A Clinical N of 1 Time Series on the Efficacy of Internal Family Systems and Christian Inner Healing Prayer with Adult Survivors of Childhood Trauma

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A Dissertation Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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Abstract

Internal Family Systems (IFS) is a non-pathologizing psychospiritual therapeutic model in which "all parts are welcome." Christian Inner Healing Prayer (CIHP) is an intervention that invites an authentic experience with the Divine to address inner wounds. Both methods are touted as beneficial to clients with trauma histories. However, IFS is an evidenced based treatment while only preliminary research on CIHP has been done. Several efforts to create a Christian cultural accommodation of IFS have been authored; two implicitly reference CIHP. None have been researched. This study is an N of 1 time series study of the efficacy of IFS with CIHP religious accommodation on symptoms of post-traumatic stress, anxiety, and depression. Additionally, effects to hope, forgiveness, Self access, Self leadership, Self qualities, love of self, and love of God were investigated utilizing multiple psycho-metric instruments and measures. The study's results demonstrated IFS/eCIHP significantly correlated with a decrease in post-traumatic stress, anxiety, and depression symptoms in a small group of N-of-1 Christian clients with histories of childhood trauma. Simultaneously, increases in Self access, Self-leadership, Self-qualities, hope, love of self, and love of God were documented in that same group of participants after eight sessions of treatment. However, IFS/eCIHP did not correlate with evidenced increased forgiveness for the participants. Future research recommendations are made.

Keywords: multicultural sensitivity, religiously accommodative treatments, Internal Family Systems, Inner Healing Prayer, multiple trauma, childhood trauma, post-traumatic stress disorder, anxiety, depression

Copyright Page

Dedication

For Brian.

He didn’t believe in counseling...

~But he believed in me.

1970-2018

Acknowledgments

Friends and Family along the way.

My Children – Forever at 2.2!

Dr. Ford and her clarity.

Dr. Garzon for his vital encouragement and guidance throughout.

To God *alone* be the Glory.

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List of Abbreviations

Acceptance and Commitment Therapy (ACT)

Adverse Childhood Experiences (ACE)

American Counseling Association (ACA)

American Psychological Association (APA)

Attention Deficit Hyperactivity Disorder (ADHD)

Child Maltreatment (CM)

Childhood Trauma (ChT)

Christ-Centered IFS (CCIFS)

Christian Inner Healing Prayer (CIHP)

Coefficients of Determination (r^2)

Cognitive Behavioral Therapy (CBT)

Complex Post-Traumatic Stress Disorder (CPTSD)

Complex Trauma (CT)

Developmental Trauma Disorder (DTD)

Diagnostic and Statistical Manual (DSM)

Diagnostic and Statistical Manual of Mental Disorders, *4th edition* (*DSM-IV)*

Diagnostic and Statistical Manual of Mental Disorders, *4th edition, revised* (*DSM-IV-R)*

Diagnostic and Statistical Manual of Mental Disorders, *5th edition* (*DSM-5)*

Disinhibited Social Engagement Disorder (DSED)

Dissociative Identity Disorder (DID)

Disturbances of Self-Organization (DSOs)

Duke University Religious Index (DUREL)

Eclectic Christian Inner Healing Prayer (eCIHP)

Eye Movement De-escalation and Reprocessing (EMDR)

Faith-based Acceptance and Commitment Therapy (FB-ACT)

Functional Magnetic Resonance Imaging (fMRI)

General Anxiety Disorder (GAD)

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Heartland Forgiveness Scale (HFS)

Herth Hope Index (HHI)

Internal Family Systems (IFS)

International Classification of Diseases 11th Revision (ICD-11)

Interpersonal Psychotherapy (IPT)

Intrinsic Religiosity (IR)

Licensed Marriage and Family Therapist (LMFT)

Licensed Professional Counselor (LPC)

Life Events Checklist for DSM-5 (LEC-5)

Major Depressive Disorder (MDD)

National Registry of Evidence-Based Practices and Programs (NREPP)

Non-Organized Religious Activity (NORA)

Organized Religious Activity (ORA)

Overall Anxiety Severity and Impairment Scale (OASIS)

Overall Depression Severity and Impairment Scale (ODSIS)

Points Exceeding the Median (PEM)

Post-Traumatic Stress (PTS)

Post-Traumatic Stress Disorder (PTSD)

Process Model of Forgiveness (PMF)

PTSD Check List – DSM-5 (PCL-5)

Randomized Control Trial (RCT)

Reactive Attachment Disorder (RAD)

Religion/Spirituality (R/S)

Religious Cognitive Behavioral Therapy (RCBT)

Rheumatoid Arthritis (RA)

Standard Deviation (*SD*)

Standard Error of the Mean (*SEM*)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Theistic Spiritual Outcome Survey (TSOS)

Transformation Prayer Ministry (TPM)

U.S. Department of Health and Human Services (USDHHS)

World Health Organization (WHO)

Chapter One: Introduction

Overview

This chapter introduces research on the integration of two therapeutic models, Internal Family Systems (IFS) and Christian Inner Healing Prayer (CIHP), as a religious cultural accommodative treatment to address post-traumatic stress, anxiety, and depression symptoms for adult survivors of childhood trauma (ChT). Background information on ChT, IFS, CIHP, Christian cultural accommodation, and the author's journey establish the rationale for the study. The problem statement, purpose statement, and the significance of the study follow. Research questions are advanced and definitions listed.

Background

Childhood trauma (ChT) can be the precursor to negative life outcomes across a spectrum of health and social arenas (Dube, 2020; Ports et al., 2021). Adult survivors of ChT frequently have maladaptive coping mechanisms, or strategies, because of the early disruption of key developmental processes and experiential emotional regulation (Sheffler et al., 2020). Diagnoses of post-traumatic stress disorder (PTSD), complex trauma (CT), and comorbid symptoms of depression and anxiety are not uncommon for adult survivors (Ford & Courtois, 2020; Herman, 1992a, 1992b). Adult survivors of ChT are found in every social, racial, and religious culture.

The codification of multiculturalism in the mental health field by both the American Counseling Association (ACA, 2014) and the American Psychological Association (APA, 2017) created opportunity for people of faith. Religion and psychology have a long history of opposition (Entwistle, 2015). Multiculturalism opened doors for the accommodation of religion for mental health professionals. For the Christian ChT survivor, a culturally accommodative

model of therapy to honor their spiritually and faith, alongside their trauma, addresses the whole person (ACA, 2014; APA, 2017).

IFS is an evidenced-based psychospiritual model of therapy shown to be effective with trauma populations (Anderson, 2021; Hodgdon et al., 2021; Schwartz & Goldsmith, 2019; Schwartz & Sweezy, 2020). Since its introduction in 1987, IFS has developed and been refined into a comprehensive therapeutic model (Schwartz, 1987; Schwartz & Sweezy, 2020). Part of the model's growth and expansion has come from those who have studied and applied the model. As individuals approached IFS founder, Richard Schwartz, with integration and application inquiries, he encouraged them to utilize IFS with established therapies (i.e., EMDR, narrative therapy, psychoanalysis, etc.) and when addressing various populations (i.e., couples, children, military, etc.; Schwartz & Sweezy, 2020). As a result, a body of published integrative applications of IFS exists alongside empirical studies of efficacy (Shadick et al., 2013; Haddock et al., 2017; Hodgdon et al., 2021). Likewise, IFS is open to all spiritual practices with its moto being "all parts are welcome" (Schwartz & Sweezy, 2020, p. 107). Yet the cultural Christian is called to "test the spirits" (*New International Bible*, 2011, 1978, 1 John 4:1).

