regarded with such a sense of outrage that the institution behind a perpetrator leaps into action to bring justice to the wrongdoer and mercy to the survivor. The Bible tells us to "learn to do good; seek justice, rebuke the oppressor" (Isaiah 1:17). The reason institutions miss this obvious ethical responsibility is because of a failure of understanding true leadership.

Servant Leadership

Servant leadership (SL) psychoeducation is the basis of the treatment of the workshop that forms the basis of this study. One research question asks if a component of SL psychoeducation would improve trauma symptoms and God attachment in participants. This review explores servant leadership and its potential therapeutic value.

Servant leadership is more than a characteristic; it is a movement impacting a variety of types of organizations (Babakus, et al., 2011; Kool & Dierendonck, 2012; Peterson, et al., 2012; Savage-Austin & Honeycutt, 2011; Sendjaya & Pekerti, 2010; Spears, 2010; Waterman, 2011; Yoshida, et al., 2014). The core principle of SL is to serve and build those being led, whereas the traditional leadership model focuses on building and serving the company or organization. van Dierendonck and Patterson (2015) conceptualize servant leadership as beginning with compassionate love, leading to virtuous behavior and the empowerment of those being led. Fortune 500 companies that have adopted an SL model have flourished (Sendjaya & Sarros, 2002). Greenleaf may have been the human agent in the movement, but it could be said

that Jesus Christ laid the groundwork Greenleaf built upon, as He led with love, saying, “the Son of man came not to be served, but to serve, and to give His life as a ransom for many” (Matthew 20:28)

A systematic review of the literature on servant leadership reveals that while there is no absolute consensus on its definition, and while it is still being studied, it is a viable leadership theory that assists organizations in improving the well-being of its followers (Parris & Peachey, 2013). Barriers to servant leadership practices include the organization’s culture, the fear of change, and lack of knowledge of the philosophy of servant leadership (Savage-Austin, & Honeycutt, 2011).

One study of 815 employees and 123 immediate supervisors revealed that several factors mediated the relationship between servant leadership and organizational citizenship behavior: commitment to the supervisor, self-efficacy, procedural justice climate, and service climate. The factors of procedural justice climate and positive service climate increased the influence of commitment to the supervisor on organizational citizenship behavior (Walumbwa, et al., 2010).

Servant leadership fosters creativity (Hunter, et al., 2013; Peterson, et al., 2012; van Dierendonck & Patterson, 2015; Yoshida, et al., 2014). It creates an atmosphere of freedom. Fear of making mistakes stifles creativity and innovation, but servant leadership lifts that fear and encourages risk-taking (van Dierendonck & Patterson, 2015). One multi-level study examined how servant leadership affected employee creativity and team innovation, finding it to promote individual relational identification, or the identification with one’s role, and collective prototypicality with the leader, or the leader’s embodiment of the group values, which then fostered employee creativity and team innovation (Yoshida, et al., 2014). Hunter, et al., (2013)

report that servant leadership appeared to foster a favorable service climate, encouraging followers to be helpful to coworkers and less inclined to quit their jobs.

Servant leadership predicts several additional positives in an organizational context. Kool and van Dierendonck (2012) report that commitment to change through interactional justice and optimism was mediated by servant leadership. Interactional justice, defined as the degree to which the people affected by a decision are treated with dignity and respect, is a predictor of organizational employee optimism (Kool & van Dierendonck, 2012). Servant leadership has been shown to be a significant predictor of trust of subordinates/followers in their leaders, with covenantal relationship, responsible morality, and transforming influence as the key SL behaviors significantly contributing to the trust outcome. Followers who perceived high SL had significantly higher trust levels compared with those who perceived low SL behavior (Sendjaya & Pekerti, 2010).

The Servant Leadership Behavioral Scale-6

Although Robert Greenleaf, who popularized the concept of servant leadership in scientific literature, introduced the concept nearly four decades ago, most of the measures of SL have been developed in the last 15 years (Green, et al., 2016). Green, et al. (2016) reported on six of the instruments. From their work came the Servant Leader Behavioral Scale, which has been condensed into a six-item scale called the SLBS-6 by the author (Sendjaya, et al., 2008; Sendjaya, et al., 2019).

The SLBS-6 is the shortest measure of SL to date for research and training purposes. Sendjaya and associates developed it at first as a 35-item scale widely used as a measure of SL behavior, but reduced it to enhance compliance of test-takers (Sendjaya, et al., 2019). Both the original test and the SLBS-6 show internal consistency reliability, criterion-related validity, and

construct validity (Sendjaya et al., 2019). Moreover, for our purposes, the measure is the most reflective of biblical values in comparison to several other measures of SL (Green et al., 2016). The six measures, rated on a 5-point Likert scale, are:

> My supervisor/direct leader: uses power in service to others, not for his or her own ambition; gives me the right to question his or her actions and decisions; respects me for who I am, not how I make him or her feel; enhances my capacity for moral actions; helps me to generate a sense of meaning out of everyday life at work; contributes to my personal growth (Sendjaya, et al., 2019, p. 947).

Those six principles were used as an outline for the treatment group servant leadership psychoeducation segments.

Servant Leadership as a Therapeutic Agency

Most of the research on SL focuses on its ethical implications, as well as the effect of SL on institutional, organizational, and individual growth and development (Green, et al., 2016). In this regard, SL has traditionally been used to train leaders to better run organizations (Parris & Peachey, 2013; Sendjaya & Sarros, 2002; Shaw & Allen, 2009; van Dierendonck & Patterson, 2015). This study departed from that application, using servant leadership psychoeducation as a therapeutic agency designed to impact the individuals receiving information about it.

Cox (2016) posited that servant leadership in a Catholic health systems context provides a conduit for love, and shows how those committed to SL experienced the growth and success of their healing ministries. SL has been found effective in conflict resolution (Jit, et al., 2016). Studies abound showing the positive effect of SL on organizations (Dutta & Khatri, 2017), and in that sense SL as a healer of organizations is well-established. There is no literature on the potential of SL psychoeducation in therapeutically recapitulating damaging experiences with

abusive leaders, particularly abusive religious leaders. There is also no literature about how SL may help heal God concept and image, and ultimately, God attachment. Given the far-reaching nature of SL and the potential of a therapist being a hermeneutical figure (Counted, 2015), this study asked if psychoeducation about SL delivered by a person who, in professional calling and position resembled the abusive leader, could be effective for deep emotional healing, particularly to those wounded by abusive leadership. Yalom (2005) calls this phenomenon, a feature of process group therapy, "corrective recapitulation."

Posttraumatic Growth

It is essential to realize that not all individuals who experience abuse trauma suffer the same aftermath. Posttraumatic growth (PTG) refers to positive character growth following traumatic life events, which some, but not all, trauma survivors experience (Tedeschi & Calhoun, 1996). Our workshop introduced PTG for the purpose of balancing out the more negative aspects of trauma psychoeducation, which Whitworth (2016) found could actually increase symptoms. An emphasis on recovery and fostering supportive relationships was found more helpful than merely dwelling on the damage accrued as the result of trauma (Whitworth, 2016).

Experiencing a traumatic event can have a transformational effect, leading to positive relational and personal deepening and changes. PTG distinguishes itself from resiliency, which is bouncing back to pre-trauma functioning. In PTG, the individual exceeds their pre-trauma functioning (Ogińska-Bulik, 2015). PTG pioneers Richard Tedeschi and Lawrence Calhoun developed the Posttraumatic Growth Inventory in 1996. It identifies five areas of growth: relating to others, new possibilities, personal strength, spiritual change, and appreciation of life (Tedeschi & Calhoun, 1996).

The posttraumatic growth inventory assesses positive outcomes from trauma in a 21-item scale. Women tend to report more benefits than men, as do people who experience more severe trauma. This scale has utility in determining how successful trauma survivors are in reconstructing perceptions of self, others, and meaning of events (Tedeschi, & Calhoun, 1996).

The authors of PTG are careful to qualify its benefits as not eliminating the difficulties of stress responses to trauma. However, research suggests that posttraumatic growth can reduce stress in some circumstances (Triplett, et al., 2012). Ogińska-Bulik (2015) found a "positive association between resiliency and posttraumatic growth, particularly with increased self-perception and appreciation of life" (p. 233). Triplett, et al. (2012) found a negative association between distress and meaning in life/life satisfaction. While these studies seem to indicate some distress-reducing benefits of PTG, the relationship is a complex and nuanced one; Ogińska-Bulik, (2015) found that some, but not all dimension of resiliency have a positive association with PTG.

Rumination and Posttraumatic Growth

Intrusive rumination is a feature of PTSD (American Psychiatric Association, 2013), and so may be regarded as a symptom needing relief. Yet, some have questioned whether there are benefits to rumination. Taku, et al. (2009) point out that not all rumination is to be thought of as maladaptive. Of the two rumination types, intrusive and deliberate, deliberate was more strongly associated with good outcomes in PTG. Intrusive rumination soon after a traumatic event was positively associated to PTG but deliberate rumination most strongly predicted the current levels of PTG for both samples (Taku, et al., 2009). Some of the homework assignments of the *Abuse, Trauma, and Jesus* workshop, such as journaling, constituted deliberate rumination.

Relationship of Topic to the Wider Subject

All the components of my study have been developed separately in the literature. Terms such as “God concept,” “God image,” “God attachment,” “sexual abuse trauma,” “sexual abuse by clergy,” “clergy sexual misconduct,” “betrayal trauma,” “institutional betrayal,” “servant leadership” and “posttraumatic growth” all yield scores of studies in a Google Scholar search. The diagnoses such as PTSD and CPTSD and the common trauma treatments all have large bodies of literature. However, a Google Scholar search of terms such as “servant leadership PTSD” and “servant leadership abuse trauma” yield nothing. Servant leadership as a means of preventing sexual misconduct has been studied (Beck, et al., 2018), but the potentially therapeutic effect of survivors of sexual abuse by clergy coming into contact with psychoeducation on SL has not been studied.

This study examined SL’s therapeutic potential on the individual. Specifically, it was asked if SL psychoeducation has the power to change the God attachment and trauma symptoms of clergy abuse survivors, the majority of whom have faced challenges in the way they experience God (Rudolfsson & Tidefors, 2014). This question was, in part, inspired by Paul’s expression of the reconciliating power of the Great Servant Leader: “Now then, we are ambassadors for Christ, as though God were pleading through us: we implore you on Christ’s behalf, be reconciled to God” (2 Corinthians 5:20). The effect of teaching the gospel, including the servant leadership that led Jesus to lay down His life, is to reconcile the estranged back to God, and to lead them on to flourishing.

Summary

Due to the multiple layers of trauma it causes, including primary trauma, broken trust (Astbury, 2013; Smith & Freyd, 2014), betrayal trauma (Kaehler & Freyd, 2012), institutional

betrayal (Holland, & Barnes, 2019; Smith, & Freyd, 2013), the marring of the God image and therefore the ability to form God attachment (Counted, 2015; Kézdy, et al., 2013; Krause & Ironson, 2017; Testoni et al., 2016), and often the loss of other relationships, sexual abuse by clergy has the potential of causing great physical, emotional, mental, financial, occupational, social, and spiritual harm. At the center of the devastation sits a religious leader who Jesus described as a wolf in sheep's clothing (Matthew 7:15) who, through craft, deceit, and abuse of power has masqueraded as a shepherd. As the survivor struggles to come to terms with the outcome, he/she often feels that familiar impulse to turn to God for help (Kézdy, et al., 2013). But the God image, that ability to experience and connect with a God of love, may be marred beyond recognition (Gardner, 2013). Might coming in contact with a servant leader who clearly explains to the survivor that what the perpetrator did constituted a failure to represent Jesus, and who puts before the survivor, in demonstrable truth, the real Jesus, who laid down His life for the sheep, bring healing? This study will examine that question.

Chapter Three: Methods

Overview

In this chapter the method used in studying the effect of two video conferencing workshops' impact on the trauma symptoms and God attachment of survivors of sexual abuse by clergy is described. This chapter also identifies our research design, questions and hypotheses. In addition, it identifies the participants and recruitment method, as well as the procedures used to conduct the study. It assesses internal and external validity, identifying potentially relevant threats to both. It assesses statistical validity issues including Type I and Type II errors, power, and effect size. Finally, it describes the participants of the study, the procedures of the study, and the study's clinical significance.

Research Design

The research design was a nonequivalent control group pretest-posttest design, an experimental design in which a dependent variable is measured in one group of participants before (pretest) and after (posttest) a treatment and that same dependent variable is also measured at pretest and posttest in another, nonequivalent group (May, 2012). This design allowed us to compare the final pretest-posttest differences of the two groups, suggesting the overall effectiveness of the intervention or treatment. The design revealed changes in both groups from pretest to posttest. It also accounted for the improvements in the control group, citing possible reasons for it.

In true experimental research involving groups, participants are randomly assigned to different treatments, whereas quasi-experimental research lacks the random assignment (May, 2012; Warner, 2012). If the conclusions differ when different tests are run, the researcher may need to think about violations of assumptions and the choice of statistical method (Warner,

2012). For the assignment to be random, the groups need to be as nearly equivalent as possible so that the difference becomes the treatment (Hepner, et al., 2015; Warner, 2012). In that our groups involved religious individuals who had been sexually abused in a church context, the groups shared those near-equivalencies.

Larger sample size allows for more modest effect to be statistically significant, given that random error is less of a factor (Warner, 2012). To set a target number for the sample size, a sample size calculator from the statulator website (Sample Size Calculator for Comparing Paired References, n.d.) was utilized. The specific calculator used compared paired differences using a two-sided p-value. The assumptions that were made included a desired power of .8 and a level of significance of .05. In addition, a value of .6 for the estimated effect size was chosen because it was slightly larger than what can be considered a medium estimated effect size. For quick reference, the website mentions that a large estimated effect size corresponds to a value of .8. After selecting these parameters we performed the calculation for how many before-and-after pairs we would need. The resulting sample size number yielded a suggested value of 25 paired observations. Although this goal was not fully realized, it provided a goal to which the sample size of 24 for the control group and 22 for the treatment group came close.

This design was a between-groups study because the members of each group were exposed to the same condition. The control group members participated in a six-week videoconferencing sexual abuse trauma recovery workshop called the *Abuse, Trauma, and Jesus* workshop. Group two members participated in the same workshop with the addition of a servant leader psychoeducation component, delivered by a guest clergy. The control group was given a pretest, the regular ATJ workshop with no servant leader psychoeducation treatment, and a posttest. The treatment group was given a pretest, the ATJ workshop with the servant leader

psychoeducation treatment, and a posttest. The research design established links between the basic workshop and changes in God attachment and trauma symptoms. The nonequivalent control group design addressed not just whether participants who received the treatment improved, but whether they improved more than participants who did not receive the treatment; this added an element of control to the study (Warner, 2012).

Each group was also separately subjected to a pretest/posttest analysis to note any effect. This addressed whether the ATJ workshop control group itself experienced any changes in trauma symptoms and God attachment. In fact, this was the substance of the first research question.

Research Question and Hypothesis

The research questions asked two things. One was if a six-session, videoconferencing workshop called the *Abuse, Trauma and Jesus* workshop would help survivors of church-related sexual abuse improve in the domains of God attachment and PTSD symptoms. All of these domains were measured using empirically-validated assessments: The Attachment to God Inventory (Beck & McDonald, 2004) and the Primary Care PTSD Screen for the DSM-V (Prins, et al., 2016). The assessments were administered before and after the workshop.

The second question was if the addition of a servant leader psychoeducation component would bring about further improvement. The treatment group participants completed the same assessments pre and posttest.

RQ1: Will participation in a six-session, videoconferencing, *Abuse Trauma, and Jesus* workshop improve measures of God attachment in survivors of sexual abuse by clergy?

Ho1: There will be no statistically significant difference between the pre and posttest measures of God attachment in participants of the *Abuse, Trauma, and Jesus* workshop.

Ha1: There will be a statistically significant difference between the pre and posttest measures of God attachment in participants of the *Abuse, Trauma, and Jesus* workshop.

RQ2: Will participation in a six-session, videoconferencing, *Abuse Trauma, and Jesus* workshop improve measures of PTSD in survivors of sexual abuse by clergy?

Ho2: There will be no statistically significant difference between the pre and posttest measures of PTSD in participants of the *Abuse, Trauma, and Jesus* workshop.

Ha2: There will be a statistically significant difference between the pre and posttest measures of PTSD in participants of the *Abuse, Trauma, and Jesus* workshop.

RQ3: Will participation in a six-session, videoconferencing, *Abuse Trauma, and Jesus* workshop with the added component of servant leadership psychoeducation more significantly improve measures of God attachment in survivors of sexual abuse by clergy than the stand-alone workshop?

Ho3: There will be no statistically significant difference in pre and posttest measures of God attachment between the treatment group and the control group of the *Abuse, Trauma, and Jesus* workshop.

Ha3: There will be a statistically significant difference in pre and posttest measures of God attachment between the treatment group and the control group of the *Abuse, Trauma, and Jesus* workshop.

RQ4: Will participation in a six-session, videoconferencing, *Abuse Trauma, and Jesus* workshop with the added component of servant leadership psychoeducation more significantly improve measures of PTSD in survivors of sexual abuse by clergy than the stand-alone workshop?

Ho4: There will be no statistically significant difference in pre and posttest measures of PTSD between the treatment group and the control group of the *Abuse, Trauma, and Jesus* workshop.

Ha4: There will be a statistically significant difference in pre and posttest measures of PTSD between the treatment group and the control group of the *Abuse, Trauma, and Jesus* workshop.

Participants and Recruitment Method

Participant Characteristics

To screen for qualifications, questions were asked on the recruitment flyer (see Appendix B): "Are you 18 years of age or older? Do you want help processing trauma acquired through sexual abuse by a male spiritual leader (at any age)? Are you open to a faith-based, scientifically-sound approach to recovery?" The recruitment flyer explained that, "The purpose of this research study is to examine the effectiveness of a six-session, Zoom-mediated, psychoeducational workshop addressing trauma and God attachment issues that have arisen from sexual abuse by spiritual leaders."

Recruitment Method

The 40 total participants (20 per group) were recruited through several online sources. One was the email database and social media platform, including Twitter, Facebook, Instagram and LinkedIn, of the main researcher. Other groups and individuals with large social media platforms were also enlisted. The workshop was offered on a first-come, first-serve basis.

Sampling Method Used

Jager, et al. (2017) say that convenience samples are the standard sampling method in developmental science; probability samples taken from the general population are cost-

prohibitive and ill-suited to examine questions having to do with human behavior and psychology. However, this convenience sample was a homogenous convenience sample, meaning that the technique was purposeful in achieving a sample whose units share similar traits, in our case the trait of having survived sexual abuse by clergy. Jager (2017) recommends homogenous convenience samples as a way of augmenting the advantages of convenience sampling. Convenience sampling is less cost prohibitive, but has less generalizability than population samples. Homogenous convenience samples have more generalizability, specifically to the subpopulation of units sharing similar traits (Jager, et al., 2017).

This research used a homogenous convenience sample, but also random assignment to the two test groups. The design was experimental because this random assignment was used. The names of participants were written on pieces of paper, shaken in a jar, and drawn out to distribute them into the two groups. The design ensures internal validity by not simply comparing posttest data, but analyzing groups in their pre-post changes (May, 2012). There were two dependent variables, PTSD as measured by the Primary Care PTSD Screen (Prins, et al., 2016) and God attachment as measured by the Attachment to God Inventory (Beck & McDonald, 2004). These aspects were measured in both the control and treatment group, pretest and posttest. The design allowed for comparison between the treatment group and the control group to assess if the treatment had any additional benefit. General effectiveness of both groups was also assessed through the pretest and posttest.

Compensation

The organization hosting the workshop, Abide Network, regularly hosted workshops, offered paid counseling and coaching services, and sold books and other educational products. In addition, the main presenter of the workshop had a thriving public presence and was a sought-

after speaker and trainer. For these reasons it was thought the workshop held sufficient value to make compensation of participants unnecessary. It was included in the plan, however, to resort to offering a small compensation of $50 per participant should the recruitment process not draw sufficient participants. The six servant leadership presenters were offered a compensation of $100 per 30-minute appearance, but the presenter forfeited the payment, asking to be taken out for ice cream instead.

Inclusion/Exclusion Criteria

The study population was drawn from the target population of survivors of sexual abuse by clergy, accessed through previously mentioned means. An informal screening process using an email interview helped identify the appropriate members. Telephone conversations also helped rule out potential participants who may disrupt group dynamics and even worsen their own condition, using part of Yalom's (2005) exclusion criteria of grossly psychotic individuals and individuals with personality traits such as paranoia and sociopathy. These determinations were based on the DSM-5 diagnoses (American Psychiatric Association, 2013).

The inclusion criteria were as follows:

Participation was open to male or female participants. The faith group most represented by the pools from which most participants were drawn was Seventh-day Adventist, a Protestant denomination. It was anticipated that the majority, but not all, of the participants would be female. The participants were all sexually abused by male clergy, a broad definition of clergy being used. In our usage, clergy was anyone in spiritual leadership, as the Seventh-day Adventist faith group from which most participants were drawn not only had a strong network of lay ministry groups, but private elementary, secondary, undergraduate, and graduate schools. The abuse criterion included not only criminal abuse such as underage sexual abuse and rape, but

seduction of adult congregants (Kleiven, 2018). This is considered form of abuse because of the power imbalance in the relationship. This is sometimes called clergy sexual misconduct against adults (CSMAA) and is considered an abuse of power (de Wegner & Death, 2017).

There were no criteria as to when the participants experienced or reported the abuse. Some studies of sexual abuse by clergy focus on child abuse, some on clergy sexual misconduct against adults. Participants who had experienced all forms were included in this workshop because the effect on God attachment and trauma symptomology is similar (de Weger & Death, 2017; Farrell, et al., 2010; Smith & Freyd, 2014; Wind, et al., 2008).

The participants experienced difficulties in either or both of God attachment problems and PTSD symptoms. Several classes of people were excluded. Those abused by female clergy were excluded because the main presenter is female and a clergy-like figure may have impacted the effect of the workshop in ways irrelevant to what was being measured. It was known ahead of time that few, if any individuals of this class were likely to apply, as very few clergy are female, and very few reports of sexually abusive female clergy exist (Thoburn, et al., 2011). The John Jay Report (2004) does not even mention female clergy.

Anyone who was uncomfortable with faith-based biblical content, something that strongly appealed to most participants, were excluded through the consent form, which specified that the treatment would be faith-based. Individuals whose diagnoses may have made group work too risky, both because of the disruption to other members it may have entailed, and the harm to themselves, were also excluded. Yalom (2005) includes in his assessment of problem group members the monopolist, the psychopathic client, and the characterologically difficult client. Through the intake process, an effort was made to minimize the number of these types of participants.