To that end, there have been multiple efforts on the part of Christian mental health providers to present IFS to fellow practitioners through a Christian world view (Cook & Miller, 2018; Harris, 2002; Riemersma, 2020; Steege, 2010). Each Christian author engaged IFS at its most current version at the time and through their unique conceptual perspective of the model. As the IFS model refined, so did the development of the Christian accommodative applications. Two of the four authors (Cook & Miller, 2018; Harris, 2002) describe prayer interventions in their versions of IFS, which align with Christian Inner Healing Prayer models (CIHP; Garzon, 2005b; Tan, 2011a).

CIHP advocates cite both early church traditions (Garzon, 2005b) and the charismatic revivals of the early 19th century (Hattendorf, 2014) when presenting the history of the intervention. Agnes Sanford's (1947/1972) writings and influence in the 1950s established multiple CIHP models and ministries that spun off others (Dignard, 2016; MacNutt, 1974/1999; Payne, 1991; Sandford & Sandford, 1982). Likewise, Ed Smith's Transformation Prayer Ministry (TPM; Smith & Smith, 2019a), formally known as Theophostics, has been influential in the development of more recent CIHP models such as Immanuel Prayer (Hattendorf, 2014; Lehman, 2016) and SOZO (DeSilva & Liebscher, 2016; Hattendorf, 2014). CIHP models invite God (Jesus, Holy Spirit) to be the instrument of change for the Christian client when addressing painful or trauma-based memories (Garzon & Burkett, 2002; Hurding, 1995).

This specific cultural accommodation of IFS with CIHP is the result of both academic inquiry and experiential seeking of a therapeutic method to help those with preverbal trauma histories. As an individual who experienced transformative healing through CIHP, the call to bring such peace and relief to others began the academic journey to become a mental health professional. Gaining experience as a lay counselor through the church care ministry brought the desire for religious integration in a professional setting. The academic exposure to the therapeutic model of IFS led to training and certification in the model. The flow of both methods blended seamlessly to provide a faith accommodative, non-pathologizing trauma intervention that addresses the heart of historical pain. Ethical practice with consenting Christian clients allowed for development of method.

The timely publishing of Cook and Miller's (2018) and Riemersma's (2020) efforts to integrate a Christian world view with the IFS model is indictive of the validity and significance of this study. Both therapists and clients want therapy interventions that work and honor the

whole person. This project endeavors to present a cultural accommodation of Internal Family Systems for Christian clients through integration of Christian Inner Healing Prayer and investigate its clinical effectiveness addressing childhood trauma.

Problem Statement

Adults with historical childhood trauma (ChT) have some of the most intractable symptomology sequalae (Ford & Courtois, 2020; Herman, 1992a) that affect all aspects of their lives, including their spirituality (Walker et al., 2015). Diagnoses of complex post-traumatic stress disorder (CPTSD) and comorbid symptoms of anxiety and depression are prevalent in this population (Cloitre et al., 2020). Integration of psychology and religion/spirituality (R/S) has become an accepted practice of mandated cultural accommodation for persons of faith (ACA, 2014; APA, 2017; Appleby & Ohlschlager, 2013; Entwistle, 2015; Tan, 2011a).

Internal Family Systems (IFS) is an evidenced-based, psychospiritual model with theoretical underpinnings of multiplicity of the mind, systems theory, and spirituality utilized with trauma populations (Anderson, 2021; Hodgdon et al., 2021; Schwartz & Goldsmith, 2019; Schwartz & Sweezy, 2020). However, IFS's undefined spirituality may not be a comfortable fit for some cultural Christians (Schwartz & Falconer, 2017; Garzon & Ford, 2016). CIHP is a faith-based intervention that is "particularly relevant" with adult survivors of ChT (Tan, 2011a, p. 371). Strategic application of an eclectic method of Christian Inner Healing Prayer (eCIHP) may provide, through an authentic experience with Jesus Christ (Garzon, 2005b), an effective intervention for adult ChT survivors who identify as cultural lifestyle Christians.

The problem is that although there have been attempts made to integrate a culturally accommodative Christian worldview to IFS (Cook & Miller, 2018; Harris, 2002; Riemersma, 2020; Steege, 2010), there have not been any empirical studies investigating these models.

Consequently, there is no research on the effectiveness of the IFS model utilizing CIHP interventions with adult survivors of ChT in Christian clinical populations.

Purpose Statement

The purpose of this study is to investigate the religious accommodation of Internal Family Systems (IFS) with eclectic Christian Inner Healing Prayer (eCIHP) and to begin to address the gap in research regarding their united effectiveness as a Christian accommodative model to treat symptoms of posttraumatic stress, anxiety, and depression as well as improve internal and spiritual relations for adult survivors of childhood trauma (ChT). Adult survivors of childhood trauma participated in an 8-week clinical treatment with a faith accommodative IFS/eCIHP model as the independent variable. The effects of the intervention on anxiety, depression, and posttraumatic symptoms, Self access (as defined by IFS), IFS Self leadership, IFS Self qualities, forgiveness, hope, love of self, and love of God were the dependent variables.

Significance of the Study

Internal Family Systems (IFS) is a psychospiritual therapy model evidenced to be effective with trauma populations (Anderson, 2021; Haddock et al., 2017; Hodgdon et al., 2021; Shaddick et al., 2013; Schwartz & Goldsmith, 2019). Christian accommodation of IFS has been conceptualized and published (Cook & Miller, 2018; Harris, 2002; Riemersma, 2020; Steege, 2010) with implicit reference to Christian Inner Healing Prayer (CIHP; Cook & Miller, 2018; Harris, 2002). This study could potentially contribute to the research on religious/spiritual accommodation of empirical therapy models (Worthington et al., 2013) and possibly begin building an evidence base for a Christian specific trauma therapy for adult survivors of childhood trauma.

Initiating the validation of IFS/eCIHP as an accommodative therapy model (ACA, 2014; APA, 2017) may eventually give clinicians an effective intervention which builds on the spiritual foundations and potential strengths of Christian clients (Wilder et al., 2020; Worthington et al., 2013). Adult survivors of ChT need every advantage as they address the painful past. A clinical model which embraces an authentic experience with Jesus Christ (Garzon, 2005a; Tan, 2011a) would be a powerful platform for addressing complex trauma for cultural Christians.

Research Questions

RQ1: Does Internal Family Systems (IFS) with eclectic Christian Inner Healing Prayer (eCIHP) religious accommodation correlate with a reduction the trauma symptoms of *post-traumatic stress*, *anxiety*, and *depression* in self-identified cultural Christian clients with childhood trauma histories?

RQ2: Does the use of IFS with eCIHP correlate with an increase of *Self access, Self leadership,* and *Self qualities,* as defined by the IFS Self Scale, for self-identified cultural Christian clients with childhood trauma histories?

RQ3: Does the use of IFS with eCIHP correlate with an increase of *love of self* and *love of God,* as defined by the TSOS, for self-identified cultural Christian clients with childhood trauma histories?

RQ4: Does the use of IFS with eCIHP correlate with an increase of *forgiveness* and of *hope* as defined by the HFS and HHI measures for self-identified cultural Christian clients with childhood trauma histories?

Definitions

For clarity, the following terms are defined within the context of this study.

- blended – *Blended* occurs when a part takes over making it indistinguishable from another part or the Self (Schwartz & Sweezy, 2020). When blended, the feelings or emotions of the part are experienced. *Blended* can be described as being flooded or overwhelmed with emotion.
- burdens – *Burdens* are negative beliefs or emotional wounds held by exiles (Schwartz & Sweezy, 2020).
- eclectic Christian Inner Healing Prayer (eCIHP) – *eCIHP* is the sum of several distinctly Christian inner healing interventions built on the scaffold of Transformation Prayer (Garzon, 2005b; Hurding, 1995; Smith & Smith, 2019a, 2019b; Tan, 2011a).
- Exiles – *Exiles* are parts burdened with emotional wounds and/or negative beliefs (i.e., "I am worthless," or "I am to blame") and are locked in historical places when the injury occurred (Schwartz & Sweezy, 2020).
- Firefighters – *Firefighters* are Protectors that mainly *reactively* utilize avoidance as they seek any distraction or solution to "put out" or avoid "the fire" of the exiles' pain (Schwartz & Sweezy, 2020).
- IFS Eight Cs – *IFS Eight Cs* are some of the qualities of the Self: Compassion, Curiosity, Calmness, Courage, Clarity, Connectedness, Creativity, and Confidence (Schwartz & Sweezy, 2020; see Self qualities).
- IFS Six Fs – *IFS Six Fs* are: Finding, Focusing on, Fleshing out, Feeling toward, befriending, and addressing Fears (Pastor & Gauvain, 2020). A method of getting to know a part.
- love of God – *Love of God* is all about one's connectedness (or closeness) with God and how we feel toward Him (Richards et al., 2005).

- love of self – *Love of self* is an implicit biblical directive about how we feel toward our self (*New International Bible*, 1978/2011, Matthew 22:39). Love of self is a demonstrative reflection of loving God (Garrity, 2021). It is not pride (*New International Bible*, 1978/2011, Psalms 10:4) nor conceit (Philemon 2:3).
- Managers – *Managers* are Protectors that mainly *proactively* utilizing control methods to attempt to prevent problems or contain the exile's pain (Schwartz & Sweezy, 2020).
- Multiplicity of the Mind – *Multiplicity of the Mind* is a foundational premise of IFS in which the presence of subpersonalities or *parts* are the natural state of the human mind (Schwartz & Sweezy, 2020).
- parts – *Parts* are the subpersonalities that make up an individual's internal system (Schwartz & Sweezy, 2020). In IFS, there are two types of parts: Protectors and Exiles.
- permission – *Permission* allows access without resistance (Schwartz & Sweezy, 2020).
    a) In IFS: is sought from Protectors to gain access to the exiles and the Self (Schwartz & Sweezy, 2020).
    b) In CIHP: is given to God to override freewill and address internal impasses.
- polarization – *Polarization* is the description of the extreme positions between parts and their opposing solutions (Schwartz & Sweezy, 2020).
- Protectors – *Protectors* are made up of Managers and Firefighters who tend to be overworked in a burdened system (Schwartz & Sweezy, 2020). In addition to protecting from internal pain, they are also charged with protecting the system from the external threats that come in daily life.
- Self – IFS asserts the *Self* is the seat of an individual's consciousness. "The *Self* exists, cannot be damaged, can often be accessed quickly, knows how to heal, moves to correct

inner or outer injustice with an open heart, and becomes the good attachment presence for parts and people alike" (Schwartz and Sweezy, 2020, p. 54).

- Self access – *Self access* is different than self-consciousness or self-reflection (Quirin & Kuhl, 2018).
    a. Conceptually, *self access* is an individual's ability to be aware of internal aspects (i.e., beliefs, needs, emotions, memories, future hopes) and to assist in the utilization and application of that self-knowledge (Quirin & Kuhl, 2018).
    b. In IFS: *Self access* is an action accomplished by helping parts create space to access the Self and can be measured by Self leadership and Self qualities (Schwartz & Sweezy, 2020).
- Self leadership – *Self leadership* in IFS is when the system is guided by the Self as leader with the Protectors and Exiles in a trusting relationship with it. A healthy, balanced internal system is Self led (Schwartz & Sweezy, 2020).
- Self qualities – *Self qualities* are characteristic of the Self: "perspective, presence, patience, playfulness, persistence, curiosity, creativity, calm, clarity, caring, connectedness, confidence, and compassion" (Schwartz & Sweezy, 2020, p. 282).
- vows – *Vows* are identified by the words "never" and "always" in a belief statement (e.g., "I will always fail," "I never can win;" Anderson, 2004, 2019). They lock beliefs in place and prevent the release of burdens if not renounced.

Summary

This chapter introduces research on a Christian accommodation of Internal Family Systems in a clinical setting with adult survivors of childhood trauma. Despite attempts made to integrate IFS to a culturally accommodative Christian worldview (Cook & Miller, 2018; Harris,

2002; Riemersma, 2020; Steege, 2010), there have not been any empirical studies investigating these efforts. The purpose of this study was to begin addressing this gap in research of Christian accommodative IFS's effectiveness in treating posttraumatic stress, anxiety, depression as well as improving internal and spiritual relations for adult survivors of childhood trauma (ChT).

Chapter Two: Literature Review

Overview

This literature review builds the conceptual framework for the cultural Christian accommodation of the evidenced-based therapeutic model IFS. The related literature briefly introduces childhood trauma, complex trauma, and touch on the diagnostic comorbidity of anxiety and depression in adult survivors. Childhood trauma and spirituality are introduced. The cross-diagnostic change agents of *hope* and *forgiveness* are discussed. God is explored as an agent of change. The constructs of Self access, IFS Self leadership, IFS Self qualities, love of self, and love of God are explored as possible instruments of, as well as potential indicators and evidence of, positive change. The IFS model is presented, followed by a brief review of published Christian applications with IFS. CIHP is then introduced, and a religious culturally accommodative model outline of IFS with eCIHP described, followed by the chapter summary.

Conceptual Framework

"Approaching something from divergent directions can sometimes lead to startling discoveries."

-Entwistle, 2015

Psychology and Christian theology, from their respective academic perspectives, both ultimately seek to study and bring understanding "to what it means to be human" (Entwistle, 2015, p. 3). In a perfect world, this mutual goal would make for a dynamic and constructive partnership. In a perfect world, there would not be an acrimonious history, fostered from both camps, to overcome and move past (see Entwistle, 2015, for a thorough review).

The integration of psychology and Christianity is a multifaceted topic with many domains (Hathaway & Yarhouse, 2021). Not only is there a spectrum of psychological schools of thought (American Psychological Association, APA, 2021; Tan, 2011a), there is also a spectrum of

Christian belief systems (Gill & Freund, 2018) that must somehow find common ground on which to build. Nowhere is the need to navigate the numerous exponential possibilities and the historical dichotomy of both disciplines more evident than in the Christian mental health professional's office.

The American Counseling Association *Code of Ethics* (2014) necessitates cultural competency for mental health practitioners. Religion is unquestionably a facet of one's culture requiring a client's religious and spiritual needs to be met in the therapeutic setting (Corey, 2019). In response, Christian accommodation of established evidenced-based therapeutic models has flourished (Appleby & Ohlschlager, 2013; Tan, 2011a; Worthington et al., 2013). The Christian accommodation of Cognitive Behavioral Therapy (CBT) derived Religious Cognitive Behavioral Therapy (RCBT; Pearce et al., 2015) and similar accommodation of Acceptance and Commitment Therapy (ACT) produced Faith-based Acceptance and Commitment Therapy (FB-ACT; Knabb, 2016, 2017). Additionally, specific Christian counseling techniques for both theory-based and population-based strategies have made their way to print (Gingrich, 2020; Knabb, 2012; Rosales & Tan, 2016, 2017; Tan, 2011b, 2013, 2020; Tan & Wong, 2012; Thomas, 2018; Wang & Tan, 2016). The precedent has been set and the way made clear for further research on distinctly Christian accommodative therapeutic models.