Procedures for the Study

The Abuse, Trauma, and Jesus Workshop

This PowerPoint-based, Zoom-mediated videoconferencing workshop drew from 13 years of clinical experience and five years of graduate-level education, much of which focused on traumatology. Drawing from the previous two years of doctoral research on traumatology, a six-session PowerPoint presentation of a total of 131 slides was created by the author of this paper. The ATJ workshop first established the general concepts of trauma and its treatment, then focused in on the unique characteristics of trauma acquired through sexual abuse. It utilized a blend of psychoeducation on exposure therapy (Foa, et al., 2013), sensorimotor therapy (Fisher, 2019), grounding techniques (Burrows, 2013), cognitive processing therapy (CPT) (Lamp, et al., 2019), and faith-based concepts (Brewer-Smyth, 2014).

Each session followed the basic outline of:

1. Greet and check in
2. Review of the previous session's homework
3. Mapping out of the current session
4. Covering the material
5. Group dialog throughout and at the end
6. Action steps assigned

Here are the session titles, in order:

1. *Comprehending* covered basic psychoeducation about trauma, its effects, and its treatments. This section explained various trauma-related phenomena, including PTSD (American Psychiatric Association, 2013; Prins, et al., 2016), CPTSD (Chu, 2011; Edwards,

et al., 2012; Felitti, et al.,1998), and betrayal trauma and institutional betrayal (Death, 2015; Holland & Barnes, 2019; Smith & Freyd, 2013).

2. *Calming* focused on grounding techniques, including calming breathing and engaging the senses (Sanderson, 2013), social support (Ramos & Leal, 2013), emotional support pets (Geist, 2011), and others as well as general healthy lifestyle instructions, including exercise (Fetzer & Asmundson, 2014).

3. *Constructing* structured plans for learning how to confront trauma triggers including thought, in vivo, and imaginal triggers (Horvath, et al., 2011; Foa, et al., 2007; Foa, et al., 2013).

4. *Confronting* introduced the concept of confronting triggers effectively (Foa, et al., 2013), learning assertiveness (Beck, et al., 2013), boundaries, and appropriate sharing.

5. *Continuing* developed more fully the ideas introduced in sessions #3 and #4.

6. *Consolidating* introduced the concept of posttraumatic growth and assists in recounting the benefits of the workshop (Ogińska-Bulik, 2015; Ramos & Leal, 2013).

The servant leadership component of the treatment group included six short presentations in addition to a short group discussion. For these, a total of 41 PowerPoint slides were created by the author of this paper. These slide presentations, which were based on doctoral-level study of trauma and trauma treatment, were divided into six sessions. These presentations were based on each of the six questions in the SLBS-6 and are: using power in service to others; giving the right to question leader's actions; respecting people for who they are; enhancing people's capacity for moral actions; helping people generate a sense of meaning out of everyday life and work, and; contributing to personal and professional growth (see Appendix C).

Implementation

Once the recruitment flyer had circulated and email addresses of interested individuals had been gathered, the registration process began. An email was sent to those interested, directing them to a registration link. The consent form (see Appendix D) was incorporated into the registration process, so that the 82 individuals who completed registration had signed the consent form and filled out the Primary Care PTSD Screen and the Attachment to God Inventory.

The workshop was scheduled for Sunday afternoon and evening, the time most participants would be available. There were two sessions per group per Sunday, making it possible to complete the entire six-session workshop in three weeks. The workshop was conducted via Zoom, where participants could choose to either remain anonymous or be seen. Interaction could take place either on the Zoom call itself or the chat feature, which was read by the moderator. Zoom also allows for screensharing for PowerPoint slides.

The recruitment of the servant leader presenter was done through an informal process based on prior knowledge of the individual. He was given already designed talking points, but was given freedom to adapt the presentation to his own style. It was predicted that some of the effect would come from the psychoeducation and biblical teaching, but part from the modeling effect of the servant leader (Counted, 2015). While some risk was entailed in introducing the presence of a clergy, that risk was thought necessary. Trauma therapies such as prolonged exposure use structured, gradual in vivo exposure as a means of teaching the nervous system to habituate to triggers (Foa, et al., 2007). Görg, et al. (2017) found that when exposed to aversive trauma-related emotions such as shame, guilt, disgust, distress, and fear, radical acceptance of those emotions, rather than avoidance of them, led to a reduction of the emotions. An encounter

with clergy within the safe and managed context of the ATJ workshop provided for some who had avoided contact with clergy, a first step toward breaking trauma-related patterns of avoidance.

Nevertheless, measures were taken to prevent participants from being retraumatized by contact with clergy. The clergy chosen to present the servant leadership psychoeducation component was personally known to the researcher for 45 years and has been observed as a pastor, father, and ministry director. He is an ordained minister of the Seventh-day Adventist Church in good and regular standing, licensed in the state of Tennessee. To my knowledge, there have never been allegations of abuse leveled against him and in fact has worked extensively to rectify abuse situations, manifesting servant leadership principles while doing so. He was presented to the workshop participants as someone she personally trusted based upon years of experience and friendship.

The participants were given opportunity to send private messages to the Zoom chat feature, in the event that they needed assistance after the session. The presenter or an assistant then followed up with them. During these follow up meetings the participant was made aware of Abide Network teletherapy options as well as local providers who were able to assist them with counseling needs.

Assessments

Participants were given two assessments. The Attachment to God Inventory (AGI) (Beck & McDonald, 2004) (see Appendix E), is a self-administered assessment designed to measure relationship quality to Deity using attachment theory as a basis. It was not known whether the inventories had been taken previous to the workshop, but the taking of the same assessments for the exit survey after taking them for the registration process may affect outcome as per the

testing limitation on validity (May, 2012). This was given at the outset and conclusion of the ATJ workshop, to both groups. Beck and McDonald (2004) reported that the AGI demonstrated stable factor structure and internal consistency estimates. They addressed whether attachment to Deity was too slippery a concept to measure but concluded that while the idea demanded continued theoretical and empirical attention, relationship with God may be characterized as an attachment bond.

The Primary Care PTSD Screen for the DSM-V (see Appendix F), also given at both the outset and conclusion of the ATJ workshop to both groups, was not designed to confirm a diagnosis for PTSD, yet has demonstrated high diagnostic accuracy (Prins, et al., 2016). Previous research with the assessment has shown good test-retest reliability and predictive validity against the Clinician Administered PTSD Scale (Prins, et al., 2016).

Clinical Significance

Having been involved in abuse response work for many years, the researcher saw the great need for the two things the study addressed. The first need was a simple, inexpensive, accessible method of helping survivors recover. The need for affordable mental health services is a global issue (Lorelle, et al., 2012). Perpetrators of sexual abuse tend to exploit power-vulnerable people, and part of vulnerability is financial (de Weger and Death, 2017). Many who seek counseling from the Abide Network teletherapy network cannot afford the fees of private sessions with professional counselors. Group work costs less and in some ways can be more helpful in that participants can build relationships with other group members (Tummala-Narra, et al., 2012). In contrast to a process group, for which Yalom (2005) discourages social contact outside the group, the ATJ workshop was a psychoeducation and support group that encouraged relationship development both within and outside the group. Ramos and Leal (2013) report that

social support, including new contacts and friendships developed as the result of sharing similar trauma, is a predictor of posttraumatic growth. This occurred during the ATJ workshop as the result of group discussions and breakout groups.

The benefits of a videoconference workshop are many. The ATJ workshop was not only COVID compliant, but generally easier to access. This made it possible to serve participants from all over the world. Indeed, participants from Africa, India, England, Europe, the Philippines, Thailand, and Canada attended. In addition, Zoom is HIPAA compliant (Zoom, 2020). In a systematic review, Backhaus, et al. (2012) found that the clinical outcomes of videoconferencing therapy were similar to in-person therapy. In the same study, associations with good feasibility, adaptability to a variety of therapeutic formats with diverse populations, and associations with good user satisfaction were found. Videoconferencing interventions have been used to successfully treat victims of domestic violence who lacked access to in-person treatment due to rural living situations (Hassija & Gray, 2011). A meta-analysis of videoconferencing psychotherapy found inferiority in working alliance but non-inferiority of outcomes in target symptom reduction (Norwood, et al., 2018)

One out of every four adults in the U.S. has a mental disorder, but only 13.4% receive treatment (National Institutes of Mental Health, 2011). Digital interventions make it possible to bring care to some who, because of distance or expense, might not receive it (Taylor, et al., 2020). During COVID, the conversion rate from in-person to videoconferencing therapy was found by Miu, et al. (2020) to be the same for people with non-serious mental illness (SMI) and SMI, roughly one-half. More can be done through technology to make interventions more feasible (Backhaus, et al., 2012). The ATJ workshop was a step in that direction.

The second need the study addressed was the need for healing of the God attachment of survivors of sexual abuse by clergy. It was hoped that a male servant leader stepping into the space left by a wolf in sheep's clothing (See Matthew 7:15) would be a potent agency in the life of a survivor, providing opportunity for corrective recapitulation (Yalom, 2005) through a hermeneutical figure (Counted, 2015). In addition, it was hoped that the utter denunciation of clergy wrongdoing by other clergy would help reverse some of the effects of institutional betrayal, which exacerbates sexual abuse trauma (Smith & Freyd, 2013).

Biblical inspiration for this study was gleaned from the story of Mary Magdalene, who suffered sexual abuse by Simon the Pharisee, a clergyman (See Luke 7:36-50). As a result, she became possessed of seven devils (Luke 8:2), turning to a life of prostitution (Luke 7:37). Meeting Jesus helped rewrite her story. Her encounter with, not just a godly man, but a God-man, who valued her, not for her body but for her soul, revised her core beliefs about God. She became Jesus' most steadfast and noteworthy disciple. So much did He value her offering that He said it should be told all over the world (Matthew 26:13). No other disciple received such an unqualified commendation.

Chapter Four: Findings

Overview

Tests were run using the two aforementioned assessments: The Attachment to God Inventory (Beck & McDonald, 2004) and the Primary Care PTSD Screen for the DSM-V (Prins, et al., 2016). These assessments were taken pre and posttest, for both the control and the treatment groups. They were administered pretest as part of the registration process, and posttest as an exit survey after the *Abuse, Trauma, and Jesus* workshop. As previously mentioned, we aimed for a group size of 25.

A total of 82 individuals registered and were assigned randomly by writing the names of participants on pieces of paper, which were then shaken in a jar, and drawn out to distribute them into the two groups of 41 each. Participants were permitted to access the course material online if they missed a live session, so the average of 15-20 participants in the live sessions only partly reflected the number of individuals consuming the workshop. Forty-six participants completed the exit survey, 24 from the control group and 22 from the treatment group.

According to Warner (2012), the mode is the score that occurs most often, and the median is obtained by ordering the scores in the sample from lowest to highest then counting the scores, and the mean is simply the average. The statistical tests for this study used the mean of the various scores. Paired sample t-tests were the primary statistical test used to compare the pre and posttest results. Then a difference-in-differences analysis was run to determine if there were any differences in the control and treatment groups' pre and posttest differences. For the PTSD Screen, histograms were used to chart the results. For the ATG Inventory, boxplots were used. Each of the five scales on the PTSD screen were analyzed separately, and also as a whole. For

the ATG Inventory, the 14 avoidant traits combined were analyzed, the 14 anxious traits combined were analyzed, and the sum of all the traits were analyzed, pre and posttest.

Descriptive Statistics

Attachment to God Inventory

A paired sample t-test was performed on three domains of the ATG Inventory: the avoidant scales, the anxiety scales, and the total of both sets of scales ("all"). Likert scales are considered ordinal, and most often used with nonparametric testing. But ordinal value can be seen as a mixture of categoric and numeric data. Sullivan and Artino (2013) report that if the intervals between the values are treated as equal intervals, and if sufficient sample size of a normal distribution is used, an ordinal scale can then be treated an interval scale which can be used with parametric tests such as a t-test. In this approach the data are used as scales rather than items, and the five responses are assigned numeric value.

A brief explanation of the ATJ Inventory will clarify: The inventory consists of 28 questions rated using a five-part Likert scale from "strongly disagree" to "strongly agree." The 14 even-numbered items indicate an avoidant attachment style. For example, if an individual strongly agrees with number 12, "I am uncomfortable being emotional in my communication with God," this indicates avoidant tendencies. The 14 odd-numbered items indicate an anxious attachment style. For example, an individual strongly agreeing with number nine, "I am jealous at how close some people are to God," indicates an anxious attachment style. Several items (4, 8, 13, 18, 22, 26, and 28) are reverse-scored, so stated in the positive, including such items as "I am totally dependent upon God for everything in my life" (Beck & McDonald, 2004). If a person disagrees with one of these, making it a low rating, it actually raises the score of avoidant attachment when the rating is reversed. Although the assessment is dated, the authors report that

it demonstrates good internal consistency and construct validity and supports a correspondence with adult attachment measures in romantic relationships. Houser and Welch (2013) have more recently found the ATG Inventory to have acceptable internal consistency.

It is essential to understand that there are no items on the ATG Inventory that indicate a secure attachment to God; all indicate either an avoidant or an anxious attachment style. This means that low scores by default indicate secure attachment and are desirable, and that high scores indicate avoidant attachment styles, anxious attachment styles, or both, and are undesirable (Beck & McDonald, 2004).

The Primary Care PTSD Screen

To test the results of the PTSD Screen, paired sample t-tests were used. The pre and posttest results were displayed in histograms of each trait, plus a sum of all the traits. As opposed to a means of diagnosing PTSD, the Primary Care PTSD Screen was used as a quick analysis of trauma symptoms. The introduction of the PTSD Screen says:

> Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: a serious accident or fire; a physical or sexual assault or abuse; an earthquake or flood; a war; seeing someone killed or seriously injured; having a loved one die through homicide or suicide (Prins, et al., 2016).

These criteria help determine a diagnosis of PTSD but do not directly relate to this study's use of the screen. The participants came with a recognition that the trauma at issue was the trauma of being abused by a religious or spiritual leader, and that they were being assessed for trauma symptoms, rather than a diagnosis of PTSD. Because of these factors, the participants knew the data on the introductory question in the screen was not the focus of the analysis. They

knew, however, that it was a PTSD screen because “Primary Care PTSD Screen” could be seen at the top of the page.

The PTSD symptoms on the screen are listed in this way, answered with a simple yes or no response:

In the past month, have you...

- Had nightmares about the event(s) or thought about the event(s) when you did not want to?
- Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
- Been constantly on guard, watchful, or easily startled?
- Felt numb or detached from people, activities, or your surroundings?
- Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? (Prins, et al., 2016)

These symptom clusters could be condensed as revisitation, avoidance, arousal, dissociation, and blame. As with the Attachment to God Inventory, adverse symptoms are measured, making a lower score more desirable. Each symptom cluster was measured and graphed individually, plus an overall score of all the PTSD symptoms combined was measured and graphed.

Results

Hypotheses

There were two basic research questions. The first, tested by the control group, asked if a six-session, videoconferencing workshop called the *Abuse, Trauma and Jesus* workshop would help survivors of church-related sexual abuse improve in the domains of God attachment and

PTSD symptoms. The second, tested by the treatment group in comparison to the control group, inquired whether an added servant leader psychoeducation component would bring about further improvement. The control and treatment group participants completed the same assessments pre and posttest. These two research questions were broken into four questions, a question for each of the two assessments for each of the two groups.

Hypothesis One

The first research question was: Will participation in a six-session, videoconferencing, *Abuse Trauma, and Jesus* workshop improve measures of God attachment in survivors of sexual abuse by clergy? The null hypothesis for this question was: There will be no statistically significant difference between the pre and posttest measures of God attachment in participants of the *Abuse, Trauma, and Jesus* workshop. The alternate hypothesis was: There will be a statistically significant difference between the pre and posttest measures of God attachment in participants of the *Abuse, Trauma, and Jesus* workshop.

There was not a significant difference between the pretest (M=2.59; SD=.66) and the posttest (M=2.45; SD=.50) of the "all scales," $t(24) = 1.86$, p=.07. No significant difference was seen between the pretest (M=2.25; SD=.51) and posttest (M=2.11; SD=.49) for avoidance scales $t(24) = 1.69$, p=.10. Finally, no difference was seen between the pretest (M=2.92; SD=.95) and posttest (M=2.79; SD=.78) for the anxiety scales $t(24) = 1.47$, p=15. These results confirm the null hypothesis in all cases.

However, one measure came close to statistical significance. As mentioned before, three tests were run—avoidant symptoms, anxious symptoms, and both together ("all"). The "all" group came very close to statistical significance in the control group but not the treatment group. The difference in means generated a p-value of .075 which is close to the cutoff of .05 or less.

The posttest scores on the assessment were lower than the pretest scores, and lower scores meant lower levels of avoidant and anxious symptoms.

While none of the t-tests of the Attachment to God Inventory showed statistical significance, the results still showed that for all the Attachment to God Inventory, including avoidant style, anxious style, and all, the posttest scores were lower than the pretest scores for both control and treatment groups. In other words, the scores lowered consistently posttest. It is interesting to note that these improvements in God attachment, while sub-threshold for statistical significance, were consistent.

Table 1.

Paired Sample T-Tests for the ATG Control Group

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Average across all ATG Inventory scores (PRE)	2.5930	24	.66555	.13585
	Average across all ATG Inventory scores (POST)	2.4539	24	.50392	.10286
Pair 2	Average across the even number ATG Scores = Avoidance (PRE)	2.2566	24	.51586	.10530
	Average across the even number ATG Scores = Avoidance (POST)	2.1131	24	.49439	.10092
Pair 3	Average across the odd number ATG Scores = Anxiety (PRE)	2.9290	24	.95310	.19455
	Average across the odd number ATG Scores = Anxiety (POST)	2.7946	24	.78764	.16078
Pair 4	Sum of the PTSD_PRE Variables (0,5) Ignoring the Intro Recode PRE variable	2.6250	24	1.66322	.33950
	Sum of the PTSD_POST Variables (0,5) Ignoring the Intro Recode POST variable	2.7083	24	1.70623	.34828

Figure 1

Boxplot of Average ATG Scores for the Control Group for Pre-Workshop

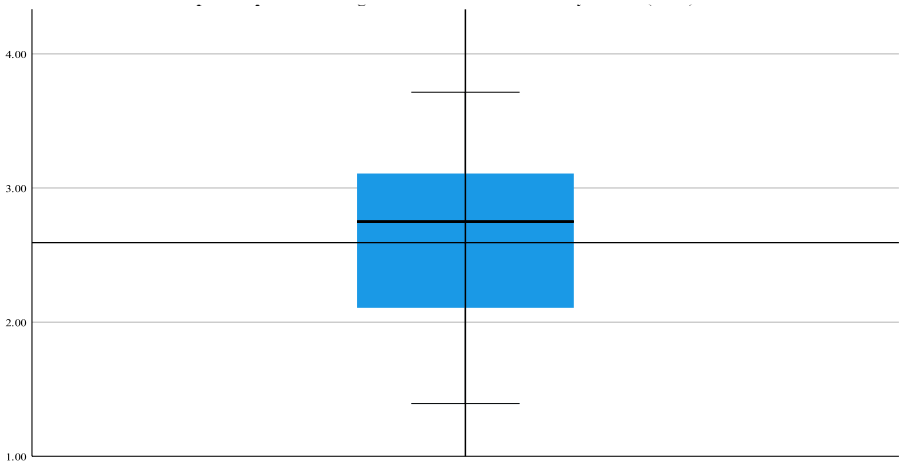


Figure 2

Boxplot of Average ATG Scores for the Control Group for Post Workshop

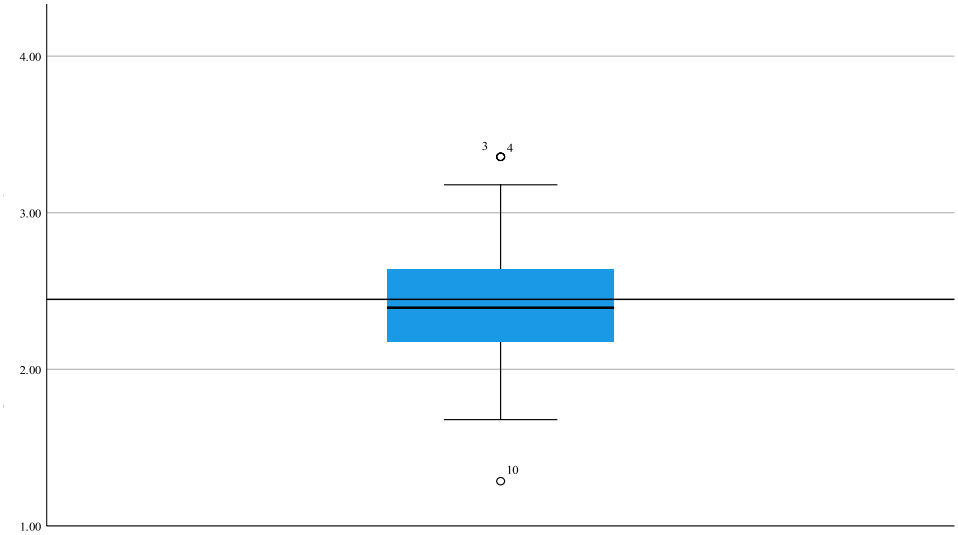


Table 2.

Paired Sample T-Tests for the ATG Treatment Group

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Average across all ATG Inventory scores (PRE)	2.4799	22	.58165	.12401
	Average across all ATG Inventory scores (POST)	2.3945	22	.64948	.13847
Pair 2	Average across the even number ATG Scores = Avoidance (PRE)	2.2348	22	.44167	.09416
	Average across the even number ATG Scores = Avoidance (POST)	2.1364	22	.65980	.14067
Pair 3	Average across the odd number ATG Scores = Anxiety (PRE)	2.7258	22	.80435	.17149
	Average across the odd number ATG Scores = Anxiety (POST)	2.6526	22	.74306	.15842
Pair 4	Sum of the PTSD_PRE Variables (0,5) Ignoring the Intro Recode PRE variable	2.7273	22	1.57908	.33666
	Sum of the PTSD_POST Variables (0,5) Ignoring the Intro Recode POST variable	3.0455	22	1.46311	.31194

Figure 3.

Boxplot of Average ATG Scores for the Treatment Group for Pre-Workshop

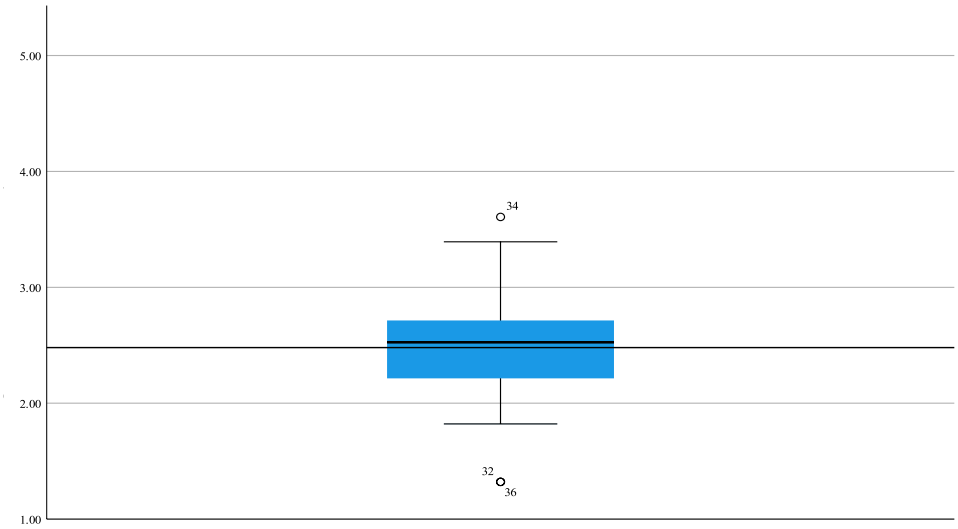
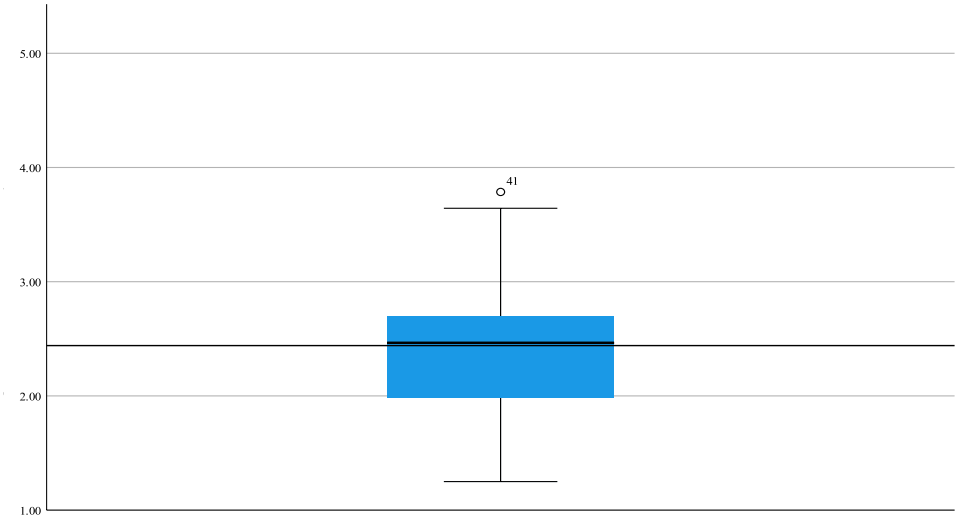


Figure 4.

Boxplot of Average ATG Scores for the Treatment Group for Post Workshop



Hypothesis Two

The second research question was: Will participation in a six-session, videoconferencing, *Abuse Trauma, and Jesus* workshop improve measures of PTSD in survivors of sexual abuse by clergy? The null hypothesis for this question was: There will be no statistically significant difference between the pre and posttest measures of PTSD in participants of the *Abuse, Trauma, and Jesus* workshop. The alternate hypothesis was: There will be a statistically significant difference between the pre and posttest measures of PTSD in participants of the *Abuse, Trauma, and Jesus* workshop.

There was not a significant difference between the pretest (M=.45; SD=.50) and the posttest (M=.54; SD=.50) of the first scale, revisitation $t(24) = .81$, p=.42. No significant difference was seen between the pretest (M=.50; SD=.51) and posttest (M=.58; SD=.50) for the second scale, avoidance $t(24) = .56$, p=.10. No significant difference was seen between the pretest (M=.54; SD=.50) and posttest (M=.50; SD=.51) for the third scale, anxiety $t(24) = .56$, p=.57. No significant difference was seen between the pretest (M=.45; SD=.50) and posttest (M=.54; SD=.50) for the fourth scale, dissociation $t(24) = .81$, p=.42. Finally, no difference was seen between the pretest (M=.66; SD=.48) and posttest (M=.54; SD=.50) for the fifth scale, blaming $t(24) = 1.00$, p=.32. In summary, the symptoms of revisitation, avoidance, and dissociation increased slightly posttest, and the symptoms of anxiety and blaming decreased slightly, but none to the point of statistical significance. These results confirmed the null hypothesis in all cases.

Figure 5.

Histogram of PTSD Screen Variables Control Group Pre-Workshop

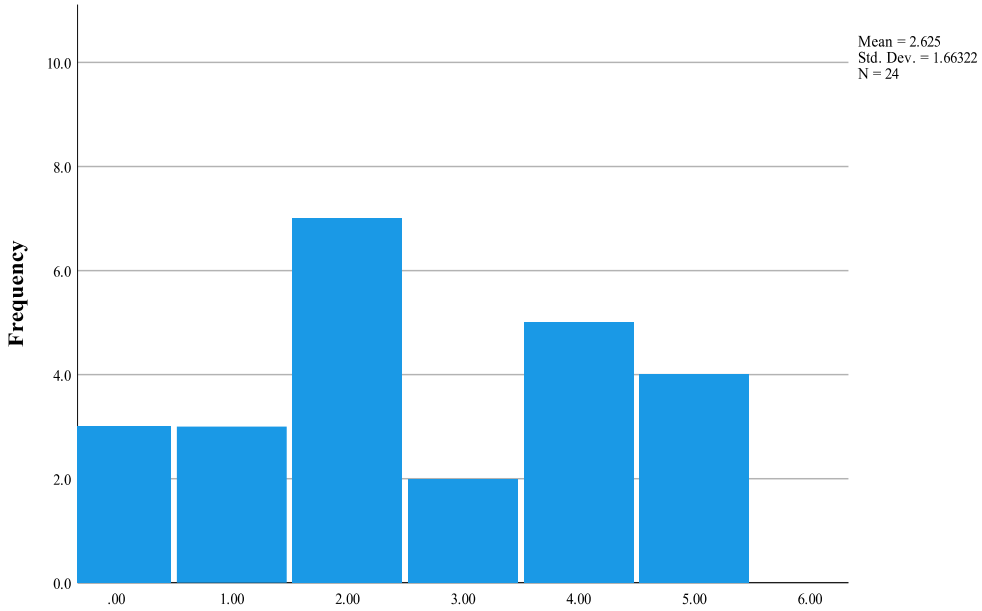


Figure 6.

Histogram of PTSD Screen Variables Control Group Post Workshop

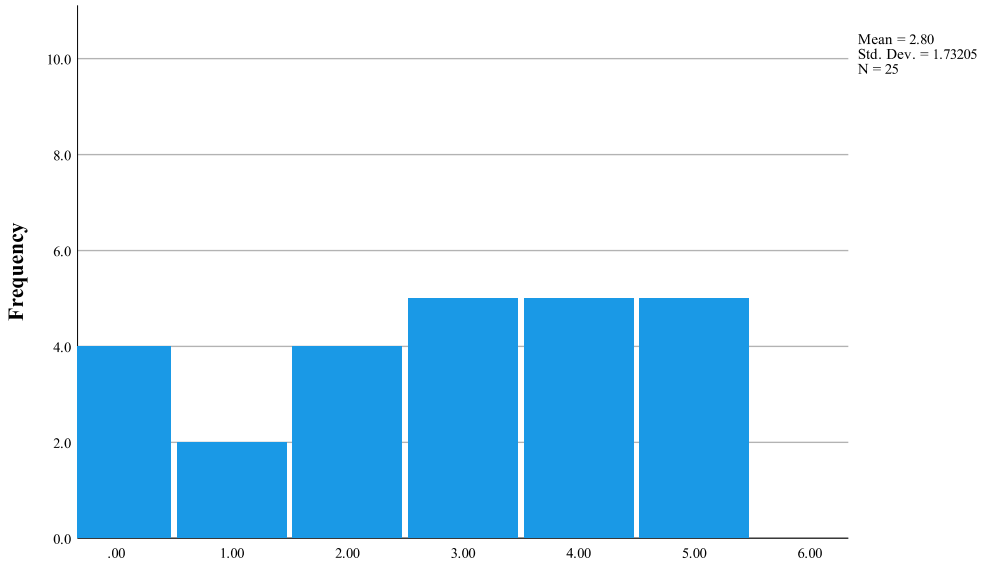


Figure 7.

Histogram of PTSD Screen Variables Treatment Group Pre-Workshop

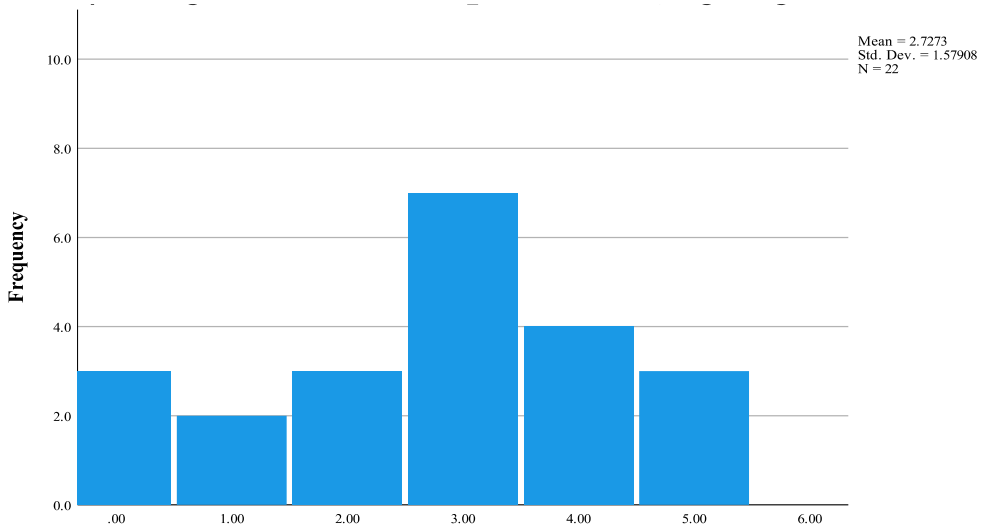
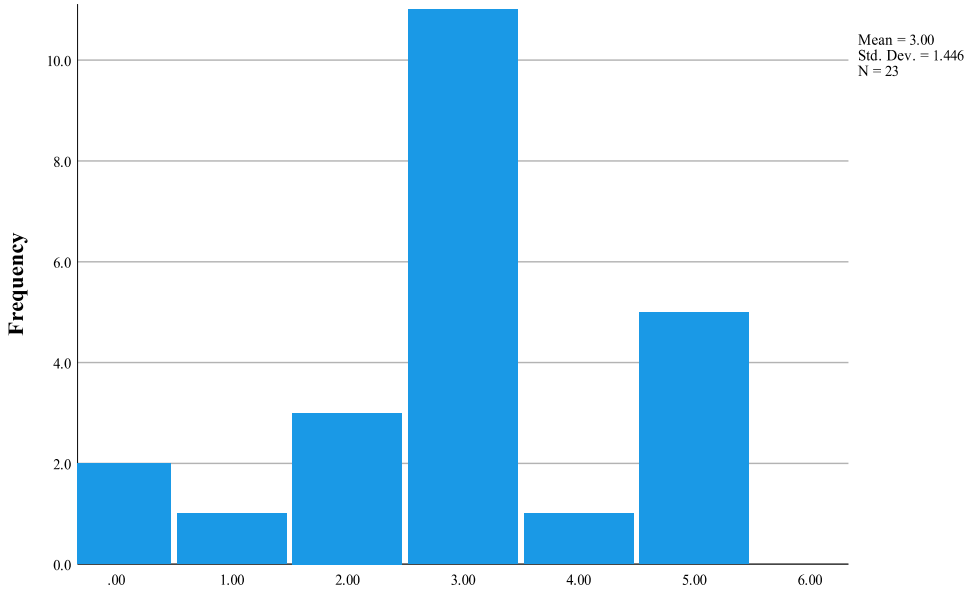


Figure 8.

Histogram of PTSD Screen Variables Treatment Group Post-Workshop



Hypothesis Three

The third research question was: Will participation in a six-session, videoconferencing, *Abuse Trauma, and Jesus* workshop with the added component of servant leadership psychoeducation more significantly improve measures of God attachment in survivors of sexual abuse by clergy than the stand-alone workshop? The null hypothesis for this question was: There will be no statistically significant difference in pre and posttest measures of God attachment between the treatment group and the control group of the *Abuse, Trauma, and Jesus* workshop. The alternate hypothesis was: There will be a statistically significant difference in pre and posttest measures of God attachment between the treatment group and the control group of the *Abuse, Trauma, and Jesus* workshop.

The test for this was twofold: First, the pre and posttest analysis of the treatment group was run to see if the treatment group yielded statistically significant results. Then there was a comparison of the treatment group with the control group, for which a difference-of-differences analysis was used. Neither produced statistically significant results.

For part one, there was not a significant difference between the pretest (M=2.47; SD=.58) and the posttest (M=2.39; SD=.64) of the "all" scales, $t(22) = 1.04$, p=.30. No significant difference was seen between the pretest (M=2.23; SD=.44) and posttest (M=2.13; SD=.65) for avoidance scales $t(22) = 1.17$, p=.25. Finally, no difference was seen between the pretest (M=2.72; SD=.80) and posttest (M=2.65; SD=.74) for the anxiety scales $t(22) = .75$, p=46 (See Table 2 & Figures 3 &4).

For part two, a difference-in-differences analysis was used. Comparing just pre and posttest is not enough to omit variable bias (Chuard, et al., 2019). Differencing compares the outcome of the control group pre to posttest difference with the pre to posttest difference of the

treatment group. It works from the assumption that whatever happened to the control group would happen to the treatment group in the absence of the treatment (Bliese & Wang, 2020). Difference-in-differences analyses are often used in observational study data to attempt to mimic an experimental design (Bliese & Wang, 2020). However, a difference-in-differences analysis is perfectly suited for the type of experimental design used in this study because it allows for a comparison between two groups within which a pre and posttest comparison is made.

The analysis is comprised of two parts. In our study, the first part looked only at the treatment group. The average measure of all the ATG Inventory scales before the treatment was subtracted from the average measure of all the ATG Inventory scales after the treatment. For the second part, the same procedure was done for the control group, with the final step of subtracting the second sum from the first sum.

In the regression approach for difference-in-differences, the coefficient table showed the coefficient to be .10. The table also showed the p-value to be .67, meaning that the estimate is not statistically significant. The same difference-in-differences analysis was performed for the ATG avoidance measure. The coefficients table shows the estimate to be .08 with a p-value of .70. When the analysis was then performed for the ATG anxiety measure, the coefficient table showed the estimate at .12 and the p-value at .71. None of these are statistically significant, supporting the null hypothesis.

Table 3.

Coefficients for ATG All

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	2.593	.125		20.714	<.001
	Treatment_Indicator	-.109	.183	-.090	-.595	.554
	Post_Indicator	-.146	.175	-.121	-.832	.407
	Diff_in_Diff	.107	.256	.075	.416	.678

a. Dependent Variable: ATG Overall Score

Table 4.

Coefficients for ATG Avoidant

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	2.257	.110		20.508	<.001
	Treatment_Indicator	-.021	.161	-.020	-.130	.897
	Post_Indicator	-.145	.154	-.137	-.943	.348
	Diff_in_Diff	.085	.225	.068	.376	.708

a. Dependent Variable: ATG Avoidance

Table 5.

Coefficients for ATG Anxiety

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	2.929	.172		17.076	<.001
	Treatment_Indicator	-.196	.251	-.118	-.780	.438
	Post_Indicator	-.146	.240	-.088	-.608	.544
	Diff_in_Diff	.127	.351	.066	.362	.718

a. Dependent Variable: ATG_Anxiety

One observation deserves attention. For all the difference-in-differences analyses, including the avoidant, anxiety, and "all" of the ATJ Inventory, the control group difference was greater, meaning there was more improvement for the control group vs. the treatment group.

Figure 9.

Difference-in-Differences Estimation for ATG All

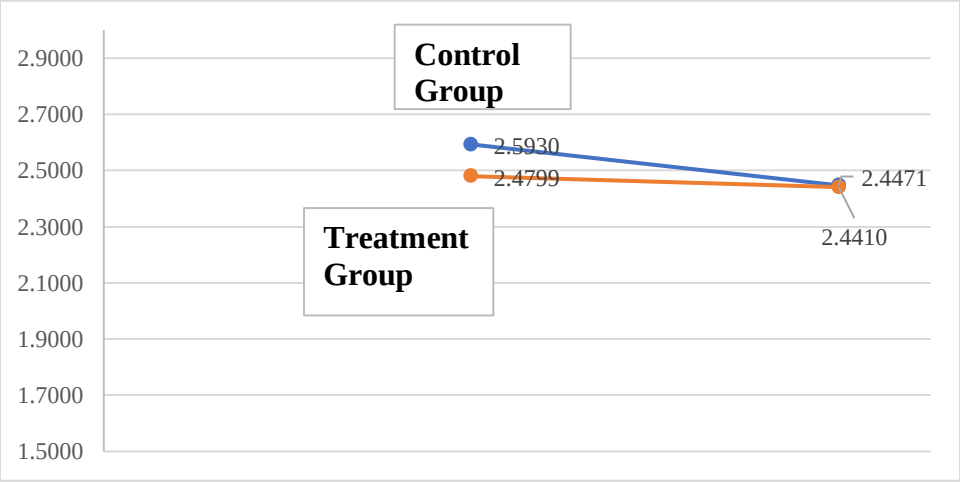


Figure 10.

Difference-in-Differences Estimation for ATG Anxiety

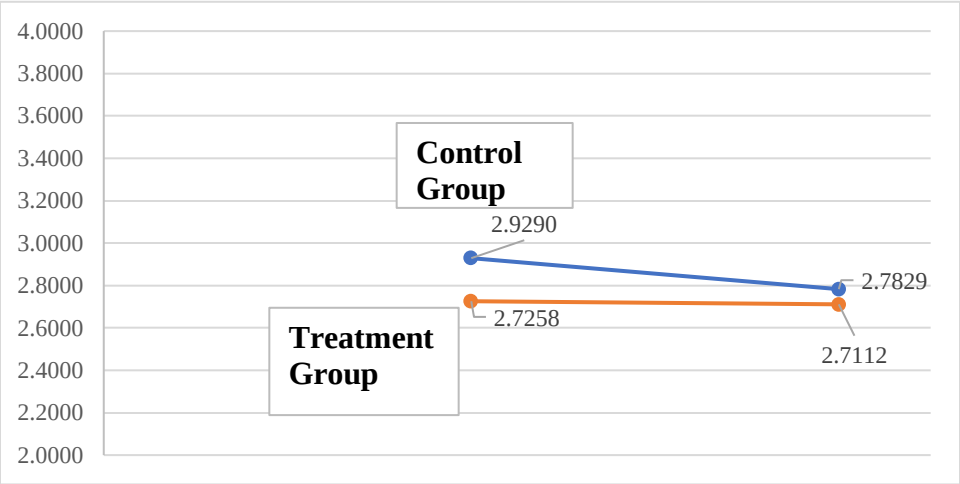
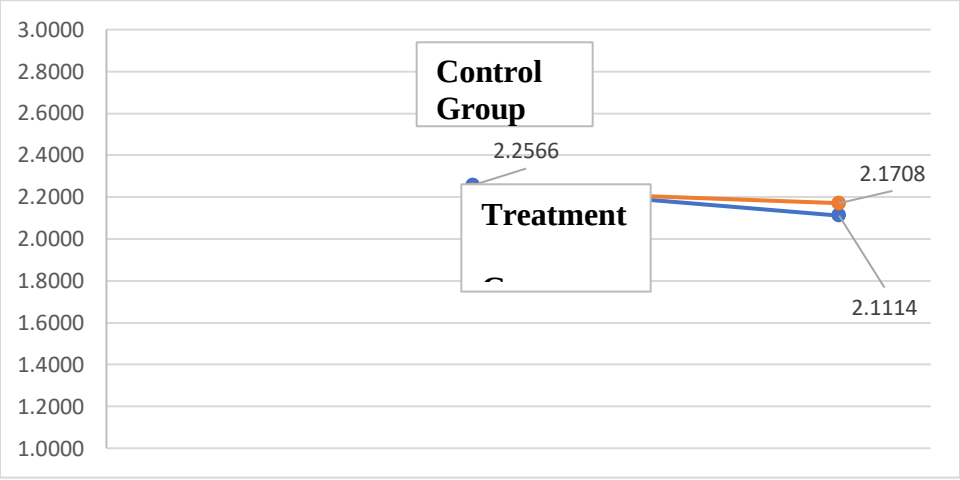


Figure 11.

Difference-in-Differences Estimation for ATG Avoidance



Hypothesis Four

The fourth research question was: Will participation in a six-session, videoconferencing, *Abuse Trauma, and Jesus* workshop with the added component of servant leadership psychoeducation more significantly improve pre and posttest measures of PTSD in survivors of sexual abuse by clergy than the stand-alone workshop? The null hypothesis for this question was: There will be no statistically significant difference in pre and posttest measures of PTSD between the treatment group and the control group of the *Abuse, Trauma, and Jesus* workshop. The alternate hypothesis was: There will be a statistically significant difference in pre and posttest measures of PTSD between the treatment group and the control group of the *Abuse, Trauma, and Jesus* workshop.

First, tests were run for treatment group outcomes. There was not a significant difference between the pretest (M=.45; SD=.50) and the posttest (M=.54; SD=.50) of the first scale, revisitation, $t(22) = .69$, p=.49. No significant difference was seen between the pretest (M=.59; SD=.50) and posttest (M=.59; SD=.50) for the second scale, avoidance, $t(22) = .00$, p= 1.0. No significant difference was seen between the pretest (M=.63; SD=.49) and posttest (M=.59; SD=.50) for the third scale, anxiety, $t(22) = .43$, p=.66. No significant difference was seen between the pretest (M=.50; SD=.51) and posttest (M=.72; SD=.45) for the fourth scale, dissociation $t(22) = 2.01$, p= .057. Finally, no difference was seen between the pretest (M=.54; SD=.50) and posttest (M=.59; SD=.50) for the fifth scale, blaming $t(22) = .37$, p=.71.