Related Literature

According to the U.S. Department of Health and Human Services (USDHHS, 2021) there were 656,243 victims of child maltreatment (CM) in the United States in 2019. This number included all ages from birth though age 17 and is published in the 30th annual report on Child Maltreatment (USDHHS, 2021). The report reveals that the youngest of all are most abused with 28.1% (more than a quarter of the total) being two years and under, and 25.7 per 1,000 children

nationally maltreated within their first year of life. Nationwide, there were 1,840 child fatalities recorded. Tragically, research shows that these numbers are most likely underreported (Gilbert et al., 2009; Sedlak & Ellis, 2014).

Adverse Childhood Experiences

Childhood trauma (ChT) and its influence on the lifespan of survivors has been the focus of an immense body of research studying 10 categories of adverse childhood experiences (ACEs): (a) physical abuse, (b) emotional abuse, (c) sexual abuse, (d) growing up in a home exposed to untreated mental illness, (e) household substance abuse, (f) witnessing mother treated violently, (g) absence of household member due to incarceration, (h) parental discord/divorce, (i) physical neglect, and (j) emotional neglect (Dube, 2020; Dube et al., 2003; Felitti et al., 1998; Petruccelli et al., 2019). As a result, the acronym ACEs has become a term frequently used interchangeably with CM and ChT in the literature (Petruccelli et al., 2019). For more than 20 years, various ACE studies (see Dube, 2020 or Petruccelli et al., 2019 for reviews) consistently show the correlation of the number of ACE exposures to exponentially increased risk of negative life outcomes in a dose related measure (Felitti et al., 1998), medically (see Vig et al., 2020 for review), psychologically (Sheffler et al., 2020), and socioeconomically (Metzler et al., 2017).

In a recent study, Merrick et al. (2019) reported approximately 60.9% (or three fifths) of adults in a 25-state study population collected between 2015-2017 experienced at least one type of ACE; those who experienced four or more ACEs totaled 15.6% (or one out of every six) adults in the study population. These numbers are significant in that individuals with high ACE scores (four or more) are more likely later in life to experience significant mental health concerns (e.g., PTSD, anxiety, eating disorders, depression; Sheffer et al., 2020). If the ACEs were interpersonal and repetitive, then a significantly higher risk is feasible of developing complex

trauma (CT) or complex post-traumatic stress disorder (CPTSD) as outlined by the World Health Organization's ([WHO], 2018/2022) *International Statistical Classification of Diseases and Related Health Problems* (11th ed.; *ICD 11)*; Cloitre, 2020).

Complex Trauma Defined

Judith Herman's (1992b) comprehensive classic, *Trauma and Recovery*, is a timeless resource that brings voice to the experiences of survivors across a litany of traumas. It was through this groundbreaking work that the depth and scale of ChT was brought to light and attention called to the complex sequelae of trauma survivors. Through straightforward discourse on terror, disconnection, captivity, and child abuse, Herman (1992b) presented a spectrum of human adaptations to a variety of traumatic scenarios and events. This recognition and identification of symptomology patterns of survivors of "prolonged and repeated abuse" led Herman (1992a, 1992b, p. 3) to spearhead the proposal of CPTSD as a diagnosis for the American Psychiatric Association's (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*).

In the 30 years since that pioneering text, there has been an impressive amount of clinical research conducted on ChT, so much so, to examine it all would be beyond the scope of this effort (see Ford & Courtois, 2020, chapter one for reviews; Herman, 2020; Karatzias & Levendosky, 2019). It is acknowledged portions of the research were driven by the controversy over the diagnostic exclusions from the latest revisions of the *DSM* (APA, 2013, 2000, 1994; Herman, 2012, 2020; Resick et al., 2012), of CPTSD (Cloitre et al., 2020; Ford & Courtois, 2020; Herman, 2020), and the child-focused Developmental Trauma Disorder (DTD) proposed by van der Kolk et al. (2009). Regardless, ChT became generally accepted conceptionally by practitioners working with trauma populations (Ferentz, 2014; Gingrich, 2013; Ogden & Fischer,

2015; Schupp, 2015; Schwartz, 2016; Walker, 2013; Ziegler, 2011) largely through the efforts of Courtois and Ford (2009, 2014), Ford and Courtois (2009, 2013), van der Kolk (2005, 2014), and many other researcher educators (Briere & Scott, 2015; Cloitre et al., 2006; Gingrich & Gingrich, 2017; Heller & LaPierre, 2012; Walker et al., 2015; *etc.*).

Accordingly, the addition of PTSD and CPTSD to the *ICD-11* (WHO, 2018/2022) has been a victory for advocates, causing some to point out that the defining of CPTSD as a stress-related disorder was in line with Herman's (1992b) original conceptualization (Karatzias & Lovendosky, 2019). However, many still state the *ICD-11* (WHO, 2018/2022) diagnosis is too limited (Cloitre et al., 2020; Ford & Courtois, 2020; Gingrich, 2020; Herman, 2020) due to the self-same controversial *complexity* of sequalae experienced by survivors. Nevertheless, the identification of three discriminating features (a) affect regulation, (b) beliefs about oneself, and (c) relational difficulties, uniformly called *disturbances of self-organization* (DSOs; Cloitre et al., 2013; Shevlin et al., 2017, 2018), created the differentiating construct between PTSD and CPTSD making inclusion in the *ICD-11* (WHO, 2018/2022) and the resulting official diagnosis possible (Ford & Courtois, 2020).

Adult survivors of ChT and ACEs potentially have the experiential exposure and resulting symptomologies that could validate a CPTSD diagnosis (Ford & Courtois, 2020). The following defining dimensions of CT as summarized by Ford and Courtois (2020) can be encapsulated in multiple ACEs:

> Intentional interpersonal acts that are inescapable and cause injury that is potentially irreparable. Additionally, complex traumatic stressors are highly intimate, intrusive, and invasive of the body and the self of the individual, often involving imminent threat, the totality of which results in deformations of identity (including the capacity to integrate

> one's identity and experience and maintain one's integrity) and disrupting interpersonal capacity for intimate and other relationships. (p. 5)

Unfortunately, for adult survivors of repetitive childhood abuse and/or other multiple ACEs, the lived experience of ChT is not so pithy or tidily packaged.

ICD-11 and Comorbidity

The previously mentioned *ICD-11* (WHO, 2018/2022) acceptance of PTSD and CPTSD came after much deliberation and clarification of which symptoms should, or should not, be included in the final defining compositions of the sibling diagnoses (Brewin et al., 2017; Gilbar, 2020; Shevlin et al., 2018). Subsequently, characteristic depression and anxiety symptomologies were *not* included in the new diagnostic formulations of PTSD and CPTSD (Maercker et al., 2013; Gilbar, 2020). When confirmation studies (Brewin, 2019; Hyland et al., 2018; Karatzias et al., 2019) identified potential depression and anxiety comorbidity with the PTSD and CPTSD diagnoses, Gilbar (2020) investigated. His findings reconfirmed the new *ICD-11* (WHO, 2018/2022) definitions and core constructs of PTSD and CPSTD as separate from potential co-occurring diagnoses of anxiety and depression (Gilbar, 2020). Nevertheless, the study results also demonstrated the associations and potential co-influences of PTSD and CPSTD on anxiety and depression symptomology, specifically the bridging of dysphoria and avoidance related symptoms (Gilbar, 2020). Consequently, an *ICD-11* (WHO, 2018/2022) diagnosis of PTSD or CPTSD could potentially endorse comorbid diagnoses of depression (Hyland et al., 2018), general anxiety disorder (GAD), and major depressive disorder (MDD; Karatzias et al., 2019). However, this is not the only study to identify this comorbidity combination.