The same difference-in-differences analysis was used to assess this fourth hypothesis for the PTSD variable. The pattern was the same with the estimate being .09 and the significance or

p-value being .88 for that estimate, meaning the difference-in-differences estimate is not statistically significant. This confirmed the null hypothesis.

Because one of the participants had been acquainted with the pastor who presented the treatment portion of the workshop, and because the data points, possibly reflecting the participant's experience, differed significantly from the rest of the participants' data points, the results were treated as an outlier. When the differences-in-differences estimate was again performed minus the outlier, the estimate increased to .15, and the p-value changed to .81. These numbers were still not statistically significant, confirming the null hypothesis.

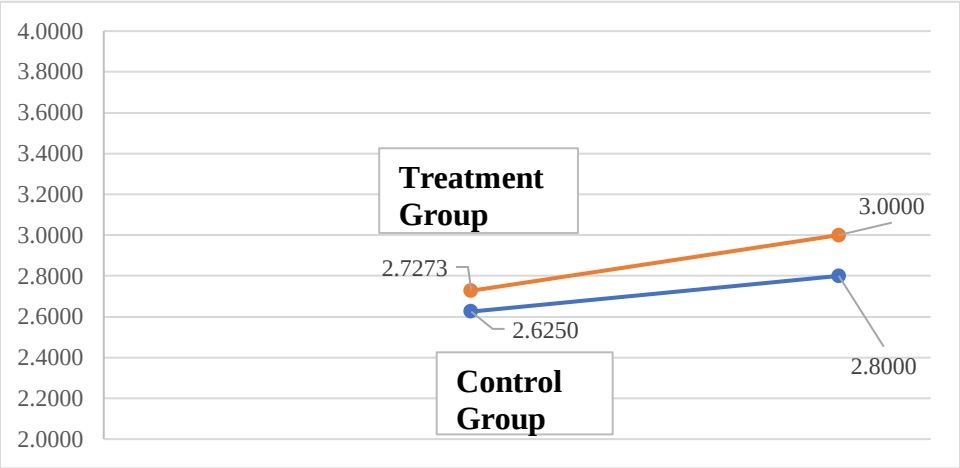
Table 6.

Difference-in-Differences Estimation for Sum of PTSD

Indicates Which Control or Treatment Group		Sum of Pre PTSD Variables	Sum of Pre PTSD Variables
Control Group	Mean	2.6250	2.8000
	N	24	25
	Std. Deviation	1.I 66322	1.73205
Treatment SL Group	Mean	2.7273	3.0000
	N	22	23
	Std. Deviation	1.57908	1.44600
Total	Mean	2.66739	2.8958
	N	46	48
	Std. Deviation	1.60630	1.58771

Figure 12.

Difference-in-Differences Estimation for Sum of PTSD



Noteworthy Observations

In spite of the absence of statistical significance, two observations are noteworthy. These will be commented on in more detail in the conclusions:

The sum of the PTSD scores were actually higher posttest than pretest in both the control and the treatment groups, and in the treatment group once the outlier was removed. In the control group, the mean was 2.62 pretest and 2.80 posttest. In the treatment group, the mean was 2.72 pretest and 3.00 posttest. With the outlier removed from the treatment group, the mean was 2.71 pretest and 3.04 posttest. This is noteworthy given that our aim was to relieve trauma symptoms rather than exacerbate them.

The overall ATG Inventory scores were consistently lower after the workshop than before. As mentioned, since the ATG Inventory measures only avoidant and anxious attachment styles, and since low scores of these assume secure attachments, lower scores on the ATG Inventory are desirable. These consistently desirable outcomes could potentially produce significant results if tests of cumulative probabilities were used (Bliese & Wang, 2020).

However, there is concern about poor scientific practices arising from excessive focus on p-values, leading to selective reporting and "p-hacking" resulting from the manipulation of data collection, usage, and analysis to obtain statistically significant outcomes (Chuard, et al., 2019).

Post Workshop Feedback Form

Workshop participants filled out a ten-item feedback form (see Appendix G) as part of their exit survey. The form used a five-item Likert scale: strongly disagree, disagree, neutral/mixed, agree, and strongly agree. The feedback was overwhelmingly positive when looking at all the items. Adding agree and strongly agree yielded the following results:

1. This workshop was helpful to me- 91.7%
2. This workshop helped me understand abuse and trauma- 95.8%
3. This workshop provided meaningful connections- 64.6%
4. This workshop changed my life for the better- 79.1%
5. This workshop helped relieve unwanted symptoms- 54.1%
6. I learned new information at this workshop- 93.8%
7. I learned helpful skills at this workshop- 93.9%
8. I benefitted from this workshop spiritually- 91.7%
9. This workshop inspired me to minister to those who are undergoing a similar trauma- 87.5%
10. I will recommend this workshop to others- 91.8%

These scores yielded a sum total of 84.4% agree or strongly feedback.

Summary

The study utilized live subjects who attended either a control or treatment group of the six-session *Abuse, Trauma, and Jesus* workshop. The basic workshop was the same with an added component of psychoeducation on servant leadership for the treatment group. Eighty-two

registered for the workshop, but only 46 completed the exit survey, with 24 in the control group and 22 in the treatment group. One participant in the treatment group was determined to be an outlier, which brought the total down to 21. The participants completed surveys pre and posttest which included two assessments, the Primary Care PTSD Screen and the Attachment to God Inventory. The exit survey also included a Post-Workshop Feedback Form.

Paired sample t-tests were used to compare the pre and posttest results of both assessments. Histograms were used to graph the results of the PTSD Survey and boxplots were used for the ATG Inventory. A difference-of-differences analysis was used to compare differences of the effect of the workshop. Four research questions, derived from the two groups (control and treatment) and the two assessments (PTSD and ATG) were addressed. None of the alternative hypotheses based on these four research questions were confirmed. However smaller-than-significant effects were seen. The PTSD scores tended to increase after the workshop, although the results were mixed. This was an undesirable outcome, as it suggests an increase in trauma symptoms. The ATG Inventory scores consistently came out lower posttest, which was a desirable outcome as the inventory measured avoidant and anxious God attachment styles, and lower scores suggested a more secure attachment style.

A difference-of-differences analysis was done to determine if the effect of the treatment group exceeded the effect of the control group. Once again, the p-values came in under statistical significance. And in fact, the control group difference was greater than the treatment group difference for the ATG Inventory, possibly suggesting greater improvement in the control group. The PTSD Screen difference was slightly greater for the treatment group, but the greater effect was increased PTSD symptoms.

CHAPTER FIVE: CONCLUSIONS

Overview

While the data from the *Abuse, Trauma, and Jesus* workshop did not show statistically significant results, some noteworthy observations were made that could inform practice and future study. Some of the potentially therapeutic factors are identified along with observations of how to improve the workshop.

Discussion

As stated previously, there were two basic research questions. The control group tested whether a six-session videoconferencing *Abuse, Trauma, and Jesus* workshop would help survivors of church-related sexual abuse improve in the domains of God attachment and PTSD symptoms. The second, tested by the treatment group in comparison to the control group, asked whether an added servant leader psychoeducation component would bring about further improvement in God attachment and PTSD symptoms. These two research questions were broken into four questions, one for each of the two assessments for each of the two groups. Although none of the outcomes were statistically significant, some interesting observations were made.

Hypothesis One

The first research question asked if participation in the six-session ATJ workshop would improve pre and posttest measures of God attachment as measured by the Attachment to God (ATG) Inventory in survivors of sexual abuse by clergy. Because none of the outcomes were statistically significant, the null hypothesis was accepted. It read: There will be no statistically significant difference between the pre and posttest measures of God attachment in participants of the *Abuse, Trauma, and Jesus* workshop.

The result that came the closest to statistical significance was the sum of all the ATG Inventory scales pre and posttest in the control group. This p-value was .075, close to the .05 cutoff. This, combined with the fact that in both the control and the treatment groups, the ATG Inventory score was lower posttest on all measures, suggests that the workshop may have helped lower avoidant and anxious God attachment patterns in participants.

While the *Abuse, Trauma, and Jesus* workshop was not a therapy or process group, but rather a psychoeducational/support group, there may have been aspects of the workshop that lowered avoidant and anxious attachment to God patterns. These aspects could be summarized as therapeutic recapitulation, myth-busting, emotional disclosure, social support, and tool-sharing.

Therapeutic Recapitulation

The God concept plays an important self-regulatory role in the lives of traumatized individuals, including those with sexual abuse trauma (Counted, 2015). Farrel, et al. (2010) identify unique features of trauma sustained from sexual abuse by clergy such as theological conflict, spiritual identity, political anger, and re-traumatization by the church. Clergy may be seen as representatives of God who must be obeyed without question (Kusner & Pargament, 2012). A supportive, compassionate image of God has predicted lower anxiety and avoidance patterns generally (Testoni, et al., 2016) and lower avoidant or anxious emotions in relationship to God, specifically (Krause & Ironson, 2017). This supportive, compassionate image of God is severely challenged in victims of sexual abuse by clergy. Healing of that God image is believed to correspondingly assist in healing of God attachment (Counted, 2015; Granqvist, et al., 2012; Rasar, et al., 2013).

Internal objects, the mental representations of our relationship with primary caregivers and other significant relationships, can be impacted by the therapeutic process. The relationship

with the counselor gives opportunity for therapeutic recapitulation (Counted, 2015). The therapeutic process can change neural networks associated with authority figures (Gardner, 2013). In the *Abuse, Trauma, and Jesus* workshop, the presenter as an authority figure, instead of enabling and excusing sexual abuse, identified it in clear terms. This gave opportunity for therapeutic recapitulation and the reversal of institutional betrayal (Smith, & Freyd, 2013).

Myth-Busting

Sexual abuse by clergy does not begin and end with the sexual aspect of the abuse. The sexual intrusion comes in the context of extreme levels of spiritual and emotional deception, manipulation, and aggression. The dark triad of narcissism, an inflated and entitled view of self, Machiavellianism, a disposition toward unprincipled manipulation, and psychopathy, the trait of impulsive and unfeeling infliction of harm, have been well-documented in abusive individuals (Jonason & Webster, 2010). Narcissistic Personality Disorder may exist at higher rates among clergy than the general population (Ruffing, et al., 2018) and preempts various forms of ethical misconduct among clergy (Ruffing, et al., 2018), including sexual abuse of congregants (Cooper-White, 2012). The effect of these dark personality traits and the psychological abuse that preempts and follows sexual contact, can be a form of brainwashing (Puls, 2018).

It is remarkable how long the hold of such brainwashing can last. The workshop participants heard straight talk on issues such as the culpability of spiritual leaders for what are wrongly termed affairs, the effect of power imbalances on the victim's psyche, the tendency of the family or church to enable the abuser, the tendency of victims to self-blame, and the reality of betrayal trauma and institutional betrayal. The workshop was promoted as a psychoeducational/support event, so focused extensively on imparting sound, research-backed information.

Referring to the workshop's identification of secondary disturbance and the normalizing of trauma-related anxiety, one participant said, "I've spent a lot of time telling myself I am not a Christian because I feel fear. It's wonderful to know that God does not condemn us for that and we can focus on Jesus and accepting His courage" (personal communication, May 30, 2021).

Because false pictures of God exacerbate trauma (Counted, 2015; Pressley & Spinazzola, 2015), the workshop included some biblical theodicy, presenting a case for why a good God allows suffering. This theodicy is sometimes called a theodicy of love, and strives to uphold both the sovereignty of God and human freedom within the context of a cosmic conflict between good and evil (Peckham, 2018).

Some examples of specific myths the workshop revised are:

- *The only thing that produces trauma symptoms is physical danger or near-death.* The workshop defined and described CPTSD as producing similar symptoms to PTSD. Adverse childhood experiences were described as well (Edwards, et al., 2012; Farrell, et al., 2010; Herman, 1997; Tummala-Narra, et al., 2012).
- *Abused people never bond with abusers.* The introduction of the concept of betrayal trauma, and a betrayal bond, made it clear that abused individuals can dissociate from the abuse in a relationship in order to maintain the connection (Gobin, et al., 2012; Kaehler & Freyd, 2012; Tang & Freyd, 2012).
- *Being sexually abused by clergy is over when the abuse is over*. The concept of institutional betrayal was introduced, helping survivors understand that often the abuser's supporting system does the worst damage in the form of secondary betrayal and trauma (Smith & Freyd, 2013; Smith & Freyd, 2014).

- *God's inaction when I was abused means He didn't care.* The concept of theodicy was explored, with the need to understand the factors that keep God from responding to injustice immediately (Peckham, 2018).
- *My emotions are uncontrollable.* The methods of grounding helped participants develop means of managing overwhelming emotions (Burrows, 2013).
- *Avoiding triggers is the best way to stay calm.* Patterns of avoidance were explained as a typical part of a traumatized condition but were also replaced with better coping methods such as grounding and systematic exposure (Burrows, 2013; Foa, et al., 2013; Thompson & Waltz, 2010).
- *If I feel something, it must be true.* Cognitive-behavioral techniques were introduced to help participants understand that shaping the thought life can help shape emotions (Burrows, 2013; Cloitre, et al., 2011; Hassija & Gray, 2011; Lamp, et al., 2019; Suris, et al., 2013).
- *I'm worthless.* The issues of self-loathing and shame were addressed and explained as a typical albeit unhealthy response to trauma. The idea of self-respect and self-care founded on God's valuing of us was introduced (Dorahy, et al., 2013; Øktedalen, et al., 2014; Pressley & Spinazzola, 2015).
- *Trauma symptoms never improve.* Trauma therapies that have been proven effective were presented and explained (Foa, et al., 2013; Lamp, et al., 2019, Lopez-Zeron & Blow, 2015; Oren & Solomon, 2012; Suris, et al., 2013; Watts, et al., 2013).
- *Trauma has ruined me.* The idea of posttraumatic growth, with scientific and biblical support, was presented as a real possibility for all who have experienced trauma

(Ogińska-Bulik, 2015; Ramos & Leal, 2013; Taku, et al., 2009; Tedeschi & Calhoun, 1996).

Self-Disclosure

Because during the discussion time and on the chat, the workshop allowed the option of participants sharing from their own experiences, some individuals did express themselves freely. Self-disclosure is one of the predictors of posttraumatic growth, in part because it assists in feeling connected to others (Ramos & Leal, 2013). For some participants, the workshop was the first time they admitted the abuse to anyone. This not only allowed them to receive social support, but it exposed their belief systems to the light of factual information regarding SAC, abuse trauma, PTSD, CPTSD, betrayal trauma, institutional betrayal, and a host of other concepts.

In some cases, the self-disclosure continued beyond the workshop. Participants were instructed to write out different-length versions of their story to share appropriately—a one sentence version, a one paragraph version, a one-page version, and a one-chapter version. They were taught the art of careful self-disclosure, making sure the audience was trustworthy. In some cases, reports were filed against abusers. One participant reported happily that, “The pastor was caught because of my testimony and officially stripped of their titles. Thank you for giving me the courage and the tools” (personal communication, May 30, 2021).

Social Support

Self-disclosure and social support are intimately linked (Ramos & Leal, 2013). The first leads to the second, both in a group setting and in everyday life. Sharing without oversharing was stressed. One participant said, “For me sharing without telling details has been so healing but also it has helped others too. I have now found a big circle in my church that had similar trauma

and now we don't feel alone and as we get healing now we are able to help even more people" (personal communication, May 30, 2021).

Self-disclosure tends to facilitate deeper intimacy (Pascoal, et al., 2012). The workshop allowed for both self-disclosure and expressions of support from participants to other participants. The group members could speak on both the chat and audibly, and could post heart and other emojis in response to testimonies shared. Because of institutional betrayal leading to the survivor being effectively punished for self-disclosure, survivors fear seeking social support. Effort was made to provide a safe and supportive environment in the workshop. A Group Etiquette Statement was posted in the chat and read aloud during the workshop sessions. Participants were required to post their agreement in the chat (see Appendix H).

Tool-Sharing

The workshop utilized a tool-based approach, imparting knowledge of methods and techniques from an array of the most effective trauma treatments. The sessions included the following tools:

1. *Comprehending* covered basic psychoeducation about trauma, its effects, and its treatments.
2. *Calming* shared grounding techniques, conscious breathing, emotional support pets, social connection, self-care, and healthy lifestyle choices
3. *Constructing* covered the basics of exposure therapy and presented a trauma hierarchy tool using subjective units of distress, or SUDs.
4. *Confronting* introduced cognitive behavioral techniques.
5. *Continuing* introduced grief work and narrative therapy.

6. *Consolidating* introduced the posttraumatic growth inventory and gave ideas for pursuing trauma therapy in counseling.

Participants found the tools helpful, with 93.3% either agreeing or strongly agreeing with "I learned helpful skills at this workshop" on the Post Workshop Feedback Form. Regarding how to appropriately self-disclose abuse history, one participant said, "I really like the 'don't stuff but don't dump' and find it very helpful!!" (personal communication, May 30, 2021). Some of the tools utilized in the workshop, and shared freely with participants in document form, are found in Appendices I through P..

Hypothesis Two

The second research question asked if participation in a six-session ATJ workshop would improve pre and posttest measures of PTSD in survivors of sexual abuse by clergy as measured by the Primary Care PTSD Screen. As mentioned, the symptoms of revisitation, avoidance, and dissociation increased slightly posttest, and the symptoms of anxiety and blaming decreased slightly, but none to the point of statistical significance.

It was interesting to note, however, that some of the symptoms did increase slightly. This suggests that a short-term psychoeducational and support group setting may not be effective in reducing trauma symptoms, and that it may even increase them, at least temporarily. Hearing about the subject of trauma acquired through sexual abuse could present significant triggers, especially to individuals who had buried or suppressed the trauma.

But this could be necessary for eventual relief of symptoms. Some trauma treatments purposely guide trauma survivors to a window of tolerance between hypoarousal and hyperarousal, in which symptoms are activated without being overactivated (Buckley, et al., 2018; Farrell, et al., 2010; Kezelman & Stavropoulos, 2012). The principles of prolonged

exposure therapy involve gradually changing avoidance patterns through the facing of triggers, allowing the nervous system to habituate. Foa, et al. (2013) report that this habituation process leads to resolution of symptoms. The initial contact with triggers, however, will produce an arousal response.

It was understood that this triggering would potentially occur during the workshop. For this reason, support calls by a follow-up team were offered. The team members were trained in how to listen empathically and supportively and refer individuals to local counseling resources and were given written instructions in how to conduct the call (see Appendix Q).

There were two team members who spoke to a total of six participants. Mostly they engaged in supportive listening. One participant struggled with binging but had otherwise made great progress in her healing. Another had many trauma symptoms before the workshop and already had a counselor. One had met her abuser recently and was having active trauma symptoms, so, with the support of the volunteer, scheduled an appointment with a crisis center near where she lived. This is an example of a confounding variable that may have affected the outcomes, but had nothing to do with the workshop itself. The participants were all left with ideas for additional help and resources (see Appendix R). A sign-off email was sent to reiterate these things (see Appendix S).

Hypothesis Three

The third research question asked if participation in a six-session ATJ workshop with the added component of servant leadership psychoeducation would more significantly improve pre and posttest measures of God attachment in survivors of sexual abuse by clergy than the stand-alone workshop.

A pre and posttest analysis of the treatment group was run to see if the treatment group yielded statistically significant results. It did not. The results of the paired sample t-tests showed no statistical significance, confirming the null hypothesis.

The hypothesis also compared the treatment group with the control group, so a difference-in-differences analysis was used. This analysis subtracted the average measure of all the ATG Inventory scales before the treatment from the average measure of all the ATG Inventory scales after the treatment for both control and treatment groups. The final step was to subtract the control group difference from the treatment group difference. This yielded nothing of statistical significance, confirming the null hypothesis. This suggests that the treatment component of the servant leader psychoeducation did not have the desired effect of lowering avoidant and anxious God attachment symptoms over and above the basic workshop. The control group showed a slight, although statistically non-significant, pretest-posttest improvement in avoidant and anxious God attachment styles, but the servant leader component did not seem to add to that outcome. It may be that servant leadership principles are better demonstrated than taught didactically, and so is better carried out and tested in an organizational, versus a teaching context (Parris & Peachey, 2013; Sendjaya & Sarros, 2002; Shaw & Allen, 2009; van Dierendonck & Patterson, 2015).

Hypothesis Four

The fourth research question asked if participation in a six-session ATJ workshop with the added component of servant leadership psychoeducation would more significantly improve pre and posttest measures of PTSD in survivors of sexual abuse by clergy than the stand-alone workshop.

A difference-in-differences analysis was used for this hypothesis as well, calculating the pre and posttest differences from both control and treatment groups, then subtracting the control group difference from the treatment group difference. This yielded nothing of statistical significance, confirming the null hypothesis. This suggests that the treatment component of the servant leader psychoeducation did not have the effect of lowering PTSD symptoms, at least as a stand-alone treatment. Given the exposure to sensitive subject matter in the workshop, clients may have been triggered by the workshop itself, but in such a way as to open the "window of tolerance" in which productive emotional processing can take place (Buckley, et al., 2018; Farrell, et al., 2010; Kezelman & Stavropoulos, 2012). It may be that the workshop in conjunction with individual therapy in which more extensive trauma would could be done would be more helpful in resolving trauma symptoms than the workshop alone (Kim & Kim, 2020). It may also be that a longer workshop, or a workshop with a follow up support group, would provide more exposure time and better opportunity for nervous system habituation to triggering material (Foa, et al., 2013; Ford & Hawke, 2012),

Implications

Mental health professionals should constantly be striving to provide high-quality, effective, affordable, and accessible interventions for a wide variety of presentations. Technological advances have made online workshops feasible for the average user. COVID -19 coming to the fore in the spring of 2020 catalyzed what has now become a revolution in mental health service delivery. Taylor, et al. (2020) said, "The unprecedented COVID-19 crisis presents an imperative for mental health care systems to make digital mental health interventions a routine part of care" (p. 1155).

The same authors identify some impediments to delivery of these services. One

impediment faced in the planning of the *Abuse, Trauma, and Jesus* workshop was that state licensure laws do not generally allow counseling across state lines. Another impediment is that insurance companies do not generally pay for teleservices from out of state. These challenges were surmounted by offering a workshop based on psychoeducation and support rather than group therapy and offering it for free. To help meet the therapeutic needs of the participants they were referred to either Abide Network, the telehealth-based counseling and coaching group that sponsored the workshop, or to local providers.

The results of this research suggest that these adjunct services and referrals may be important for best practices. Trauma reactions can be unpredictable; the emotional arousal occurring in response to traumatic exposure is said to "hijack" the amygdala, the fear-mediating part of the brain, preventing the sound, calm reasoning of the cerebral cortex (Morelli, et al, 2020). Since some of the participants in a sexual abuse trauma-related workshop will have established patterns of avoidance, the sudden facing of their trauma history as well as hearing the trauma stories of others makes the attenuation of trauma symptoms an unrealistic goal for a six-week group videoconferencing workshop.

The workshop may, however, provide enough good information and connections for an eventual improvement in trauma symptoms. Abide Network, which sponsored the workshop, offers counseling, coaching, workshops, trainings, free support groups, and free online community Bible studies. These opportunities may help workshop participants further internalize what they learned. One participant said, "Hearing the scientific basis of how to heal from someone who has been there and loves us and then having people share what helps with them. Beautiful ladies! THANK YOU" (personal communication, May 30, 2021). The amygdala can hijack the cerebral cortex, but that path goes both ways. Good information can eventually shape

the amygdala through repeated exposure to healthy, balanced thinking (Burrows, 2013; Hassija & Gray, 2011; Cloitre, et al., 2011; Suris, et al., 2013). A psychoeducational workshop and connected online community can provide the informational basis for long-term emotional change.

Of all the trauma treatment approaches studied, our approach came the closest to Whitworth's recommendations for psychoeducation, which include:

- Emphasizing resiliency and recovery rather than merely delineating the negative effects of trauma,
- A relational/support component, cultural sensitivity, and
- Delivery of services along with information for seeking additional help (Whitworth, 2016).

Trauma psychoeducation is defined as "helping someone understand how their exposure to traumatic threat(s) can impact their functioning, how to lessen those impacts, and ways to bounce-back from these experiences" (Whitworth, 2016, p. 442). The *Abuse, Trauma, and Jesus* workshop increased comprehension of common reactions to trauma, normalized them, and taught effective coping techniques (Whitworth, 2016). Normalizing common reactions prevents secondary disturbance. Effective coping techniques not only assist with symptoms, but instill a sense of empowerment, agency, and the ability to regulate one's emotions (Domhardt, et al., 2015).

Although not to a statistically significant level, the reduction in avoidant and anxious patterns of God attachment was consistent for both the control and treatment groups. This may have been due to some of the myth-busting efforts made in the workshop. The *Abuse, Trauma, and Jesus* workshop was promoted as faith-based, making it possible to directly address the

theological implications of the participants' experience of being abused within a religious context by a religious leader.

As previously discussed, God concept is the cognitive and explicit theological belief system about God (Gardner, 2013), God image is the emotional and implicit perceptions of God (Testoni, et al., 2016), and God attachment, which has been shown to be predicted by God image (Gardner, 2013), is how humans connect with God on a relational level (Counted, 2015; Kézdy, et al., 2013; Krause & Ironson, 2017). Because a religious leader represents God, survivors of sexual abuse by clergy have received a withering blow to their image of God. Even if they are able to retain an accurate God concept, the damaged God image will often compromise the survivor's attachment to God.

It is the work of the gospel to reverse this damage. "Now then, we are ambassadors for Christ, as though God were pleading through us: we implore you on Christ's behalf, be reconciled to God" (2 Corinthians 5:20). The emotionality of the words "pleading" and "implore" hint at reconciliation to God occurring on an emotional as well as a cognitive level. The gospel messenger must aim at fully restoring hearts and relationships through sweeping away myths about God's character and replacing them with a restored image of God. In sharp contrast to the narcissistic character of a sexually-abusive clergy who sacrifices the flock for selfish lust, Christ sacrificed Himself for the flock.

> You know that the rulers of the Gentiles lord it over them, and those who are great exercise authority over them. Yet it shall not be so among you; but whoever desires to become great among you, let him be your servant. And whoever desires to be first among you, let him be your slave—just as the Son of Man did not come to be served, but to serve, and to give His life a ransom for many" (Matthew 20:24-28).

Limitations

This study had many limitations. We will examine them within the frameworks of internal and external validity. Warner (2012) says that internal validity is the degree to which outcomes of a study can be used to make causal inferences. External validity is the degree to which findings can be generalized to groups, settings, and events in the real world.

Internal Validity

In a study like this one that attempted to assess the effects of a workshop, it was hoped that results would establish that the treatment workshop made a difference. While none of the measures reached statistical significance, there was consistency in the reduction of avoidant and anxious God attachment styles after the workshop in both the control and the treatment group. In the control group, this measure reached near statistical significance. These results may be limited by the following internal validity factors mentioned by May (2012): history, testing, and attrition.

History

Hstory refers to the events that occur between the pre and posttest. An experimental design, which did not control all the environmental factors of the subjects between measurements, was used. Subjects may have been impacted by personal factors experienced over the three weeks the workshop occurred. The workshop may have influenced them to engage differently with their world, and this may have had an influence on posttest measures. For example, one workshop participant, mentioned before, followed through on bringing her abuse to the attention of authorities. Experiences like this can change outcomes.

Many factors difficult to measure impacted the experiences of the workshop participants. Because of this, the workshop could not be called a “well-controlled experimental situation” (Warner, 2012, p. 66). Some may have had previous exposure to the presenters, with either good

or bad impressions or expectations, and their attendant outcomes. The participants in each session differed, and because the workshop format allowed for group discussion, each session played out differently. For example, toward the end of the workshop one of the participants told the group about her abuse experience, then disclosed that this group was the first place she'd ever told her story. The sense of concern, as well as the group cohesion that results when one participant experienced a major life event within the context of a session, made that particular session quite different from the others. Such factors would consistently affect outcomes.

Testing

Testing refers to the effect of the test itself, in this case the exit survey which included the two assessments and the evaluation form. Subjects sometimes perform differently when they know they are being assessed or evaluated. This can affect results. Out of a desire to help the workshop look good or be effective, subjects could have underreported the symptoms they continued to experience. Anxiety is often an outcome of complex trauma (Dorahy, et al., 2013; Edwards, et al., 2012; Tang & Freyd, 2012), and any sense of being evaluated could change outcomes.

Attrition

Attrition is caused by subjects dying or dropping out of the study. This did occur, as many dropped out before completing the exit survey. Of the 82 individuals who registered and were assigned to two groups of 41 each, only 24 from the control group and 22 from the treatment group completed the exit survey. Then one from the treatment group was treated as an outlier, bringing that total down to 21. Any positive effect of the workshop could be partially caused by higher levels of agency in the participants who finished the process.

External Validity

External validity asks if the results of a test are generalizable to other situations and people. Threats to external validity relevant to this study include sample bias (Warner, 2012) and experimenter effect (Bierman & Jolij, 2020).

Sample Bias

The workshop was promoted as faith-based and for victims of church-related sexual abuse. This narrowed the sample down to people who had either been Christian or were still Christian. The sample was gathered largely through the platform of the author. This platform includes >4000 twitter followers, a cumulative >14,000 Facebook connections, >2000 Linkedin connections, >1000 Instagram followers, an email list of >5000. Although there were no denominational requirements for participation, the majority of those connections were likely affiliated with the author's denomination. As a result, although the intake and exit surveys did not inquire regarding denomination, it is believed that the majority of the participants were either active or previous Seventh-day Adventists. No research has been done on the psychological profiles of Adventists per se, but some interesting inferences can be drawn from the fact that Adventists tend toward a plant-based diet, which has been linked to better mood (Beezhold, et al., 2010). These and other factors unique to Adventists may have impacted outcomes.

Experimenter Effect

Experimenter effect occurs when the individuals conducting the research contribute unintentionally to the outcomes. In the *Abuse, Trauma, and Jesus* workshop, an effort was made by the presenters to create a sense of safety and inclusion conducive to positive outcomes. In addition, the presenters were known by some of the participants, having impacted them through social interaction, writing, speaking, counseling, and coaching. This may have impacted the outcome as well, and would make this test very difficult to replicate through other experimenters.

Recommendations for Future Research

Future research in this field is needed. More and effective interventions should be created for survivors of sexual abuse by clergy by addressing populations, assessments, and theories.

Broader Populations

The existing workshop could be promoted and offered to broader populations by using promotional options besides the author's existing media platform. This might include boosting posts on Facebook and other media-based methods of advertising. Registries such as clinicaltrials.gov could also be used. This website matches potential subjects with researchers through a simple database tool. Offering a fee to participants would probably improve the response rate of a website like this.

Different Assessments

For future workshops, it would be beneficial to measure outcomes beyond PTSD symptoms and God attachment. Complex trauma has been linked to multiple mental health outcomes, including anxiety and depression (Dorhay, et al., 2013). Inventories for these and other conditions could be added to the entrance and exit surveys.

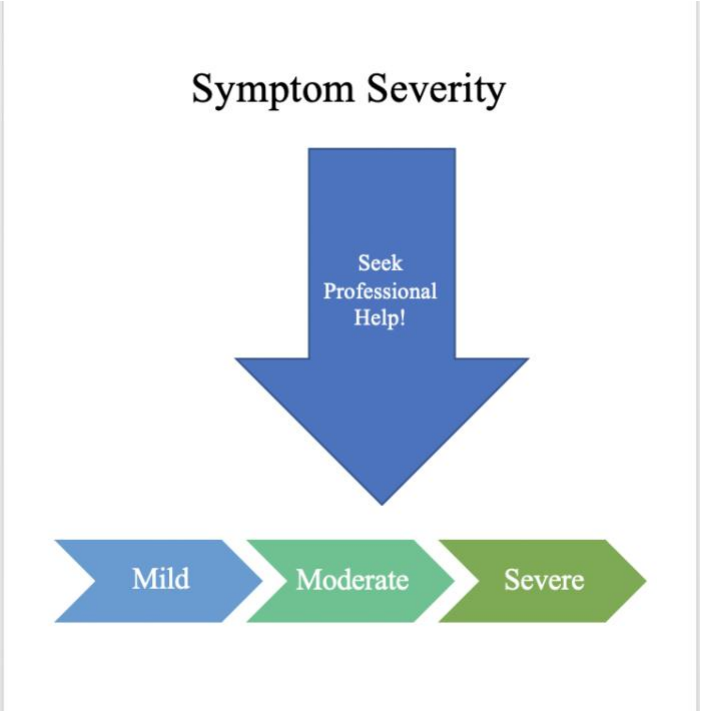
In addition, measures of some of the unique aspects of trauma acquired from sexual abuse by clergy could reveal which aspects of the workshop produce positive results. "For adult survivors of childhood trauma, experiences related to shame, betrayal, meaning-making, and mourning often complicate their spiritual and/or religious beliefs" (Pressley & Spinazzola, 2015, p. 8). If the source of trauma was a religious figure, these things are even more the case (de Weger & Death, 2017; Farrell, et al., 2010). Inventories that measure these outcomes, such as the Trauma Related Shame Inventory (Øktedalen, et al., 2014), could be used.

New Theoretical Constructs

The *Abuse, Trauma, and Jesus* workshop presented a blend of trauma treatment methods. Participants were cautioned to self-observe in order to determine the severity level of their symptoms. They were told that if their symptom severity escalated to the high side of moderate, they should see a professional to complete the exercises, and to get additional help for trauma.

Figure 13

Slide Used in Workshop to Help Participants Know When to Seek Professional Help



A more complex study could be done offering the workshop along with individual counseling. The group treatment used for this study did not include individual clinical counseling. Studies have shown the benefits of combined group and individual therapy for victims of sexual trauma. “However, group interventions are limited because deep interventions are difficult in cases of sexual trauma, and victims have difficulty sharing” (Kim & Kim, 2020, p. 392). Group and individual modalities complement one another well, with basic education

presented in a group setting, and deep processing occurring in an individual setting.

More could be done to attempt to package the concepts of servant leadership in ways that will increase the impact of a trauma workshop and also more directly address the unique features of trauma caused by sexual abuse by clergy. Servant leadership is most often taught in an organizational context characterized by prolonged and repeated contact (Parris & Peachey, 2013; Sendjaya & Sarros, 2002; Shaw & Allen, 2009; van Dierendonck & Patterson, 2015). The short-term workshop context may not be the best context for the conveyance of its vial principles.

Summary

The *Abuse, Trauma, and Jesus* workshop set out to help those who had been sexually victimized by religious and spiritual leaders. A recruitment process resulted in 82 registrations, which were randomly assigned to two groups. Both groups presented information about abuse, trauma PTSD, CPTSD, institutional betrayal, betrayal trauma, and the theology of suffering. Then the workshop moved into presenting tools for recovery, including grounding exercises, self-care, exposure, cognitive behavioral therapy, journaling, and meaning-making through narrative therapy and posttraumatic growth. The treatment group added a component of teaching on servant leadership principles, presented by a male clergy.

Two six-session groups were run over three Sundays (two sessions per day, per group) with a control and a treatment group. Attendance was roughly 15-20 members per session, with a total of 46 participants finishing the workshop by either attending the live sessions or watching the videos, and filling out the exit survey. The pre and posttest assessments were the Primary Care PTSD Survey and the God Attachment Inventory. A Post-Workshop Feedback Form was used to raise awareness of participant experience.

The analyses of the pre and posttest of the two assessments were not statistically

significant, but were helpful in opening up possibilities of future research. More study needs to take place on what best helps those who have suffered exploitation at the hands of those who claimed to be shepherds of the flock. These survivors are, and always will be, beloved of the God who died for them.

References

Ainsworth, M. S., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist, 46*(4), 333–341. https://doi.org/10.1037/0003-066X.46.4.333

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Arkowitz, H. & Lilienfeld, S.O. (2016, August 1). EMRD: Taking a closer look. *Scientific American.* https://www.scientificamerican.com/article/emdr-taking-a-closer-look/

Astbury, J. (2013). Child sexual abuse in the general community and clergy-perpetrated child sexual abuse. *Australian Psychological Society,* 1-34. https://www.psychology.org.au/getmedia/c4d9a79f-e2ce-4d4a-8145-22b8401d2b15/Child-sexual-abuse-in-the-general-community-and-clergy-perpetrated-child-sexual-abuse.pdf.pdf

Alavi, S. Z., Amin, F., & Savoji, A. P. (2013). Relationship between pathological guilt and God image with depression in cancer patients. *Social and Behavioral Sciences, 84,* 919–924. https://doi.org/10.1016/j.sbspro.2013.06.674

Babakus, E., Yavas, U., & Ashill, N. J. (2011). Service worker burnout and turnover intentions: Roles of person-job fit, servant leadership, and customer orientation. *Services Marketing Quarterly, 32*(1), 17–31. https://doi.org/10.1080/15332969.2011.533091

Backhaus, A., Agha, Z., Maglione, M. L., Repp, A., Ross, B., Zuest, D., Rice-Thorp, N. M., Lohr, J., & Thorp, S. R. (2012). Videoconferencing psychotherapy: A systematic review. *Psychological Services*, *9*(2), 111–131. https://doi.org/10.1037/a0027924

Bass, J., Murray, S. M. I., Mohammed, T. A., Bunn, M., Gorman, W., Ahmed, A. M. A.,

Murray, L., & Bolton, P. (2016). A randomized controlled trial of a trauma-informed support, skills, and psychoeducation intervention for survivors of torture and related trauma in Kurdistan, Northern Iraq. *Global Health Science and Practice, 4*(3), 452–466. https://doi.org/10.9745/GHSP-D-16-00017s

Beck, C. D. (2014). Antecedents of Servant Leadership: A Mixed Methods Study. *Journal of Leadership and Organizational Studies*, *21*(3), 299–314. https://doi.org/10.1177/1548051814529993

Beck, C. D., Black, G. L., Cooper, S. E., Dranger, P. N., Denney, A. S., Kerley, K. R., Gross, N. G., Gottman, J. M., Coan, J., Carrere, S., Swanson, C., Gottman, J. M., Coan, J., Carrere, S., Swanson, C., Gross-Schaefer, A., Feldman, L., Perkowitz, N., Jacobson, N., … Wurtele, S. K. (2018). Building a culture of respect across genders: Eliminating sexual misconduct. *Journal of College Student Psychotherapy*, *32*(2), 129–150. https://doi.org/10.1080/87568225.2017.1353896

Beck, R. & McDonald, A. (2004). Attachment to god: The attachment to god inventory, tests of working model correspondence, and an exploration of faith group differences. *Journal of Psychology and Theology, 32*(2), 92–103. https://doi.org/10.1177/009164710403200202

Beezhold, B. L., Johnston, C. S., & Daigle, D. R. (2010). Vegetarian diets are associated with healthy mood states: a cross-sectional study in Seventh-day Adventist adults. *Nutrition Journal, (9)*26. https://doi.org/10.1186/1475-2891-9-26

Bell, S. C. (2016). The relationship between the effects of rape, posttraumatic stress disorder, complex trauma, and post-attack victim-perpetrator interaction in female college students. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, *76*(10-B), 1-137.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc13a&NEWS=N AN=2016-16234-010

Bierman, D., & Jolij, J. J. (2020). Dealing with the Experimenter Effect. *Journal of Scientific Exploration, 34*(4), 703–709. https://doi.org/10.31275/20201871

Bliese, P. D., & Wang, M. (2020). Results Provide Information About Cumulative Probabilities of Finding Significance: Let's Report This Information. *Journal of Management, 46*(7), 1275–1288. https://doi.org/10.1177/0149206319886909

Bockers, E., Roepke, S., Michael, L., Renneberg, B., & Knaevelsrud, C. (2014). Risk recognition, attachment anxiety, self-efficacy, and state dissociation predict revictimization. *PLoS ONE, 9*(9), 1–9. https://doi.org/10.1371/journal.pone.0108206

Bomyea, J., Risbrough, V., & Lang, A. J. (2013). A consideration of select pre-trauma factors as key vulnerabilities in PTSD *Diego Joint Doctoral Program in Clinical Psychology. 32*(7), 630–641. https://doi.org/10.1016/j.cpr.2012.06.008.A

Bradshaw, M., Ellison, C. G., & Marcum, J. P. (2010). Attachment to God, images of God, and psychological distress in a nationwide sample of Presbyterians. *International Journal for the Psychology of Religion, 20*(2), 130–147. https://doi.org/10.1080/10508611003608049

Brewer-Smyth, K., & Koenig, H. G. (2014). Could spirituality and religion promote stress resilience in survivors of childhood trauma? *Issues in Mental Health Nursing, 35*(4), 251-256. https://doi.org/10.3109/01612840.2013.873101

Buckley, T., Punkanen, M., & Ogden, P. (2018). The role of the body in fostering resilience: A Sensorimotor Psychotherapy perspective. *Body, Movement and Dance in Psychotherapy, 13*(4), 225–233. https://doi.org/10.1080/17432979.2018.1467344

Burrows, C. J. (2013). Acceptance and commitment therapy with survivors of adult sexual

assault: A case study. *Clinical Case Studies, 12*(3), 246–259. https://doi.org/10.1177/1534650113479652

Chaves, M., & Garland, D. (2010). The prevalence of clergy sexual advances towards adults in their congregations. *Journal of the Scientific Study of Religion, 48* (4), 817–824.

Cheston, S. E., Piedmont, R. L., Eanes, B., & Patrice, L. (2003). Changes in client's images of God over the course of outpatient therapy. *Counseling and Values, 47*, 96-108. https://doi.org/10.1002/j.2161-007X.2003.tb00227.x

Chu, J.A. (2011) *Rebuilding shattered lives* (2nd ed.). Wiley & Sons.

Chuard, P. J. C., Vrtílek, M., Head, M. L., & Jennions, M. D. (2019). Evidence that nonsignificant results are sometimes preferred: Reverse P-hacking or selective reporting? *PLoS Biology, 17*(1), 3–9. https://doi.org/10.1371/journal.pbio.3000127

Cloitre, M., Courtois, C.A., Charuvastra, A., Carapezza, R. Stolbach, B.C. & Green, B.L., (2011). Treatment of complex PTSD: Results of the ISTSS Expert Clinician Survey on Best Practices. *Journal of Traumatic Stress, 24*(6), 615-627. https://doi.org/10.1002/jts.20697

Codone, S. (2019). *Caring well: A report from the SBC sexual abuse advisory group.* https://caringwell.com/wp-content/uploads/2019/06/SBC-Caring-Well-Report-June-2019.pdf

Cooper-White, P. (2012). *The cry of Tamar: Violence against women and the church's response*. Fortress Press.

Counted, V. (2015). Understanding god images and god concepts: Towards a pastoral hermeneutics of the god attachment experience. *Verbum et Ecclesia, 36*(1), 1–14. https://doi.org/10.4102/ve.v36i1.1389

Cox, M.D. (2016). Servant leadership as loving leadership: Explorations for Catholic health ministry. *The International Journal of Servant-Leadership, 12*(1), 285–297. https://www.gonzaga.edu/-/media/Website/Documents/Academics/School-of-Leadership-Studies/DPLS/IJSL/Vol-12/IJSL-Vol-12-14-Cox.ashx?la=en&hash=5F36658D11DC0A5CCB21FF192E55324982901973

Danielson, C.K., McCart, M.R., de Arellano, M.A., Macdonald, A., Silcott, L., & Resnick, H. (2010). Risk reduction for substance use and trauma-related psychopathology in adolescent sexual assault victims: Findings from an open trial. *Child Maltreatment, 15*(3), 261-268. https://doi.org/10.1177/1077559510367939

Davidson, R.M. (2007). *Flame of Yahweh: Sexuality in the Old Testament.* Hendrickson.