ACEs and Comorbidity

In a recent cross-sectional analysis study of 2,430 self-report survey participants, King (2021) sought to determine if certain combinations of ACEs could indicate specific risk outcomes later in life. The study identified that GAD was a high-risk result of ChT, especially for individuals who experienced the multiple ACEs cluster combination of *physical abuse*, *emotional abuse*, and *maternal battering* (King, 2021). Additionally, the ACEs combination of *physical abuse* and *maternal battering* was one of two identified dyad-clusters that indicated a high-risk for the development of PTSD/CPTSD (King, 2021). That specific combinations of only two ACEs could indicate risk of PTSD/CPTSD is noteworthy. Historically, ACEs scores of four or more have been attributed to PTSD/CPTSD diagnoses (Brockie et al., 2015; van der Feltz-Cornelis, 2019).

The second PTSD/CPTSD dyad-cluster *sexual abuse* with *physical abuse* overlapped with the ACEs cluster of *sexual abuse*, *physical abuse*, and *emotional abuse* that indicated a high risk for MDD (King, 2021). The overlay of these ACEs clusters demonstrates how the potential for comorbidity of GAD, MDD, and PTSD/CPTSD can occur in individuals with multiple ACEs (Gilbar, 2020; Karatzias et al., 2019; King, 2021).

Comorbid Diagnoses

The recognition of the potential for comorbid diagnoses of anxiety and depression alongside PTSD/CPTSD is important for the mental health practitioner and for this study. Clients with ChT histories seek out a mental health therapist for a variety of reasons. Some of the most common incentives for seeking help are due to experiencing symptoms of anxiety or depression, or potentially a combination of both (Ligabue & Tenconi, 2021). These diagnoses are often a gateway to trauma histories of ACEs and the identification of ChT sequalae. For such clients,

ChT was often “normal”, and they may have not connected the events of the past to their current distress. Awareness of the possibility for a comorbid diagnosis of PTSD or CPTSD has practitioners following lines of inquiry to make such a determination. Comorbidity adds to the complexity of the client’s already potentially complex experience and factors in the overarching therapeutic approach of the practitioner. Treatments that effectively address more than one set of symptoms are beneficial and preferred. Moreover, monitoring anxiety and depression symptoms can help the practitioner gauge therapeutic progress.

Childhood Trauma and Spirituality

One of the most significant consequences of ChT is how it factors into shaping an individual’s beliefs about themself and the world around them (Ford & Courtois, 2020; Herman, 1992a; van der Kolk, 2014; Walker et al., 2015). Depending on where a child is developmentally (i.e., infant, child, adolescent) determines their capacity, or complete lack thereof, to understand and interpret adverse or traumatic experiences (Ford & Courtois, 2020; van der Kolk, 2014; Zepinic, 2019). Studies show the earlier the exposure a child has to interpersonal trauma or an event that is traumatic in their developmental timeline, the more deleterious the consequences (Cloitre et al., 2020, Ford & Courtois, 2020; Gingrich, 2020; Spinazzola et al. 2021; van der Kolk, 2014). Children aged two and under are most vulnerable with no capacities to protect or defend themselves at all (USDHHS, 2021). Survivors of preverbal trauma (e.g., accidents, invasive medical procedures) or attachment trauma (e.g., neglect, parental death, adoption, abuse) often have no cognitive memories of the events and yet they can be profoundly shaped by them as evidenced by the various sequalae of Disinhibited Social Engagement Disorder (DSED), Reactive Attachment Disorder (RAD), and other diagnoses rooted in early ChT exposure (APA, 2013; Ford & Courtois, 2020; Spinnazola et al., 2021; van der Kolk, 2014).

Without life experience nor higher reasoning skills or cognitive ability, children can come to erroneous conclusions of meaning in their attempts to make sense of their world. Without supportive or attuned parenting to help a child process a situation or an experienced life event, they are left to make their own connections and assumptions as to why it occurred, what it means, and what it says about them (Fasko & Fair, 2021). When it is a parent's negative actions or words that must be processed, there is an added dimension of betrayal trauma layered into the mix (Freyd, 1996; Walker et al., 2015). Unguided childhood *cause-and-effect* logic (Chatfield, 2018; Payir et al., 2021) potentially lay the foundation for core beliefs (i.e., schemata or internalizations) about the world (e.g., safe or unsafe) and their place in it (e.g., "I am valued" or "I am not good enough"). Likewise, how they experience God and interpret His involvement in those events can become the foundational rock or sand of their faith (*New International Version*, 1978/2011, Matthew 7:24-27; Lehmann & Steele, 2020; Nygaard & Heir, 2012).

Studies have shown that those who have experienced any type of ChT, whether they identify as religious or nonreligious, are less likely to ascribe to God positive characteristics (i.e., loving, always present, forgiving (Kosarkova et al., 2020b). However, other research has shown that adult survivors of ChT may develop strong religious beliefs as they seek to overcome the reactive patterns and negative distrust acquired in early childhood (Granqvist, 2014; Leo et al., 2021; Miner, 2009). Through the acquisition of religious resources (e.g., beliefs, values, ethical principles) along with faith-based practices (e.g., church attendance, prayer, serving others), individuals have utilized spiritual faith as a key means to address and cope with historical trauma (Bryant-Davis & Wong, 2013; Lehmann & Steele, 2020). To that end, Kosarkova et al. (2020b) report findings of less anxiety and depression symptoms connected with client spirituality. Likewise, developing a positive image of God may help ChT survivors satisfy needs for a safe-

haven or a sense of security that were never realized in their family of origin (Korsakova et al., 2020a).

Instruments of Change

With all the known ChT sequalae, what are the solutions? Research into what helps facilitate healing change in the symptomologies of trauma survivors is ongoing (Ford & Courtois, 2020; Sheffler et al., 2020). The application of identified effective change agents is what trauma-focused therapies are designed to implement (Cloitre, 2021; Gingrich, 2020). Case in point, Herman's (1992b) three stage design for recovery stressed the *therapeutic relationship* and the creation of *safety* for the client as foundational instruments of change. In recent years, research on *mindfulness* and *mind-body approaches* as change agents have taken center stage (Bethell et al., 2016; Sheffler et al., 2020).

Self Access

In the IFS model, a central instrument of change is the ability to have *Self access.* According to Schwartz and Sweezy (2020), "When we help clients access their Selves, we are activating the client's innate ability to heal" (p. 23). Protective parts tend to block the way to the Self, needing safety and trust to allow a clear path. Consequently, working with parts to gain this access is a key function of the therapists' role in IFS therapy.

According to Quirin and Kuhl (2018), self-access is different than self-consciousness or self-reflection. Conceptually, self-access is an individual's ability to be aware of internal aspects (i.e., beliefs, needs, emotions, memories, future hopes) and to assist in the utilization and application of that self-knowledge (Quirin & Kuhl, 2018). In a series of studies, their research determined the intuitive process of self-access is distinguishable from mindfulness, self-examination, and other forms of self-awareness (Quirin & Kuhl, 2018). Most significantly, their

results indicate self-access seems to be a key factor in one's ability to adapt, develop emotionally, and maintain good mental health (Quirin & Kuhl, 2018). These findings validate the IFS model's utilization of Self access as a powerful change agent. Moreover, a measurement of Self access — the IFS Self Scale (DeLand et al., 2006) — can be utilized to quantify a client's progress.

IFS Self Leadership

In the IFS model, *Self leadership* is when system is guided by the Self as the leader with the various parts in a trusting relationship with it (Schwartz & Sweezy, 2020). According to Schwartz and Sweezy (2020), a healthy, balanced internal system is Self led thus making Self leadership a goal of IFS therapy and worth promoting as an instrument of change. In a recent study investigating Self leadership in adults, increased Self leadership was associated with reductions in symptoms of depression, anxiety, dissociation, and sleeping disturbances (Fitzgerald, 2022). DeLand et al. (2006) created the Self Leadership subscale of the IFS Self Scale to quantify this change aspect.

IFS Self Qualities

To detect when an individual is experiencing Self, the qualities of Self were identified early in the formulation of the IFS model (Schwartz & Sweezy, 2020). Compassion, Curiosity, Calmness, Courage, Clarity, Connectedness, Creativity, and Confidence are all acknowledged as *Self qualities*; also known as the IFS Eight Cs (Schwartz & Sweezy, 2020). According to the IFS model, client increases in Self qualities are desirable and demonstrates therapeutic change. To that end, in a recent study by Fitzgerald and Barton (2022), increased Self qualities were significantly associated with reduced depressive symptoms and increased relationship quality in a group of adults who reported histories of child maltreatment. The IFS Self Scale: Self Qualities

subscale was specifically designed to quantify any changes to these aspects of Self (DeLand et al., 2006).

Love of Self

Love of self is an implicit biblical directive. In the New Testament, Jesus teaches the second greatest law is to "love your neighbor, as you love yourself," indicating a tacit expectation of an existing *love of self* (*New International Bible*, 1978/2011, Matthew 22:39). Considering God is love (1 John 4:16) and he made us in His image (Genesis 1:27), it can be argued *love of self* is a demonstrative reflection of loving God (Garrity, 2021). Perhaps even the ultimate expression of loving God (Garrity, 2021). Conversely, *love of self* is not pride (Psalms 10:4) nor conceit (Philemon 2:3), because Jesus would never instruct one to sin (1 John 3:5) or do something contrary to God's will (John 5:19, NIV).

From a clinical perspective and understanding, *love of self* is contrary to narcissism's entitled exploitive-ness (APA, 2013) and separate from self-esteem's worth measurements (van Tuijl et al., 2020; Henschke & Sedlmeier, 2021). Moreover, Neff (2003, 2011) insists it is not to be confused with self-compassion, which can be understood best as a gentle response to personal suffering (Henschke & Sedlmeier, 2021; Wallace, 2010). *Love of self* has been described as having a curative effect (Henschke & Sedlmeier, 2021; Irvani, 2007; Orbanic, 2001) and it is recognized as a strength that can promote personal growth (Patrick, 1982).

In a recent study, a direct correlation was identified between increased *love of self* and increased life satisfaction (Jauncey & Strodl, 2018). Additionally, an inverse relationship was found to exist between one's *love of self* and symptoms of anxiety and depression (Jauncey & Strodl, 2018). Such results identify *love of self* as an important agent of change. To that end, the

Theistic Spiritual Outcome Survey (TSOS; Richards et al., 2005) provides a means to quantify and observe changes in both one's *love of self* and one's *love of God.*

God

In CIHP, the triune God (i.e., Father, Son, & Holy Spirit; *New International Bible*, 1978/2011, Matthew 28:19) is the invited agent of change (Garzon et al, 2009; Hurding, 1995; Tan, 2011a) who is able to do more than we can imagine (Ephesians 3:20). As Creator (Genesis 1:1, 1:27), He is our designer and ultimate authority on what we need to optimally function. As Savior (1 John 4:14), He wants none to perish (John 3:16). As Counselor (Isaiah 9:6), He desires to instruct and guide (Psalm 32:8). As Healer (Exodus 15:26), He addresses wounds of the heart (Ezekiel 11:19; Psalm 147:3) and mind (Luke 8:35; Mark 5:15), providing rest (Psalm 62:1) and restoration for the soul (Psalm 26:9).

The mental health provider utilizing CIHP is tasked with facilitating the client's interface with God *however* the Lord leads (Garzon 2005; Hurding, 1995; *New International Bible,* 1978/2011, Galatians 5:25, Isaiah 48:17, Psalms 143:10; Tan, 2011a). He is infinitely creative (Ecclesiastes 3:11; Psalm 65:8). He provides understanding, knowledge, and visions of all kinds (Daniel 1:17). He comforts and has compassion (Isaiah 49:13). He does not do what is expected (1 Corinthians 1:27). He listens to confessions and prayer (James 5:16). He makes all things possible (Mark 10:27).

He has given authority in His name to heal (*New International Bible*, 1978/2011, Matthew 10:1). Scriptures are clear; God is greater than self-condemnation (1 John 3:20, 4:4). He works for our good (Romans 8:28). The mental health provider utilizing CHIP offers themself as an instrument in His hands (Romans 6:13).

Love of God

In Matthew 22:37-40 (*New International Bible*, 1978/2011), Jesus identified the greatest commandment of Jewish law: to love God with all we are (heart, soul, and mind). As an instrument of change, *love of God* is all about one's connectedness (or closeness) with God and how we feel toward Him (Richards et al., 2005). Studies have shown individuals who report experiencing more closeness with God and feelings of love toward Him tend to prioritize their religion and faith beliefs, identifying their *love of God* as a source of comfort and encouragement (Richards et al., 2005).

In a study seeking to investigate the effects of clinical interventions on feelings of love toward God, self, and others, Richards et al. (2005) found support for improved outcomes in clients' spiritual emotional connectedness with God. Jauncey and Strodl (2018), in investigating the mental health of Christians, identified increased *Love of God* as associated with increased life satisfaction—a recognized factor in anxiety and depression reduction (Lopez & Nihei, 2021). In a study inviting God to explicitly participate in an intervention for Christian mental health clients, measuring the responding *love of God* is simply germane.

Hope and Forgiveness

Two cross-diagnostic change agents, which are not uniquely Christian but have strong scriptural themes, are *hope* and *forgiveness*. For the Christian counseling client, the utilization of these elemental aspects of the gospel message has the added benefit of building on the conceptual strength of a potentially preexisting spiritual scaffold. In a recent study on hope by Koenig et al. (2020), an inverse relationship to symptoms of PTSD, anxiety, and depression was evidenced, while the relation to religiosity (i.e., religious belief and behaviors) was found to be significant and positive even with participant demographics controlled for. Hope has been

identified as a contributor to increased resilience (Koenig et al., 2020). Religious teachings are recognized as promoting hope in the future. Isaiah 61:3 reads “to give them beauty for ashes” (*New International Bible*, 1978/2011) and Jeremiah 29:11 states “plans to prosper you, not to harm you, plans to give you a hope and a future.” Increased resilience through encouraging hope could contribute to positive posttraumatic growth. The Herth Hope Index (HHI) provides a way to measure hope (Herth, 1992).