Death, J. (2015). Bad apples, bad barrel: Exploring institutional responses to child sexual abuse by Catholic Clergy in Australia. *International Journal for Crime, Justice and Social Democracy, 4*(2), 94–110. https://doi.org/10.5204/ijcjsd.v3i2.229

Denney, A.S., Kerley, K.R., & Gross, N.G. (2018). Child sexual abuse in Protestant Christian congregations: A descriptive analysis of offense and offender characteristics. *Religions, 9*(27), 1-13. https://doi.org/10.3390/rel9010027

de Weger, S. & Death, J. (2017). Clergy sexual misconduct against adults in the Roman Catholic Church: The misuse of professional and spiritual power in the sexual abuse of adults. *Journal for Academic Study of Religion, 30*(3) 227-257. https://doi: 10.1558/jasr.32747

de Zulueta, P. C. (2016). Developing compassionate leadership in health care: An integrative review. *Journal of Healthcare Leadership, 8*, 1–10. https://doi.org/10.2147/JHL.S93724

DiMauro, J., Carter, S., Folk, J. B., & Kashdan, T. B. (2014). A historical review of trauma-related diagnoses to reconsider the heterogeneity of PTSD. *Journal of Anxiety Disorders,*

28(8), 774–786. https://doi.org/10.1016/j.janxdis.2014.09.002

Dinenberg, R.E., McCaslin, S. E., & Bates, M.N., (2014). Social support may protect against development of posttraumatic stress disorder: Findings from the Heart and Soul study. *American Journal of Health Promotion, 28*(5), 294-297. https://doi.org/10.4278/ajhp.121023-QUAN-511

Domhardt, M., Münzer, A., Fegert, J. M., & Goldbeck, L. (2015). Resilience in Survivors of Child Sexual Abuse: A Systematic Review of the Literature. *Trauma, Violence, and Abuse*, *16*(4), 476–493. https://doi.org/10.1177/1524838014557288

Dorahy, M. J., Corry, M., Shannon, M., Webb, K., McDermott, B., Ryan, M., & F.w. Dyer, K. (2013). Complex trauma and intimate relationships: The impact of shame, guilt and dissociation. *Journal of Affective Disorders*, *147*(1–3), 72–79. https://doi.org/10.1016/j.jad.2012.10.010

Doyle, T. (2020, September 8). A very short history of clergy sexual abuse in the Catholic Church. https://www.crusadeagainstclergyabuse.com/htm/AShortHistory.htm

Drebing, H., Dölling, D., Hermann, D., Kruse, A., Schmitt, E., Bannenberg, B., Hoell, A., Voss, E., & Salize, H. J. (2019). Sexual abuse at the hands of Catholic clergy. *Deutsches Arzteblatt International*, *116*(22), 389–396. https://doi.org/10.3238/arztebl.2019.0389

Duchene, C. (2017). Rethinking religious exemptions from Title IX after Obergefell. *Brigham Young University Education and Law Journal*, *2017*(2), 249–284. https://digitalcommons.law.byu.edu/elj/vol2017/iss2/4

Dunaetz, D. R., Jung, H. L., & Lambert, S. S. (2018). Do larger churches tolerate pastoral narcissism more than smaller churches? *Great Commission Research Journal*, *4*(4), 146–153. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3105119/

Dutta, S. & Khatri, P. (2017). Servant leadership and positive organizational behavior: the road ahead to reduce employees' turnover intentions. *On the Horizon, 25*(1), 60–82. https://doi.org/10.1108/OTH-06-2016-0029

Ebisike, N. (2020). Clergy abuse: What is to be done? *Society*, *57*(1), 3–8. https://doi.org/10.1007/s12115-019-00435-9

Edwards, V. J., Freyd, J. J., Dube, S. R., Anda, R. F., & Felitti, V. J. (2012). Health outcomes by closeness of sexual abuse perpetrator: A test of betrayal trauma theory. *Journal of Aggression, Maltreatment and Trauma, 21*(2), 133–148. https://doi.org/10.1080/10926771.2012.648100

Ehring, T., Welboren, R., Morina, N., Wicherts, J. M., Freitag, J., & Emmelkamp, P. M. G. (2014). Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse. *Clinical Psychology Review*, *34*(8), 645–657. https://doi.org/10.1016/j.cpr.2014.10.004

Eliot, J. L. (2020). Resilient Leadership: The impact of a servant leader on the resilience of their followers. *Advances in Developing Human Resources*, 1–15. https://doi.org/10.1177/1523422320945237

Farrell, D., Dworkin, M., Keenan, P., & Spierings, J. (2010). Using EMDR with survivors of sexual abuse perpetrated by Roman Catholic priests. *Journal of EMDR Practice and Research*, *4*(3), 124–133. https://doi.org/10.1891/1933-3196.4.3.124

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study.

The American Journal of Preventative Medicine, 14(4), 245-258. DOI: 10.1016/s0749-3797(98)00017-8

Fetzer, M.G., & Asmundson, G.J.G. (2014). Aerobic exercise reduces symptoms of posttraumatic stress disorder: A randomized controlled trial. *Cognitive Behavioral Therapy, 44*(4), 301-313. DOI: 10.1080/16506073.2014.916745

Fisher, J. (2019). Sensorimotor psychotherapy in the treatment of trauma. *Practice Innovations, 4*(3), 156–165. https://doi.org/10.1037/pri0000096

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD-Emotional processing of traumatic experiences, therapist guide.* Oxford University Press.

Foa, E. B., McLean, C. P., Capaldi, S., & Rosenfield, D. (2013). Prolonged exposure vs supportive counseling for sexual abuse-related PTSD in adolescent girls: A randomized clinical trial. *Journal of the American Medical Association, 310*(24), 2650–2657. https://doi.org/10.1001/jama.2013.282829

Ford, J. D. & Hawke, J. (2012). Trauma affect regulation psychoeducation group and milieu intervention outcomes in juvenile detention facilities. *Journal of Aggression, Maltreatment and Trauma, 21*(4), 365–384. https://doi.org/10.1080/10926771.2012.673538

Francis, L. J., Gibson, H. M., & Robbins, M. (2001). God images and self-worth among adolescents in Scotland. *Mental Health, Religion & Culture, 4*, 103-108.

Gallup Religion (2017, July 18). More U.S. Protestants have no denominational legacy. https://news.gallup.com/poll/214208/protestants-no-specific-denominational-identity.aspx

Gardner, J. K. (2013). Attachment, trauma, and intimacy with God. Conversations: A graduate student journal of the humanities. *Social Sciences, and Theology, 1*(2), 1. https://digitalcommons.acu.edu/conversations/vol1/iss2/1/

Garland, D.R. (2006) When wolves wear shepherds' clothing: Helping women survive clergy sexual abuse. *Social Work & Christianity, 33*(1) 1-35. https://doi.org/10.1300/J154v08n02_04

Garland, D.R., & Argueta, C. (2010). How clergy sexual misconduct happens: A qualitative study of first-hand accounts. *Social Work & Christianity,* 1-27. https://www.baylor.edu/content/services/document.php/96038.pdf

Gavrielides, T. (2012). Clergy child sexual abuse and the restorative justice clergy child sexual abuse and the restorative justice dialogue. *Journal of Church and State 55*(4), 617-639. https://doi.org/10.1093/jcs/css041

Geist, T. (2011). Conceptual framework for animal assisted therapy. *Childhood and Adolescence Social Work Journal, 28*, 243–256. DOI:10.1007/s10560-011-0231-3

Gobin, R. L., & Freyd, J. J. (2014). The impact of betrayal trauma on the tendency to trust. *Psychological Trauma: Theory, Research, Practice, and Policy, 6*(5), 505–511.

Görg, N., Priebe, K., Böhnke, J. R., Steil, R., Dyer, A. S., & Kleindienst, N. (2017). Trauma-related emotions and radical acceptance in dialectical behavior therapy for posttraumatic stress disorder after childhood sexual abuse. *Borderline Personality Disorder and Emotion Dysregulation*, *4*(1), 1–13. https://doi.org/10.1186/s40479-017-0065-5

Granqvist, P., Mikulincer, M., Gewirtz, V., & Shaver, P. R. (2012). Experimental findings on god as an attachment figure: Normative processes and moderating effects of internal working models. *Journal of Personality and Social Psychology, 103*(5), 804–818.

https://doi.org/10.1037/a0029344

Green, M., Rodriguez, R., Wheeler, C., & Baggerly-Hinojosa, B. (2016). Servant leadership: A quantitative review of instruments and related findings. *Servant Leadership: Theory & Practice*, *2*(2), 5.

Greenleaf, R. (1970). *The servant as leader.* Center for Applied Studies.

Greenleaf Center for Servant Leadership (2016). https://www.greenleaf.org/

Grimes, C. (2008). God image research. *Journal of Spirituality in Mental Health, 9*(3/4), 227-246. https://doi.org/10.1300/J515v09n03

Gross-Schaefer, A., Feldman, L., & Perkowitz, N. (2011). A time to learn: A comparison of policies dealing with clergy sexual misconduct. *Pastoral Psychology, 60*(2), 223–231. https://doi.org/10.1007/s11089-010-0310-y

Grosuch, R. L. (1968). The conceptualization of God as seen in adjective ratings. *Journal for the Scientific Study of Religion, 7*, 56-64. https://doi.org/10.2307/1385110

Gurda, K. (2015). Emerging trauma therapies: Critical analysis and discussion of three novel approaches. *Journal of Aggression, Maltreatment, & Trauma, 7*, 773-793. https://doi.org/10.1080/10926771.2015.1062445

Harsey, S., & Freyd, J. J. (2020). Deny, Attack, and Reverse Victim and Offender (DARVO): What is the influence on perceived perpetrator and victim credibility? *Journal of Aggression, Maltreatment and Trauma*, *29*(8), 897–916. https://doi.org/10.1080/10926771.2020.1774695

Hartford Institute for Religious Research (2015). Nondenominational & independent congregations. http://hirr.hartsem.edu/cong/nondenom.html

Hassija, C., & Gray, M. J. (2011). The effectiveness and feasibility of videoconferencing

technology to provide evidence-based treatment to rural domestic violence and sexual assault populations. *Telemedicine and E-Health, 17*(4), 309–315. https://doi.org/10.1089/tmj.2010.0147

Herman, J. (1997). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. Basic Books.

Hernandez, G., Salerno, J. M., & Bottoms, B. L. (2010). Attachment to god, spiritual coping, and alcohol use. *International Journal for the Psychology of Religion, 20*(2), 97–108. https://doi.org/10.1080/10508611003607983

Hepner, P. P., Wampold, B. E., Owen, J., Wang, K. T., & Thompson, M. N. (2015). *Research design in counseling, (4th ed.)*. Cengage Learning.

Holland, K.J., & Barnes, M.L. (2019). Institutional responses to sexual trauma. *Journal of Trauma & Dissociation, 20*(3), 259-262. https://doi.org/10.1080/15299732.2019.1592642

Horvath, A.O., Del Re, A. C., Flückiger, C., Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9-16. doi.org/10.1037/a0022186

Houser, M. E., & Welch, R. D. (2013). Hope, religious behaviors, and attachment to God: A trinitarian perspective. *Journal of Psychology and Theology, 41*(4), 281–297. https://doi.org/10.1177/009164711304100402

Hunter, E. M., Neubert, M. J., Perry, S. J., Witt, L. A. A., Penney, L. M., & Weinberger, E. (2013). Servant leaders inspire servant followers: Antecedents and outcomes for employees and the organization. *Leadership Quarterly*, *24*(2), 316–331. https://doi.org/10.1016/j.leaqua.2012.12.001

Im, H., Jettner, J. F., Warsame, A. H., Isse, M. M., Khoury, D., & Ross, A. I. (2018). Trauma-informed psychoeducation for Somali refugee youth in urban Kenya: Effects on PTSD and

psychosocial outcomes. *Journal of Child and Adolescent Trauma, 11*(4), 431–441. https://doi.org/10.1007/s40653-017-0200-x

Jager, J., Putnick, D.L., & Bornstein, M.H. (2017). More than just convenient: The scientific merits of homogeneous convenience samples. *Monographs of the Society for Research in Child Development, 82*(2): 13–30. https://doi.org/10.1111/mono.12296

Jit, R., Sharma, C. S., & Kawatra, M. (2016). Servant leadership and conflict resolution: a qualitative study. *International Journal of Conflict Management*, *27*(4), 591–612. https://doi.org/10.1108/IJCMA-12-2015-0086

Jit, R., Sharma, C. S., & Kawatra, M. (2017). Healing a broken spirit: Role of servant leadership. *Vikalpa, 42*(2), 80–94. https://doi.org/10.1177/0256090917703754

Jonason, P. K., & Webster, G. D. (2010). The dirty dozen: A concise measure of the dark triad. *Psychological Assessment, 22*(2), 420–432. https://doi.org/10.1037/a0019265

John Jay College of Criminal Justice (2004). *The nature and scope of sexual abuse of minors by Catholic priests and deacons in the United States 1950–2002*. United States Conference of Catholic Bishops. https://www.usccb.org/sites/default/files/issues-and-action/child-and-youth-protection/upload/The-Nature-and-Scope-of-Sexual-Abuse-of-Minors-by-Catholic-Priests-and-Deacons-in-the-United-States-1950-2002.pdf

Kaehler, L. A., & Freyd, J. J. (2012). Betrayal trauma and borderline personality characteristics: Gender differences. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(4), 379–385. https://doi.org/10.1037/a0024928

Kaiser, H. (1996). Sexual abuse in US mainline churches. *American Studies International, 34*(1) 30-42. https://www.jstor.org/stable/41279397

Kézdy, A., Martos, T., & Robu, M. (2013). God image and attachment to God in work addiction

risk. *Studia Psychologica*, *55*(3), 209–214. https://doi.org/10.21909/sp.2013.03.636

Kezelman, C., & Stavropoulos, P. (2012). The last frontier: Practice guidelines for treatment of complex trauma and trauma informed care and service delivery. *Adults Surviving Child Abuse (ASCA),* 1-154. Kirribilli. https://www.childabuseroyalcommission.gov.au/sites/default/files/IND.0521.001.0001.pdf

Kim, G. U., & Kim, M. Y. (2020). The effectiveness of psychological interventions for women traumatized by sexual abuse: A systematic review and meta-analysis. *Issues in Mental Health Nursing*, *4*1(5), 385–394. https://doi.org/10.1080/01612840.2019.1677830

Kleiven, T. (2018). Sexual misconduct in the church: What Is it about? *Pastoral Psychology, 67*(3), 277–289. https://doi.org/10.1007/s11089-018-0807-3

Kliethermes, M., Schacht, M., & Drewry, K. (2014). Complex trauma. child and adolescent *Psychiatric Clinics of North America, 23*(2), 339–361. https://doi.org/10.1016/j.chc.2013.12.009

Kolaitis, G. (2017). Trauma and post-traumatic stress disorder in children and adolescents. *European Journal of Psychotraumatology, 8*(4), 1-3. https://doi.org/10.1080/20008198.2017.1351198

Koohsar, A. A. H. & Bonab, B. G. (2011). Relation between quality of image of God with anxiety and depression in college students. *Social and Behavioral Sciences, 29*, 252–256. https://doi.org/10.1016/j.sbspro.2011.11.234

Kool, M., & van Dierendonck, D. (2012). Servant leadership and commitment to change, the mediating role of justice and optimism. *Journal of Organizational Change Management*, *25*(3), 422–433. https://doi.org/10.1108/09534811211228139

Krause, N., & Ironson, G. (2017). Positive God images and positive emotions toward God: Exploring variations among Whites, Blacks, and Hispanics. *Pastoral Psychology, 66*(2), 269–280. https://doi.org/10.1007/s11089-016-0742-0

Kucharska, J. (2018). Religiosity and the concept of god moderate the relationship between the type of trauma, posttraumatic cognitions, and mental health. *Journal of Trauma and Dissociation 19*(5), 535–551. https://doi.org/10.1080/15299732.2017.1402399

Kunkel, M. A., Cook, S., Meshel, D. S., Daughtry, D., & Hauenstein, A. (1999). God images: A concept map. *Journal for the Scientific Study of Religion, 38,* 193-202. https://doi.org/10.2307/1387789

Kusner, K., & Pargament, K. I. (2012). Shaken to the core: Understanding and addressing the spiritual dimension of trauma. In *Trauma therapy in context: The science and craft of evidence-based practice*. (pp. 211–230). https://doi.org/10.1037/13746-010

Lamp, K. E., Avallone, K. M., Maieritsch, K. P., Buchholz, K. R., & Rauch, S. A. M. (2019). Individual and group cognitive processing therapy: Effectiveness across two Veterans Affairs posttraumatic stress disorder treatment clinics. *Psychological Trauma: Theory, Research, Practice, and Policy*, *11*(2), 197–206. https://doi.org/10.1037/tra0000370

Láng, A. (2016). Relationship between recalled parental care and religious coping the mediating effect of attachment to god. *European Journal of Mental Health, 11*(1–2), 144–150. https://doi.org/10.5708/EJMH.11.2016.1-2.9.

Leman, J., Hunter, W., Fergus, T., & Rowatt, W. (2018). Secure attachment to God uniquely linked to psychological health in a national, random sample of American adults.\ *International Journal for the Psychology of Religion, 28*(3). https://doi.org/10.1080/10508619.2018.1477401

Levers, L.L. (2012). *Trauma counseling: Theories and interventions.* New York, NY: Springer.

Lopez-Zeron, G. & Blow, A. (2015). The role of relationships and families in healing from trauma. *Journal of Family Therapy, 39*(4), 580-597. https://doi.org/10.1111/1467-6427.12089

Lorelle, S., Byrd, R., & Crockett, S. (2012). Globalization and counseling: Professional issues for counselors. *The Professional Counselor, 2*(2), 115–123. https://doi.org/10.15241/sll.2.2.115

May, H. (2012). *Nonequivalent comparison group designs. APA Handbook of Research Methods in Psychology, Vol. 2: Research Designs: Quantitative, Qualitative, Neuropsychological, and Biological*., *2*, 489–509. https://doi.org/10.1037/13620-026

Maltby, L. E., & Hall, T. W. (2012). Trauma, attachment, and spirituality: A case study. *Journal of Psychology and Theology, 40*(4), 302–312. https://doi.org/10.1177/009164711204000405

McGraw, D. M., Ebadi, M., Dalenberg, C., Wu, V., Naish, B., & Nunez, L. (2019). Consequences of abuse by religious authorities: A review. *Traumatology*, *25*(4), 242–255. https://doi.org/10.1037/trm0000183

Miu, A. S., Vo, H. T., Palka, J. M., Glowacki, C. R., & Robinson, R. J. (2020). Teletherapy with serious mental illness populations during COVID-19: telehealth conversion and engagement. *Counselling Psychology Quarterly*, *00*(00), 1–18. https://doi.org/10.1080/09515070.2020.1791800

Morelli, N., Rota, E., Immovilli, P., Spallazzi, M., Colombi, D., Guidetti, D., & Michieletti, E. (2020). The hidden face of fear in the COVID-19 era: The amygdala hijack. *European Neurology*, *83*(2), 220–221. https://doi.org/10.1159/000508297

Narang, J., Schwannauer, M., Quayle, E., & Chouliara, Z. (2019). Therapeutic interventions with child and adolescent survivors of sexual abuse: A critical narrative review. *Children and Youth Services Review, 107,* 1-11. https://doi.org/10.1016/j.childyouth.2019.104559

National Institutes of Mental Health (2011). *Use of mental health services and treatment among adults.* Author. https://www.nimh.nih.gov/index.shtml

Nelsen, H.M., Neil, C.H., & Au, P. (1985) Gender differences in the images of God. *Journal for the Scientific Study of Religion, 24*(4), 396-402. https://www.jstor.org/stable/1385990?origin=crossref

Norwood, C., Moghaddam, N., Malins, S., & Sabin-Farrell, R. (2018). Working alliance and outcome effectiveness in videoconferencing psychotherapy: a systematic review and non-inferiority meta analysis. *Clinical Psychology & Psychotherapy*, *25*(6), 797-808. https://doi.org/10.1002/cpp.2315

Øktedalen, T., Hagtvet, K. A., Hoffart, A., Langkaas, T. F., & Smucker, M. (2014). The trauma related shame inventory: Measuring trauma-related shame among patients with PTSD. *Journal of Psychopathology and Behavioral Assessment*, *36*(4), 600–615. https://doi.org/10.1007/s10862-014-9422-5

Ogińska-Bulik, N. (2015). The relationship between resiliency and posttraumatic growth following the death of someone close. *Omega (United States), 71*(3), 233–244. https://doi.org/10.1177/0030222815575502

Oliver, J., Palmer, D., Feldman, V., Lohrmann, M., de Weger, S. E., Death, J., Birchard, T., Birchard, T., Death, J., Crisp, B. R., Brown, E., & Brown, E. (2017). Toward a more comprehensive analysis of the role of organizational culture in child sexual abuse in institutional contexts. *Journal of Chemical Information and Modeling*, *74*(3), 227–257.

https://doi.org/10.1017/CBO9781107415324.004

Oren, & Solomon, R. (2012). EMDR therapy: An overview of its development and mechanisms of action. *Revue Europeenne de Psychologie Appliquee, 62*(4), 197–203. https://doi.org/10.1016/j.erap.2012.08.005

Ozkan, T., Clipper, S. J., Piquero, A. R., Baglivio, M., & Wolff, K. (2020). Predicting Sexual Recidivism. *Sexual Abuse: Journal of Research and Treatment*, *32*(4), 375–399. https://doi.org/10.1177/1079063219852944

Papendick, M. Bohner, G. (2017) "Passive victim – strong survivor"? Perceived meaning of labels applied to women who were raped. *PLoS One 12*(5). https://doi.org/10.1371/journal.pone.0177550

Parris, D., & Peachey, J. (2013). A systematic literature review of servant leadership theory in organizational contexts. *Journal of Business Ethics, 113*(3), 377–393. https://doi.org/10.1007/s10551-012-1322-6

Pascoal, P. M., Narciso, I., & Pereira, N. M. (2012). Emotional intimacy is the best predictor of sexual satisfaction of men and women with sexual arousal problems. *International Journal of Impotence Research, 25,* 51–55. https://doi.org/10.1038/ijir.2012.38

Peckham, J. (2018). *Theodicy of love: Cosmic conflict and the problem of evil.* Baker Academic.