Forgiveness has also been identified as an indicator and contributor to posttraumatic growth (Heintzelman et al., 2014; Schultz et al., 2010; Wusik et al., 2015) as well as predicting increased meaning making of the trauma (Van Tongeren et al., 2015). For those who have experienced multiple offenses, research indicates that by *not* stockpiling unforgiveness, the intentional action of perpetually offering forgiveness is protective (Schultz et al., 2014; Van Tongeren et al., 2015). Studies on forgiveness interventions indicate efficacy in anxiety and depression reduction while promoting the development of forgiveness (Wade et al., 2014). Additionally, posttraumatic growth has been demonstrated in religious faith and or spirituality when forgiveness interventions were implemented (Luskin et al., 2005; Rye & Pargament, 2002).

Wade et al. (2017) in their discussion of reconstructing meaning after trauma, describe forgiveness as:

> A process that occurs internal to the person who was offended against in which they experience less anger, hurt, bitterness, and/or vengefulness, and a return to pre-offense levels of benevolence, compassion, and/or love. Furthermore, this forgiveness occurs without giving up important interpersonal boundaries that can keep the offended person safe from future harm. (p. 71)

For clients with early ChT, it must be noted there may not be a pre-offense level to return to. However, that does not negate the possibility of being able to experience compassion and peace toward offenders through forgiveness.

The two methods of intervention for integration in this study embrace these instruments of change. Specifically, IFS is known for instructing practitioners in how to become "hope merchants" for their clients (Pastor & Gauvain, 2020, p. 123), while CIHP recognizes forgiveness as a core healing element (Sanford, 1947/1972), a prevention against Satan taking advantage (*New International Bible*, 1978/2011, 2 Corinthians 2:10-11), and a command to be rid of bitterness and to forgive as we have been forgiven in Christ (Ephesians 4:31-32). The Heartland Forgiveness Scale (HFS) was utilized to quantify forgiveness.

Internal Family Systems

IFS is a psychospiritual model of psychotherapy constructed on the synthesis of three core paradigms: the multiplicity of the mind, systems thinking, and spirituality (Pastor & Gauvain, 2020; Schwartz & Goldsmith, 2019). Foundationally, IFS is built on the premise that multiplicity of the mind (i.e., the presence of subpersonalities or *parts*) is the natural state of the human mind (Schwartz & Falconer, 2017; Schwartz & Sweezy, 2020). As a result, the inner world of an individual is systemically like a *family,* or tribe, with the various parts taking on roles resulting from life experiences and the subsequent interpretations of such (Schwartz & Sweezy, 2020). Within this inner family system, there is a seat of consciousness that Schwartz (1987) calls "the Self" and identifies as the spiritual element of the model (Pastor & Gauvain, 2020; Schwartz & Falconer, 2017; Schwartz & Goldsmith, 2019).

Multiplicity or "Parts"

The IFS therapy model utilizes interventions from many schools of philosophy and therapeutic practice (i.e., Family Systems, Virginia Satir, Hakomi Method, Buddhism) to work within the system to unburden and help restructure parts' relations for optimal system cooperation and interaction (Schwartz & Sweezy, 2020). This ability to work with the various parts of an individual comes from understanding their unique motivations and roles.

There are two main types of *parts* in the IFS model: Protectors and Exiles (Schwartz & Sweezy, 2020). The Exiles are parts burdened with emotional wounds and/or negative beliefs (i.e., "I am worthless," "I am to blame") and are anchored in historical places when the injury occurred. Their pain/hurt has the Protectors shutting them down, locking them away, and overriding them anyway they can to prevent them from flooding the whole system—effectively *exiling* them so the system can continue to function. Protectors do this in various ways but usually from somewhere on the continuum between *control* and *avoidance*. Protectors that mainly *proactively* utilize control are called Managers (Schwartz & Sweezy, 2020). Protectors that mainly *reactively* utilize avoidance are called Firefighters because they seek any distraction or solution to put out or avoid the fire of the exiles' pain (Schwartz & Sweezy, 2020).

Protectors tend to be overworked in a burdened system (Schwartz & Sweezy, 2020). In addition to protecting from internal pain, they are also charged with protecting the system from the external threats that come in daily life. Patterns of behaviors and reactions to the external world can be mapped out in the interactions between internal *Managers*, *Firefighters* and *Exiles*. Each Protector part believes they have *the solution* regarding Exiles and external forces (Schwartz & Sweezy, 2020). This can lead to *polarizations* between parts and their opposing

solutions. Internal conflict results as they battle to determine which part will lead to see their solution agenda carried out.

The Self

A healthy, balanced internal system is Self led (Schwartz & Sweezy, 2020). This occurs when the leader of the system is the Self, with the Protectors and Exiles in a trusting relationship with it. It is the presence of a Self that makes IFS a psychospiritual model (Schwartz & Goldsmith, 2019). According to Schwartz and Sweezy (2020) the Self is *not* a part, yet it is the "centerpiece of the model" (p. 54). It is what is at our core and what all the various parts are layered over in the system. As parts "step back" and make space inside, the Self is revealed. Like the sun behind clouds, the Self is always present.

> IFS asserts that the Self exists, cannot be damaged, can often be accessed quickly, knows how to heal, moves to correct inner or outer injustice with an open heart, and becomes the good attachment presence for parts and people alike. (Schwartz & Sweezy, 2020, p. 54)

It is the qualities of the Self that led to the formulation and identification of the IFS Eight Cs: Compassion, Curiosity, Calmness, Courage, Clarity, Connectedness, Creativity, and Confidence (Schwartz & Sweezy, 2020). When a person is Self led, the Parts in the system look to the Self, trusting that it can handle whatever the world dishes out.

IFS Therapy

An IFS therapist is charged with helping their clients to access Self (Schwartz & Sweezy, 2020). To accomplish this, first and foremost, a safe and healing space must be created and held for the client to do the work in. It is within this held space that the Self can be sought through the application the IFS Six Fs: Finding, Focusing on, Fleshing out, Feeling toward, beFriending, and addressing Fears (Pastor & Gauvain, 2020). Therapists are trained in both indirect and direct

access methods of communication when working with clients' parts (Pastor & Gauvain, 2020). Through utilization of the Six Fs, the communication with the various parts negotiates creating space for the Self and its qualities. It is in these discussions that polarized parts, legacy burdens, and parts' interactive relationships can be identified and balance, harmony, and leadership can be pursued for the inner system (Schwartz & Sweezy, 2020).

IFS holds that the system wants to heal, and that it intuitively knows and has the wisdom of *how* to heal (Schwartz & Sweezy, 2020). From a place of Self and its qualities, Exiles can be given opportunity to unburden, heal, and be freed from where they have been frozen in time. Once unburdened, Exiles have opportunity to embrace the purpose or qualities that were theirs from before becoming burdened. This translates into transformation for the client (Schwartz, 2013). For a full presentation of IFS, the second edition of *Internal Family Systems Therapy* by Schwartz and Sweezy (2020) offers the model in its most current form. For training opportunities, visit the IFS Institute (*https://ifs-institute.com/*) for more information.

Evidence Based

Since the publication of Richard Schwartz's seminal article in 1987, IFS has matured and developed as a model and is increasingly supported and endorsed in research circles (Schwartz & Sweezy, 2020). In 2015, IFS earned recognition as an evidenced-based psychotherapy model from the National Registry of Evidence-Based Practices and Programs (NREPP), a division of U.S. government's Substance Abuse and Mental Health Services Administration (SAMHSA; Matheson, 2015). NREPP based its determination on an independent review of the randomized control trial (RCT) conducted by Shadick et al. (2013) implementing IFS with a sample of adults with rheumatoid arthritis (RA). The independent review of the RCT results found IFS to be "effective for improving general functioning and well-being" for chronic pain from RA

(Matheson, 2015, para. 5). Additionally, the NREPP determined IFS showed "promising outcomes for: 1) reducing anxiety disorders and symptoms; 2) improving physical health conditions and symptoms; 3) improving self-concept; and 4) reducing depression and depressive symptoms" (Matheson, 2015, para. 5).