Perillo, A. D., Mercado, C. C., & Terry, K. J. (2008). Repeat offending, survivor gender, and extent of survivor relationship in catholic church sexual abusers: Implications for risk assessment. *Criminal Justice and Behavior*, *35*(5), 600–614. https://doi.org/10.1177/0093854808314368

Peterson, S. J., Galvin, B. M., & Lange, D. (2012). CEO servant leadership: Exploring executive characteristics and firm performance. *Personnel Psychology, 65*(3), 565–596.

https://doi.org/10.1111/j.1744-6570.2012.01253.x

Pressley, J., & Spinazzola, J. (2015). Beyond survival: Application of a complex trauma treatment model in the Christian context. *Journal of Psychology and Theology, 43*(1), 8. https://doi.org/10.1177/009164711504300102

Prins, A., Bovin, M. J., Smolenski, D. J., Marx, B. P., Kimerling, R., Jenkins-Guarnieri, M. A., Kaloupek, D. G., Schnurr, P. P., Kaiser, A. P., Leyva, Y. E., & Tiet, Q. Q. (2016). The Primary Care PTSD screen for DSM-5 (PC-PTSD-5): Development and evaluation within a veteran primary care sample. *Journal of General Internal Medicine, 31*(10), 1206–1211. https://doi.org/10.1007/s11606-016-3703-5

Puls, D. (2018, September 27-29). *The narcissist pastor as marriage partner and parent.* [Conference presentation]. American Association of Christian Counselors Mega-Conference, Dallas, TX, United States. http://conflicttopeace.com/images/Narcissist_Pastor_as_Spouse_and_Parent.pdf

Rasar, J. D., Garzon, F. L., Volk, F., O'Hare, C. A., & Moriarty, G. L. (2013). The efficacy of a manualized group treatment protocol for changing God image, attachment to God, religious coping, and love of God, others, and self. *Journal of Psychology and Theology 41*(4), 267–280. https://doi.org/10.1177/009164711304100401

Ramos, C., & Leal, I. (2013). Posttraumatic growth in the aftermath of trauma: A literature review about related factors and application contexts. *Psychology, Community & Health, 2*(1), 43–54. https://doi.org/10.5964/pch.v2i1.39

Rashid, F. & Barron, I. (2019). Why the focus of clerical child sexual abuse has largely remained on the Catholic Church amongst other non-Catholic Christian denominations and religions. *Journal of Child Sexual Abuse, 28*(5), 564–585.

https://doi.org/10.1080/10538712.2018.1563261

Ringel, S. (2014). An integrative model in trauma treatment: Utilizing eye movement desensitization and reprocessing and a relational approach with adult survivors of sexual abuse. *Psychoanalytic Psychology, 31*(1), 134–144. https://doi.org/10.1037/a0030044

Rizzuto, A. M. (1979). *The birth of the living God: A psychoanalytic study.* University of Chicago Press.

Robert K. Greenleaf Center for Servant Leadership (2016). Organizations. https://greenleaf.org/organizations/

Roof, W. C., & Roof, J. (1984). Review of the polls: Images of God among Americans. *Journal for the Scientific Study of Religion, 23,* 201-205. https://doi.org/10.2307/1386110

Rudolfsson, L., & Tidefors, I. (2014). I have cried to Him a thousand times, but it makes no difference: Sexual abuse, faith, and images of God. *Mental Health, Religion and Culture, 17*(9), 910–922. https://doi.org/10.1080/13674676.2014.950953

Ruffing, E. G., Paine, D. R., Devor, N. G., & Sandage, S. J. (2018). Humility and narcissism in clergy: A relational spirituality framework. *Pastoral Psychology, 67*(5), 525–545. https://doi.org/10.1007/s11089-018-0830-4

Salas, J., Scherrer, J. F., Tuerk, P., van den Berk-Clark, C., Chard, K. M., Schneider, F. D., Schnurr, P. P., Friedman, M. J., Norman, S. B., Cohen, B. E., & Lustman, P. (2020). Large posttraumatic stress disorder improvement and antidepressant medication adherence. *Journal of Affective Disorders, 260,* 119–123. https://doi.org/10.1016/j.jad.2019.08.095

Sanderson, C. (2013). Counseling skills for working with trauma: *Healing from childhood sexual abuse, sexual violence and domestic abuse.* Jessica Kingsley Publishers.

Savage-Austin, A. R., & Honeycutt, A. (2011). Servant leadership: A phenomenological study of practices, experiences, organizational effectiveness, and barriers. *Journal of Business and Economic Research, 9*(1), 49–54.

Schaap-Jonker, H. Eurelings-Bontekoe, E., Verhagen, P.J., & Zock, H. (2002). Image of God and personality pathology: an exploratory study among psychiatric patients. *Mental Health Religion & Culture, 5*(1) 55-71. https://doi.org/10.1080/13674670110112712

Sendjaya, S., Eva, N., Butar Butar, I., Robin, M., & Castles, S. (2019). SLBS-6: Validation of a short form of the Servant Leadership Behavior Scale. *Journal of Business Ethics, 156*(4), 941–956. https://doi.org/10.1007/s10551-017-3594-3

Sendjaya, S., & Pekerti, A. (2010). Servant leadership as antecedent of trust in organizations. *Leadership and Organization Development Journal*, *31*(7), 643–663. https://doi.org/10.1108/01437731011079673

Sendjaya, S., & Sarros, J. C. (2002). Servant leadership: Its origin, development, and application in organizations. *Journal of Leadership & Organizational Studies*, *9*(2), 57–64. https://doi.org/10.1177/107179190200900205

Sendjaya, S., Sarros, J., & Santora, J. (2008). Defining and measuring servant leadership behavior in organizations. *Journal of Management Studies*, *45*(2), 402–424. https://doi.org/10.1111/j.1467-6486.2007.00761.x

Shapiro, F. & Forrest, M.S. (2016) EMDR: The breakthrough therapy for overcoming anxiety, stress, and trauma. Basic Books.

Shaw, S., & Allen, J. B. (2009). “To Be a Business and to Keep Our Humanity.” A critical management studies analysis of the relationship between a funder and nonprofit community organizations. *Nonprofit Management and Leadership*, *20*(3), 83–96.

https://doi.org/10.1002/nml

Smith, C. P., & Freyd, J. J. (2013). Dangerous safe havens: Institutional betrayal exacerbates sexual trauma. *Journal of Traumatic Stress*, *26*(1), 119–124. https://doi.org/10.1002/jts.21778

Smith, C. P., & Freyd, J. J. (2014). Institutional betrayal. *American Psychologist, 69*(6), 575-584. https://doi.org/10.1037/a0037564

Spears, L. C. (2010). Character and servant leadership: Ten characteristics of effective, caring leaders. *The Journal of Virtues & Leadership, 1*(1), 25–30. https://www.regent.edu/acad/global/publications/jvl/vol1_iss1/Spears_Final.pdf

Statulator. (n.d.). *Sample Size Calculator for Comparing Paired Differences*. https://www.lib.sfu.ca/help/cite-write/citation-style-guides/apa/websites

Steil, R., Dittmann, C., Müller-Engelmann, M., Dyer, A., Maasch, A. M., & Priebe, K. (2018). Dialectical behaviour therapy for posttraumatic stress disorder related to childhood sexual abuse: a pilot study in an outpatient treatment setting. *European Journal of Psychotraumatology*, *9*(1). https://doi.org/10.1080/20008198.2018.1423832

Stone, A.M. (2013). Thou shalt not: Treating religious trauma and spiritual harm with combined therapy. *Group*, *37*(4), 323. https://doi.org/10.13186/group.37.4.0323

Sullivan, G. M., & Artino, A. R. (2013). Analyzing and Interpreting Data From Likert-Type Scales. *Journal of Graduate Medical Education*, *5*(4), 541–542. https://doi.org/10.4300/JGME-5-4-18

Surís, A., Link-Malcolm, J., Chard, K., Ahn, C., & North, C. (2013). A randomized clinical trial of cognitive processing therapy for veterans with PTSD related to military sexual trauma. *Journal of Traumatic Stress*, *26*(1), 28–37. https://doi.org/10.1002/jts.21765

Taku, K., Cann, A., Tedeschi, R. G., Calhoun, L.G. (2009). Intrusive versus deliberate rumination in posttraumatic growth across US and Japanese samples. *Anxiety, Stress & Coping 22*(2), 129-136. https://doi.org/10.1080/10615800802317841

Tang, S., & Freyd, J. J. (2012). Betrayal trauma and gender differences in posttraumatic stress. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(5), 469–478. https://doi.org/10.1037/a0025765

Tausch, C., Marks, L.D., Brown, J.S., Cherry, K.E., Frias, T. McWilliams, Z., Melancon, M., & Sasser, D.D. (2011). Religion and coping with trauma: Qualitative examples from Hurricanes Katrina and Rita. *Journal of Religion and Spiritual Aging 23*(3), 236 253. https://doi.org/10.1080/15528030.2011.563203

Taylor, C. B., Fitzsimmons-Craft, E. E., & Graham, A. K. (2020). Digital technology can revolutionize mental health services delivery: The COVID-19 crisis as a catalyst for change. *International Journal of Eating Disorders, 53*(7), 1155–1157. https://doi.org/10.1002/eat.23300

Tedeschi, R.G., & Calhoun, L.G. (1996). Posttraumatic growth inventory: Measuring the legacy of trauma. *Journal of Traumatic Stress, 9*(3), 455-471. https://doi.org/10.1002/jts.2490090305

ter Kuile, H., & Ehring, T. (2014). Predictors of changes in religiosity after trauma: Trauma, religiosity, and posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy, 6(4*), 353–360. https://doi.org/10.1037/a0034880

Testoni, I., Visintin, E. P., Capozza, D., Carlucci, M. C., & Shams, M. (2016). The implicit image of God: God as reality and psychological well-being. *Journal for the Scientific Study of Religion, 55*(1), 174–184. https://doi.org/10.1111/jssr.12252

Thoburn, J., Baker, R., & Dal Maso, M. (2011). *Clergy Sexual Misconduct: A Systems Approach to Prevention, Intervention, and Oversight*. Gentle Path Press.

Terry, K. & Freilich, J., (2012). Understanding child sexual abuse by Catholic priests from a situational perspective. *Journal of Child Sexual Abuse, 21*(4), 437-455. https://doi.org/10.1080/10538712.2012.693579

Texas Penal Code, (2003) https://statutes.capitol.texas.gov/Docs/PE/htm/PE.22.htm

Tisdale, T. C., Key, T. L., Edwards, K., J., Brokaw, B. F., Kemperman, S. R., & Cloud, H. (1997). Impact of God image and personal adjustment, and correlations of the God image to personal adjustment and object relations development. *Journal of Psychology and Theology, 25*, 227-239. https://doi.org/10.1177/009164719702500207

Thompson, B.L. & Waltz, J. (2010). Mindfulness and experiential avoidance as predictors of posttraumatic stress disorder avoidance symptom severity. *Journal of Anxiety Disorders, 24*(4), 409-415. https://doi.org/10.1016/j.janxdis.2010.02.005

Triplett, K.N., Tedeschi, R.G., Cann, A., Calhoun, L.G., & Reeve, C.L. (2012). Posttraumatic growth, meaning in life, and life satisfaction in response to trauma. *Psychological Trauma: Theory, Research, Practice, and Policy, 4(4)* 400-410. https://doi.org/10.1037/a0024204

Tummala-Narra, P., Kallivayalil, D., Singer, R., & Andreini, R. (2012). Relational experiences of complex trauma survivors in treatment: Preliminary findings from a naturalistic study. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(6), 640–648. https://doi.org/10.1037/a0024929

Ullman, S.E., Peter-Hagene, L.C., & Relyea, M. (2014). Coping, emotion regulation, and self-blame as mediators of sexual abuse and psychological symptoms in adult sexual assault.

Journal of Child Sexual Abuse, 23(1), 74-93. https://doi.org/10.1080/10538712.2014.864747

van Dierendonck, D. (2011). Servant leadership: A review and synthesis. *Journal of Management, 37*(4), 1228–1261. https://doi.org/10.1177/0149206310380462

van Dierendonck, D., & Patterson, K. (2015). Compassionate love as a cornerstone of servant leadership: An integration of previous theorizing and Research. *Journal of Business Ethics, 128*(1), 119–131. https://doi.org/10.1007/s10551-014-2085-z

van Minnen, A., Harned, M. S., Zoellner, L., & Mills, K. (2012). Examining potential contraindications for prolonged exposure therapy for PTSD. *European Journal of Psychotraumatology, 3*(1), 1-14. https://doi.org/10.3402/ejpt.v3i0.18805

Walumbwa, F. O., Hartnell, C. A., & Oke, A. (2010). Servant leadership, procedural justice climate, service climate, employee attitudes, and organizational citizenship behavior: A cross-level investigation. *Journal of Applied Psychology, 95*(3), 517–529. https://doi.org/10.1037/a0018867

Warner, R. (2012). *Applied statistics: From bivariate through multivariate techniques (2ed.).* Sage.

Waterman, H. (2011). Principles of "servant leadership" and how they can enhance practice. *Nursing Management, 17*(9), 24–26. https://doi.org/10.7748/nm2011.02.17.9.24.c8299

Watts, B., Schnurr, P.P., Mayo, L., Young-Xu, Y., Weeks, W.B., & Friedman, M.J. (2013). Meta-analysis of the efficacy of treatments for post-traumatic stress disorder. *Journal of Clinical Psychiatry, 74*(6), 541-550. https:// doi:10.4088/JCP.12r08225

Whitehead, A. L. (2014). Male and female He created them: Gender traditionalism, masculine images of God, and attitudes toward same-sex unions. *Journal for the Scientific Study of Religion, 53*(3), 479–496. https://doi.org/10.1111/jssr.12130

Whitworth, J. D. (2016). The role of psychoeducation in trauma recovery: Recommendations for content and delivery. *Journal of Evidence-Informed Social Work, 13*(5), 442–451. https://doi.org/10.1080/23761407.2016.1166852

Wind, L. H., Sullivan, J. M., & Levins, D. J. (2008). Survivors' perspectives on the impact of clergy sexual abuse on families of origin. *Journal of Child Sexual Abuse, 17*(3–4), 238-254. https://doi.org/10.1080/10538710802329734

Wortmann, J.H., Park, C.L., & Edmondson, D. (2011). Trauma and PTSD symptoms: Does spiritual struggle mediate the link? *Psychological Trauma, 3*(4), 442-452. https://doi.org/10.1037/a0021413

Yalom, I. D. (2005). *The theory and practice of group psychotherapy* (5th ed.). Basic Books.

Yeater, E. A., & O'Donohue, W. (1999). Sexual assault prevention programs: Current issues, future directions, and the potential efficacy of interventions with women. *Clinical Psychology Review, 19*(7), 739–771. https://doi.org/10.1016/S0272-7358(98)00075-0

Yoshida, D. T., Sendjaya, S., Hirst, G., & Cooper, B. (2014). Does servant leadership foster creativity and innovation? A multi-level mediation study of identification and prototypicality. *Journal of Business Research, 67*(7), 1395–1404. https://doi.org/10.1016/j.jbusres.2013.08.013

Zarzycka, B. (2019). Parental attachment styles and religious and spiritual struggle: A mediating effect of God image. *Journal of Family Issues, 40*(5), 575–593. https://doi.org/10.1177/0192513X18813186

Zoom (2020, April) HIPAA compliance guide. https://zoom.us/docs/doc/Zoom-hipaa.pdf

Appendices

Appendix A: The Dirty Dozen: A Concise Measure of the Dark Triad

1. I tend to manipulate others to get my way.
2. I have used deceit or lied to get my way.
3. I have used flattery to get my way.
4. I tend to exploit others towards my own end.
5. I tend to lack remorse.
6. I tend to not be too concerned with morality or the morality of my actions.
7. I tend to be callous or insensitive.
8. I tend to be cynical.
9. I tend to want others to admire me.
10. I tend to want others to pay attention to me.
11. I tend to seek prestige or status.
12. I tend to expect special favors from others (Jonason & Webster, 2010, p. 422).

Appendix B: Recruitment Flyer

The Efficacy of a Zoom Workshop on Survivors of Sexual Abuse by Clergy

- Are you 18 years of age or older?
- Do you want help processing trauma acquired through sexual abuse by a male spiritual leader (at any age)?
- Are you open to a faith-based, scientifically-sound approach to recovery?

If you answered **yes** to these questions, you may be eligible to participate in a research study.

The purpose of this research study is to examine the effectiveness of a six-session, Zoom-mediated, psychoeducational workshop addressing trauma and God attachment issues that have arisen from sexual abuse by spiritual leaders. Participants will be asked to take two brief assessments (20 minutes maximum) before and after the workshop and attend the six, approximately two-hour long workshop sessions.

The study is being conducted on Zoom

Jennifer Schwirzer, LPC, a doctoral candidate in the Department of Community Care and Counseling at Liberty University, is conducting this study.

Please contact Jennifer at jschwirzer@liberty.edu for more information.

Liberty University

IRB- 1971 University Blvd. Green Hall 2845, Lynchburg, VA 24515

Appendix C: The Servant Leadership Behavior Scale-6 (SLBS-6)

Please evaluate your supervisor or direct leader with regard to their leadership behaviors by circling the most appropriate number in the following scale.

My supervisor/direct leader . . .

1-Strongly Disagree

2- Disagree

3- Neither

4- Agree

5- Strongly Agree

1. Uses power in service to others, not for his or her own ambition 1 2 3 4 5
2. Gives me the right to question his or her actions and decisions 1 2 3 4 5
3. Respects me for who I am, not how I make him or her feel 1 2 3 4 5
4. Enhances my capacity for moral actions 1 2 3 4 5
5. Helps me to generate a sense of meaning out of everyday life at work 1 2 3 4 5
6. Contributes to my personal and professional growth 1 2 3 4 5

Appendix D: Consent Form

You are invited to be in a research study of the effect of the *Abuse, Trauma, and Jesus* workshop (ATJ workshop) on various features of mental and relational health. You were selected as a possible participant because you are a survivor of sexual abuse by male clergy (SAC). By SAC, we mean that you experienced sexual harassment, abuse, or assault in a church or ministry context, perpetrated by a pastor, priest, elder, Christian schoolteacher, chaplain, Bible teacher, or another spiritual leader. In addition, you are 18 years of age or older, are comfortable with a faith-based approach to recovery, and are comfortable with an educational setting that may include group dialog. Please read this form and ask any questions you may have before agreeing to be in the study.

Jennifer J. Schwirzer, a doctoral candidate in the Department of Community Care and Counseling at Liberty University, is conducting this study.

Background Information: The purpose of this study is to examine the effect of the ATJ workshop in treating survivors of sexual abuse by clergy.

Procedures: If you agree to be in this study, I would ask you to do the following things:

1. Take the following assessments: The Attachment to God Inventory and the Primary Care PTSD Screen for the DSM-V. (10-20 minutes)
2. Attend the weekly six-session ATJ workshop (dates to be determined). (2 hours per session)
3. Fill out the two assessments again at the conclusion of the workshop. (10-20 minutes)

Risks: There are some risks involved in participating in this study. Given that the topic is sexual abuse, survivors of sexual abuse may at times be triggered. In addition, there are limits to confidentiality: Should intent to harm self or others become known by the workshop facilitators, they must report this according to mandatory reporting procedures. Limits to confidentiality also pertain to the other group members. Although we will have a group etiquette statement, which will require confidentiality, as part of the workshop, and although that statement will be reviewed regularly, I cannot assure participants that other participants in the workshop will not share their presence or what was discussed in the workshop.

Benefits: Direct benefits of the ATJ workshop include access to information on the nature of sexual abuse trauma, the specific features of SAC trauma, and helpful keys to managing the effects. For individuals who would like to pursue deeper healing, the ATJ workshop will include information about and referrals for additional helpful trauma interventions such as professional counselors. Participants will also have the opportunity to ask questions and dialog within an online learning environment and will be provided with suggested resources for further learning and healing.

Benefits to society include a greater understanding of interventions effective for sexual abuse trauma in general and SAC trauma specifically. The efficacy of online workshops will also be observed through this study.

Compensation: Participants will not be compensated for participating in this study.

Confidentiality: The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify a subject.

Research records will be stored securely, and only the researcher will have access to the records. I may share the data I collect from you for use in future research studies or with other researchers; if I share the data that I collect about you, I will remove any information that could identify you, if applicable, before I share the data.

- Participation will be confidential and will use a protected HIPAA compliant gsuite email account. Participant names will be removed from the data and replaced by codes or pseudonyms.
- Data will be stored on a password locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- I cannot assure participants that other members of the workshop will not share what was discussed with persons outside the group.

Conflicts of Interest Disclosure:

The researcher serves as CEO of Abide Network, the organization sponsoring this study. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study. No action will be taken against an individual based on his or her decision to participate in this study.

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 Liberty University or Abide Network. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

How to Withdraw from the Study: If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will not be included in the study and will be destroyed.

Contacts and Questions: The researcher conducting this study is Jennifer Schwirzer. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at 215-233-1286 or jennifer@jenniferjill.org. You may also contact the researcher's faculty chair, Courtney Evans-Thompson, at cevans75@liberty.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Your Consent: By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

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.

_____

Signature of Participant Date

_____

Signature of Investigator Date

Appendix E: The Attachment to God Inventory

The following statements concern how you feel about your relationship with God. We are interested in how you generally experience your relationship with God, not just in what is happening in that relationship currently. Respond to each statement by indicating how much you agree or disagree with it. Write the number in the space provided, using the following rating scale:

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Neutral/Mixed	Agree	Strongly Agree		

_____ 1. I worry a lot about my relationship with God.

_____ 2. I just don't feel a deep need to be close to God.

_____3. If I can't see God working in my life, I get upset or angry.

_____ 4. I am totally dependent upon God for everything in my life. (R)

_____ 5. I am jealous at how God seems to care more for others than for me.

_____ 6. It is uncommon for me to cry when sharing with God.

_____ 7. Sometimes I feel that God loves others more than me.

_____ 8. My experiences with God are very intimate and emotional. (R)

_____ 9. I am jealous at how close some people are to God.

_____10. I prefer not to depend too much on God.

_____11. I often worry about whether God is pleased with me.

_____12. I am uncomfortable being emotional in my communication with God.

_____13. Even if I fail, I never question that God is pleased with me. (R)

_____14. My prayers to God are often matter-of-fact and not very personal.*

_____15. Almost daily I feel that my relationship with God goes from “hot” to “cold.”

_____16. I am uncomfortable with emotional displays of affection to God.*

_____17. I fear God does not accept me when I do wrong.

_____18. Without God I couldn’t function at all. (R)

_____19. I often feel angry with God for not responding to me when I want.

_____20. I believe people should not depend on God for things they should do for themselves.

_____21. I crave reassurance from God that God loves me.

_____22. Daily I discuss all of my problems and concerns with God. (R)

_____23. I am jealous when others feel God’s presence when I cannot.

_____24. I am uncomfortable allowing God to control every aspect of my life.

_____25. I worry a lot about damaging my relationship with God.

_____26. My prayers to God are very emotional. (R)

_____27. I get upset when I feel God helps others, but forgets about me.

_____28. I let God make most of the decisions in my life. (R)

Scoring:

Avoidance = sum of even numbered items

Anxiety = sum of odd numbered items

Items 4, 8, 13, 18, 22, 26, and 28 are reverse scored

* Researchers may want to consider dropping these items (14 and 16)

Appendix F: Primary Care PTSD Screen for DSM-V

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: a serious accident or fire

a physical or sexual assault or abuse

an earthquake or flood

a war

seeing someone be killed or seriously injured having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES NO

In the past month, have you...

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

YES NO

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? YES NO

3. been constantly on guard, watchful, or easily startled? YES NO

4. felt numb or detached from people, activities, or your surroundings? YES NO

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? YES NO

Appendix G: Post Workshop Feedback Form

Rate from Strongly Disagree, Disagree, Neutral/Mixed, Agree, and Strongly Agree.

1. This workshop was helpful to me.

2. This workshop helped me understand abuse and trauma.

3. This workshop provided meaningful connections.

4. This workshop changed my life for the better.

5. This workshop helped relieve unwanted symptoms.

6. I learned new information at this workshop.

7. I learned helpful skills at this workshop.

8. I benefitted from this workshop spiritually.

9. This workshop inspired me to minister to those who are undergoing a similar trauma.

10. I will recommend this workshop to others.

Appendix H: Group Etiquette Statement

1. Confidentiality- What is said in the group stays in the group. Group members should consider the group work sacred, creating an environment where members can share freely without fear of their stories "leaking out."

2. Privacy- No group member is forced to disclose personal information. Each member controls their own narrative, choosing what to share and what to keep back.

3. Dignity- No group member is ever treated disrespectfully. Undue criticism, belittling, sarcastic put-downs, will destroy the tone of the group and should never come into play. Members also come to group free of intoxicating substances.

4. Propriety- Members will keep language and communication pure. While some delicate things may need to be shared in order to convey the participant's story, members should avoid unneeded information of a sexual nature and foul language.

5. Conciseness- Members will stay within their allotted time to speak. Group therapy is not individual counseling. Each member needs time to speak. Therefore, when a time limit is given, talking past that limit takes time away from another member. Group members should be sensitive to this.

6. Technology- Be aware of how your phone affects the group. Mute your line if you're not in a very quiet place. Make sure you have a good connection so that everyone can hear you and so that you can be heard.

Appendix I: The Adverse Childhood Experiences Scale

Give yourself one point for each "yes" answer. The more "points" you have, the higher your ACE score, and the more likely you are to be continuing to deal with post-traumatic issues.

1. Before your 18th birthday, did a parent or other adult in the household often or very often...

swear at you, insult you, put you down, or humiliate you?

or act in a way that made you afraid that you might be physically hurt?

2. Before your 18th birthday, did a parent or other adult in the household often or very often...

push, grab, slap, or throw something at you, or ever hit you so hard that you had marks or were injured?

3. Before your 18th birthday, did an adult or person at least five years older than you ever...

touch or fondle you or have you touch their body in a sexual way?

or

attempt or actually have oral, anal, or vaginal intercourse with you?

4. Before your 18th birthday, did you often or very often feel that...

no one in your family loved you or thought you were important or valued?

or

your family didn't look out for each other, feel close to each other, or support each other?

5. Before your 18th birthday, did you often or very often feel that...

you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or

your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6. Before your 18th birthday, was a biological parent ever lost to you through divorce, abandonment, or other reason?

7. Before your 18th birthday, was your mother or stepmother:

often or very often pushed, grabbed, slapped, or had something thrown at her?

or

sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

8. Before your 18th birthday, did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

9. Before your 18th birthday, was a household member depressed or mentally ill, or did a household member attempt suicide?

10. Before your 18th birthday, did a household member go to prison?

Appendix J: Distorted Thoughts

Instructions: After each entry rate from 0 to 10 your level of participation (10 being the most). After that, give an example from your own experience.

Catastrophizing- You think that past, present and/or future events will be awful and unbearable. "If I don't get an A, it will be horrible!"

Dichotomous thinking- You regard situations and people in all-or-nothing, black-and-white terms. "Either we have fun on this campout, or we don't!"

Discounting positives- You trivialize the positive things you and others do: "Of course I take care of my children. Who wouldn't?"

Emotional reasoning- You believe that because you feel something, it must be so. "I'm feeling guilty. I must be guilty!"

External locus of control- You believe that life "happens" to you, and minimize the effect your choices have on the outcome. "I can't be happy unless so-and-so changes. It's totally in their hands."

Fallacy of fairness- You believe that everything must be measured on the basis of fairness and equality, and fail to accept the reality that things aren't always that way. "He cheated, so now I'll cheat."

Fortunetelling- You assume the past is entirely predictive of the future, rather than allowing for change. "I failed in that relationship, so I must not have what it takes."

Judgment focus- You view events, situations or people completely in terms of how they measure against some arbitrary standard, rather than just seeing things for what they are. "He's too talkative and people don't like him because of it."

Labeling- A severe type of overgeneralization, labeling is the practice of labeling a person or other entity after having little exposure. “That day care center is child abuse central.”

Mind reading- Without evidence, you assume that your intuitions never misfire and that you know what people are thinking about you. “I can tell they hated my lecture.”

Negative filtering- You perceive only the worst of past and present events and circumstances. “Everyone I’ve ever known has rejected me.”

Personalizing- You take an undue amount of responsibility upon yourself. “If I looked better, my husband wouldn’t be into pornography.”

Blaming- You project personal responsibility onto other people or circumstances. “If he had been kinder, I wouldn’t have cheated. He made me do it!”

Monsterifying- You exaggerate the wrongs of others, attributing to them a global pattern of evil for which you lack evidence. “She’s wholly given over to evil and can’t be trusted.”

Projecting- You see others through the lens of your own traits, assuming they share them. “Of course he was angry! *I’d* be angry!”

Overgeneralizing- You apply negative traits or actions to the entire person or situation. “My husband can’t do anything right!”

Overidentifying- You see yourself entirely in terms of one trait or event. “My shyness makes me into a complete, antisocial reject.”

Overvaluing- You attribute to others excessive authority or worth in contrast to yourself and/or others. “She always knows what’s best for me. She’s never wrong! I can’t take a step without her.”

Regret orientation- You focus on past mishaps, assuming that they have been ruinous to your life. “If only I hadn’t gotten that surgery!”

Self-inflation- You claim personal assets, achievements and abilities while lacking the courage to test your beliefs. “I’m a great singer. If I tried, I could be famous.”

Self-serving bias- You see all positive events as due to your goodness, and all negative events as outside your control. “People hate me because they’re hateful, but when they love me, it’s because I’m so awesome.”

Singling- You place yourself in position of complete contrast to others. “God’s forgiveness is for everyone, but I’m too evil.”

Shoulds- You see people and events entirely in terms of ideals rather than reality. “People should be friendly and warm.”

Supernaturalizing- You interpret events and circumstances too readily and confidently in terms of direct divine intervention. “People don’t like me, so God must be judging me.”

Unfair comparisons- You view yourself in contrast to unrealistic standards. “If I’m not as smart as he is, I won’t even try.”

-Thanks to Leehy and Holland for some of these concepts.

Appendix K: F.A.R. Exercise

This exercise is designed to assist in thought control, which helps stabilize mood and emotions. I've broken this process down into three main steps: Find, Argue and Replace, or "F.A.R."

F=Find-

-First, find or identify the triggering event or circumstance, such as, "My boss ignores me," or "Traffic jam."

-Now, learn to identify your anxious or sad feelings and admit to yourself that you're feeling them. Use the list called "Feeling Words."

-Next, find the thoughts that underlie the feelings. These will be things like: "I will miss this deadline, lose my job, and live in poverty." Or "That person thinks they're better than me. I hate to be put down!" This will take more time and energy, even prayer. Write them down in the space provided.

Congratulations, you've accomplished the first step!

A=Argue- Learn to argue with yourself. Use the Distorted Thoughts document. In doing this, you are breaking up the fallow ground of your own thinking so that the seed of truth can take root. Tell yourself what's wrong with the way you're thinking: "I'm catastrophizing missing the deadline. I'm making it much worse than it is!" Or "Where is the evidence that person thinks they're better than you? You're mindreading. And you're also catastrophizing how bad it is to deal with an arrogant person." In this step, you're not beating yourself up so much as holding yourself accountable for the way you're treating yourself.

R=Replace- Learn to replace misbeliefs with truth. Truth will be much more nuanced, complex and detailed than distorted thinking. If the distorted thought is, "My wife is an idiot and I can't stand it!" then the truth would be something like, "My wife gets distracted sometimes when too

much is going on. She loses her concentration. Sometimes she makes mistakes, like locking the keys in the car or leaving the stove on all night. Most of the time, the mistakes aren't catastrophic. A few times they have caused inconvenience. But she's a PhD in Microbiology, so it's not that she lacks intelligence. I get frustrated with her, but her occasional flakiness isn't horrible, it's just irritating." Truth has shades of gray whereas distorted thinking tends to be very black and white, or extreme.

Use this table to write down your answers.

Find	Argue	Replace
Event: Feeling word: Thought:		
Event: Feeling word: Thought:		
Event: Feeling word: Thought:		
Event: Feeling word: Thought:		

Appendix L: Journaling Template

This journaling exercise is best done with document software. If you do it by hand, write out the original story on every fifth line, leaving room for the subsequent writing.

Day One: Take 15-20 minutes to write out a memory in detail, focusing on the FACTS. Write those in **black**.

Day Two: Read your story out loud, writing down the FEELINGS you experienced in **red**.

Day Three: Read your story out loud again, writing down what THOUGHTS you had in **blue**.

Day Four: Read your story out loud again, writing down any HOT SPOTS, or things that cause intensely negative feelings like sadness, shame, fear, and anger, in **orange**.

Day Five: Read your story out loud again, writing down the CORE BELIEFS that resulted from your experiences, in **green**. Revise those core beliefs into more truthful beliefs by putting a line through them and writing the new belief down.

Some things to keep in mind:
-Write continually for 15-20 minutes. Try to be somewhere without distractions.

-Don’t worry about spelling or grammar. This is for you. No one will judge you for it.

-If a memory is too stressful to address, move to a memory that is more tolerable. -Expect to feel perhaps a little down after writing. This should resolve in a few hours. If you have lingering distress, you can discontinue. It may be of benefit to you to contact a professional therapist.

Appendix M: Making Core Beliefs Plain

Counselors and coaches in session can help clients identify core beliefs by asking this simple series of questions. The series typically comes when a client expresses intense emotion. The helper should help the client to slow down and process that emotion through this series of questions. This will also connect the thinking part of the brain with the emotional part of the brain.

Permission- Ask permission by saying, “Can we make a space for that feeling? Can you stay with it for a moment?”

Label- Ask, “What feeling is that?”

Area- Ask, “Where do you feel that feeling? In your chest? Stomach? Throat? Other area?”

Intensity- Ask, “Can you rate that feeling on a scale of 1=10, 10 being the most intense?”

Narrative- Ask, “If that feeling could talk, what would it say?

Appendix N: Posttraumatic Growth Inventory

What growth have you experienced as the result of trauma? Rate on a scale of 1-6, 6 being the highest.

1. My priorities about what is important in life
2. I'm more likely to try to change things that need changing
3. An appreciation for the value of my own life
4. A feeling of self-reliance
5. A better understanding of spiritual matters
6. Knowing that I can count on people in times of trouble
7. A sense of closeness with others
8. Knowing I can handle difficulties
9. A willingness to express my emotions
10. Being able to accept the way things work out
11. Appreciating each day
12. Having compassion for others
13. I'm able to do better things with my life
14. New opportunities are available which wouldn't have been
15. Putting effort into my relationships
16. I have stronger religious faith
17. I've discovered that I'm stronger than I thought I was
18. I learned a great deal about how wonderful people are
19. I developed new interests
20. I accept needing others

21. I establish a new path for my life

Total the scores. The lowest score is 21, and the highest is 126. Midpoint is 63.

Appendix O: Simple SUDs Assignment

Create your SUDs anchor points, then think of five situations that fall around the middle point (or lower if you have severe PTSD symptoms). These will be your courage steps for the week.

SUDS Anchor Points

0- _____

50- _____

100- _____

Situation

1. _____

2. _____

3. _____

4. _____

5. _____

Appendix P: Suggested Schedule

Having a daily schedule is very important for everyone, but especially people who struggle with distressing emotions. The idea is to be regular, but not rigid. Especially schedule your morning routine, your meals, your exercise, and your sleep.

Create a schedule something like the one below:

__AM- Wake up

__AM- Breathing

__AM- Water

__AM- Get dressed

__AM- Breakfast

__AM- Work

-Noon-

__PM- Lunch

__PM- Studying

__PM- Exercise

__PM- Supper

__PM- Family time

__PM- Bath

__PM- Breathing

__PM- Bedtime

Appendix Q: The Abuse, Trauma, and Jesus Follow-up Team Instructions

Hello Team ATJ!

I'm grateful you've agreed to help out with participants of the workshop who want extra help. As discussed, this will be delivered in the form of half-hour phone calls. Your steps are:

1. Meet and greet. Get to know them for a few minutes. Let them know you have 30 minutes to speak to them.

2. Ascertain their trauma-symptom level. Try as much as possible to weave these questions into your conversation discretely. But you can set up for it by asking, "Do you mind if I ask a few questions?"

This is a modified version of the assessment they've already taken when they registered for the workshop.

In the past month, have you...

-Had nightmares about traumatic events in your life?

-Tried hard not to think about the events or went out of your way to avoid situations that reminded you of the events?

-Been constantly on guard, watchful, or easily startled?

-Felt numb or detached from people, activities, or your surroundings?

-Felt guilty or unable to stop blaming yourself for the traumatic events?

3. If the participant says yes to three or more of those questions, mention that they need to be checked for PTSD. Offer the following:

-Ask them, "Would you like me to help you find some treatment options?"

-If yes, then do a quick google search of their town and "PTSD treatment."

-Give them that information.

-The top three therapies for PTSD are: Prolonged Exposure Therapy, Cognitive Processing Therapy, and EMDR. I share this in the workshop. You can mention those modalities as being effective.

-They can also explore resources at Abide.Network. These include distance coaching (we limit what we do to non-severe cases, so it would be necessary for them to find local help for severe trauma symptoms), free telephone support groups (Tuesday and Wednesday 7PM, Thursday 8PM, and Sunday 8AM. Simply call (712) 770-4010, Access code- 305624#--this info is also on the web page). We also have workshops and other events they can watch for (they'll be invited to join our notification list).

4. Listen for suicidal ideation, such as "I don't want to live anymore," "There's no reason to continue," "I should just end it all." Take that cue and say, "It sounds like you're having some thoughts about death. Do you ever think of taking your own life?" That is the first question on the TIP MAP assessment (attached) (see Appendix T). If they answer "yes," go to the next question, and on down the line with each "yes." If they answer yes to anything more than "thoughts," they may be considered actively suicidal. Then follow the Actively Suicidal Person Protocol (attached) (see Appendix U).

5. If they do not answer yes to three or more of the PTSD questions, but they want additional/ongoing help, you can recommend Abide.Network's services (see #3).

6. At about 25 minutes, say, "We're almost at the end of the 30 minutes, and I'd like to pray for you. Would that be okay?" I've never had a person say no, but I always ask ☺

7. Pray.

Appendix R: Resources to Help You Heal

Jesus Meditations

These 10-minute audio files take you on a meditation journey leading to the feet of Jesus. We begin by helping you slow and deepen your breathing, then share a devotional and a prayer. Finally, you'll hear a beautiful scripture song by world-renouned recording artist Neville Peter. We recommend doing each meditation each day twice a day over a 30-day period. Access to these meditations, a $50 value, is free to you. Cut and paste this into your web browser: http://www.jesusmeditations.org/jesus-meditations-vol-1/

Abide Network

Abide Network, a group of biblically-based counselors and coaches who do distance work (phone or Skype), is found at abide.network. We would love to serve your mental health needs. Most insurances do not cover distance work, however our fees are lower than industry standard. Costs range from $25 per 50-minute session for an Abide-trained mental health coach to $50-120 per 50-minute session for a licensed Abide counselor. As a first step, please go to the website and fill out the intake form and we'll take it from there.

Free Abide Support Groups

Abide offers free telephone support groups, Tuesdays at 7PM ET, Wednesday 7PM ET, Thursday 8PM ET and Sundays at 8AM ET. The groups use the books *13 Weeks to Peace, 13 Weeks to Love,* and *13 Weeks to Joy.* You don't have to read the books to participate, but if you'll be going regularly, buying the books and following along with the chapters the group is reading will be helpful. You can obtain the books at jenniferjill.org/shop. You can join anytime, and leave any time--they are open groups, a free support service offered with love. Groups honor confidentiality, but if you wish you can also choose not to disclose your full identity

Here are the numbers you'll need: (712) 770-4010, ACCESS CODE- 305624#

Healing Books

13 Weeks to Peace addresses mental health- http://jenniferjill.org/product/13-weeks-to-peace/

13 Weeks to Love addresses relational health- http://jenniferjill.org/product/13-weeks-to-love/

13 Weeks to Joy celebrates both- http://jenniferjill.org/product/13-weeks-to-joy/

You can get them as a discount bundle here- http://jenniferjill.org/product/13-weeks-bundle/

These books are excellent small group and/or personal healing journey resources.

God in Pain by David Asscherick addresses theodicy, the study of why a loving God allows suffering.

Anxiety & Depression Relief

This course helps participants find relief from anxiety and depression symptoms, giving detailed explanations of the diagnoses but also oodles of helpful techniques to help manage or even resolve the conditions!

Abide Network offers this live six-session Zoom workshop several times a year for the low price of $100. Our next one is scheduled to begin on March 14. Buy tickets at https://www.eventbrite.com/e/157498872367

The online course can also be purchased as a stand-alone for $100 at http://jenniferjill.org/product/anxiety-depression-relief-course/

Or bundled with six sessions with an Abide mental health coach for $200 at http://jenniferjill.org/product/anxiety-depression-relief-bundle/

Appendix S: The Abuse, Trauma, and Jesus Sign-Off Email

Hello, team!

I wanted to briefly check-in and, at the same time, sign off.

First of all, a praise! I have enough surveys for statistical significance. That means I can go forward with my research. HOWEVER, I'd rather have more. If you haven't yet, please fill out the exit survey here. I'll be waiting till Monday midnight, ET, so try to get it in today or tomorrow.

I will not be sending individual reports, but the outcome of the research will be available once I get the dissertation written!

Fill out the survey about your preference for staying connected here. Right now it looks as if we may have a special web page.

Some of you have asked, where do we go from here? This is an excellent question, one I planned on addressing. Here are my suggestions for continuing your recovery journey:

1. Consider working with a local trauma-informed therapist or, if your symptoms aren't severe, coaching with an Abide.Network helper may be a good fit. We don't accept insurance, but fees are reasonable, typically around $40 to $80. To explore that option, go here and fill out the intake form.

2. Consider signing up for our upcoming trainings and workshops: The Abide Helper Training, this coming Sunday, will equip you to help others (and yourself at the same time) with mental health issues. Click here to check that out. Anxiety & Depression Relief is a six-session workshop designed to help relieve symptoms of anxiety and depression. Click here to check that one out.

3. Consider Abide's FREE telephone support groups, Tuesdays at 7PM ET, Wednesday 7PM ET, Thursday 8PM ET and Sundays at 8AM ET. The groups use the books *13 Weeks to Peace, 13 Weeks to Love,* and *13 Weeks to Joy.* You don't have to read the books to participate, but if you'll be going regularly, buying the books and following along with the chapters the group is reading will be helpful. You can obtain the books here. You can join anytime, and leave any time-- they are open groups, a free support service offered with love. Groups honor confidentiality, but if you wish you can also choose not to disclose your full identity. Here are the numbers you'll need: (712) 770-4010, ACCESS CODE- 305624#

4. Every Friday night at 8PM ET we conduct the Food for the Heart Bible Study--a Bible study focused on mental health. Just go to Zoom meeting # 656 079 5097. It's an open meeting. The meetings are recorded and posted to my public Facebook page--Jennifer JIll Schwirzer.

5. Read, read, read. Here are a few books I can recommend:

- *Healing for Damaged Emotions,* David Seamands

- *On the Threshold of Hope*, Diane Langberg

-*The Hidden Half of the Gospel*, Paul Coneff

- *The Ministry of Healing*, Ellen White

-*The God Attachment,* Tim Clinton

- *Feeling Good*, David Burns

-*Telling Yourself the Truth*, David Bacchus

- *The Lost Art of Thinking*, Neil Nedley

I hope this is helpful!

Thank you again for participating, joining in, and sharing yourself with the broader community.

You are appreciated! -Jennifer Jill Schwirzer, LPC

Appendix T: T.I.P. M.A.P. Suicide Assessment and Prevention

Often we assume that directly asking a depressed person about suicide is a bad idea. We think even mentioning it will plant the thought in their minds, such that the power of suggestion will lead them to the very thing we dread. This assumption is incorrect. Research shows that inquiry about suicide helps prevent it. Here is a simple line of questioning using the acronym TIP MAP. With each "yes," move on to the next question. Then rate the level of danger and act appropriately. You could save a life!

Thought- "Have you ever thought about taking your life?"

Intent- "Is this something you intend to follow through on?"

Plan- "Have you actually planned how you would do it?"

Means- "Have you thought about how to get the means you would use?"

Access- "Do you have ready access to those things?"

Past- "Have you tried to do this kind of thing in the past?

If the only "yes" is to thoughts, or suicidal ideation, urge the person to get professional counseling. Tell them depression can be treated, and that their suffering can be helped. Encourage them!

If "intent" comes into the picture, you have a serious problem. Any other "yes" answers mean the problem is even more serious. Here are the steps to handling suicidal people:

1. Contract with the person. Have them write a simple statement of agreement to refrain from self-harm for a specific period of time. The reason for the specific period is that most people are willing to postpone for a time, but some may not be willing to postpone indefinitely. : “I, _____, agree to refrain from any act of self-harm for the next two weeks.”

2. During that period of time, do all you can to connect the person with a mental health provider who can treat them for depression. Many people overcome depression and suicidality. Encourage them that this is a fixable situation and that there are people trained to help them. Then call the local crisis center—put “crisis center” and the name of the town in the search engine. Call that number, tell them the situation, and ask for direction.

3. The best way to stabilize a person is often reflective listening. When they comment, repeat back to them in your own words what you heard them say. Feeling understood will help calm them and increase your influence upon them.

4. If a suicidal person refuses to comply, let them know that you can’t allow them to go untreated. Tell them you care enough about them to have them involuntarily admitted. This is done by simply calling the 911 emergency hotline and reporting the suicidal person. Let them know that if they haven’t gotten help by the end of the contract, you may have to follow through on this.

5. Call the national suicide hotline number (800-273-8255) or go to www.yourlifeyourvoice.org for coaching through the situation.

Appendix U: Actively Suicidal Person Protocol

1. Ask the person to admit themselves to the local mental health crisis unit, offering to escort them there. If you don't know where to take them, google "mental health crisis" and the town where the person is located. This should yield either a hospital or stand-alone mental health facility.

2. If they will not, call 911.

3. Typically, 911 does a "welfare visit."

4. If the person is deemed at risk, they will "302," or involuntarily admit them.