A second RCT conducted by Haddock et al. (2017) executed an investigation of IFS with a sample of female college students with depressive symptoms. The trial results substantiated the effectiveness of IFS in reducing depression symptoms equally as well as the comparative "gold standard" therapies of CBT (cognitive-behavioral therapy) and IPT (interpersonal psychotherapy; Haddock et al., 2017).

Most recently, an uncontrolled pilot effectiveness study of IFS with survivors of multiple childhood traumas with PTSD diagnoses and comorbid symptoms was conducted by Hodgdon et al. (2021). Each participant received 16 IFS sessions (90 minutes each) and filled out four questionnaires evaluating symptomology at strategic points during therapy and at the 30-day mark post-treatment. Results indicated "significant" reductions of PTSD (clinically and statistically), related PTSD features (observed), and depression symptoms (observed) through the course of treatment, with over 90% of participants no longer meeting requirements for PTSD diagnosis (*DSM-IV*-TR; Hodgdon et al., 2021). Ancillary measurements of self-compassion rated with "medium affect size in the expected direction" and interoceptive awareness was deemed "not significant." These preliminary findings indicate IFS may be effective as a comprehensive model in the treatment of "complex" PTSD (Hodgdon et al., 2021).

IFS Treatment Model Applications

With van der Kolk (2014) touting IFS as an effective therapy for trauma in *The Body Keeps the Score* and NREPP recognition of IFS as an evidenced-based psychotherapy model

(Matheson, 2015), there has been a surge in peer-reviewed articles and books applying IFS to various populations. The IFS model has been utilized to assist children (Krause, 2013; Spiegel, 2017); teens (Sweezy, 2011a); college students (Haddock et al., 2017); couples (Schwartz, 2010; Herbine-Blank et al., 2015), families with troubled children and teens (Mones, 2014), lesbian and gay individuals (Minaiy et al., 2017); same-sex couples (DiGloria, 2019); adult mental health and relationships (Fitzgerald, 2022); combat veterans with PTSD (Lucero et al., 2018); survivors of sexual trauma (Jones et al., 2021); and incarcerated offenders (Di Fulvio, 2019). Likewise, *DSM-5* (APA, 2013) and *ICD-11* (WHO, 2018/2022) diagnoses have also been the focus of IFS application toward eating disorders (Grabowski, 2017; Minaiy et al., 2017), addictions (Anderson et al., 2017; Smith et al., 2019), mood and personality disorders (Anderson et al., 2017; Sweezy, 2011b), dissociative identity disorder (DID; Goulding & Schwartz, 1995), childhood sexual abuse (Miller et al., 2007), and complex trauma (Anderson, 2021). Similarly, the medical diagnoses of rheumatoid arthritis (Shadick et al., 2013) and chronic illness (Sowell, 2013) as well as the fields of neuroscience and pharmacology (Anderson, 2013) have also been investigated through the lens and application of IFS.

IFS Integration with Other Treatment Models

IFS has been applied to and integrated with other therapeutic models and methods: art therapy (Lavergne, 2004), psychoanalysis (Schlief, 2014), couples therapy (Herbine-Blank, 2016; Herbine-Blank et al., 2015; Schwartz, 2010), group therapy (Burris & Burris, 2022; Irabli, 2017; Weiss, 2018), 12-step applications (Smith et al., 2019), narrative therapy (Miller et al., 2007), EMDR (Brown, 2020; Mille, 2017; Twornbly & Schwartz, 2008), Solutions Focused Brief Therapy (Jones et al., 2021), Feminist informed therapy (Prouty & Protinsky, 2002), hypnotherapy (Papagianni & Kotera, 2022), somatic integration with yoga and dance (Cahill,

2015), integration with psychedelics (Morgan, 2020; Morgan et al., 2021), and sand tray integration (Turns et al., 2021). Likewise, IFS has been utilized in training supervision (Reed, 2019; Redfern, 2022), managed care (Lester, 2017), law negotiation (Riskin, 2013), critical race theory (Yong, 2020), and to promote novice therapist self-awareness (Mojta et al., 2014).

Multicultural Applications

Additionally, IFS ethnic applications and studies with African American (Wilkins, 2007), Cherokee (McVicker, 2017; McVicker & Pourier, 2021), and Korean (Boim, 2018) cultures expand the model beyond racial borders. Recently, IFS has been applied to a study on racial identity attitudes and race-related stress (Phillips et al., 2022). Furthermore, IFS has been framed for people of faith through the lenses of Buddhism (Engler & Fulton, 2012; Schwartz & Sparks, 2015), Christianity (Cook & Miller, 2018; Harris, 2002; Riemersma, 2020; Steege, 2010), spirituality (Holmes, 1994), eco-spirituality (Baldwin, 2021), spirituality in supervision (Janes et al., 2022), and the Diamond Approach spiritual teaching (Parke, 2018). Nevertheless, in all these studies and applications, there has not been any investigation or outcome-based study into the utilization of Christian Inner Healing Prayer (CIHP) with IFS.

IFS and Christianity

Internal Family Systems therapy with its Buddhist influenced origins may not be a comfortable fit for practicing evangelical Christians (Hathaway & Tan, 2009; Gingrich, 2020; Schwartz & Sparks, 2015; Schwartz & Sweezy, 2020). One example of this discomfort was demonstrated by a Christian counselor and author who, after acknowledging that IFS has led the way in making parts work more popular with therapists, pithily wrote, “I do not agree with aspects of Schwartz’s theory” (Gingrich, 2020, p. 78). Unfortunately, such influences of

disapproval may discourage other Christian therapists from discovering and engaging with an effective model of therapy (Hodgdon et al., 2021; Matheson, 2015).

To address concerns over misalignment of faith and therapeutic practice, there have been integration and accommodation efforts made by various Christian IFS practitioners (ACA, 2014; Cook & Miller, 2018; Harris, 2002; Riemersma, 2020; Steege, 2010). This study is building on the efforts of individuals who stand with their feet firmly planted in both philosophies despite the well documented acrimonious history of psychology and religion (Entwistle, 2015). Being able to honor both foundations is important to the cultural Christian mental health counselor as they balance their faith with their professional calling. IFS, with its undefined spirituality being a core tenet of the model, necessitates accommodation for some cultural Christians (ACA, 2014; APA, 2017; Schwartz & Falconer, 2017). What follows is a brief comparison and discussion of the four available published conceptualizations.

Four Integrations

The first author, Harris (2002), working with an earlier version of IFS, called his model Christ-Centered IFS (CCIFS) and added a bulky chapter of concepts about the *internal survival organization of parts* and how they need to be reformed into a *Christ-centered organization of parts*. Harris is clear in informing readers that advanced techniques of IFS are beyond the scope of his book and directs readers to seek further training from official IFS resources.

Steege (2010) did not present the IFS model, but rather offered a glimpse into her spiritual journey as an both an IFS practitioner and pastor to challenge readers to live an authentic Spirit-led life through use of the model. Though scattered commentary on Parts and polarities, burdens and sins, and the IFS Self and God, there is no doubt Steege is familiar with the model. However, her writing obfuscates a clear conceptualization of it. She concludes her

efforts with a transcribed interview with Richard Schwartz discussing Christianity and the IFS model.

Cook and Miller (2018), working with a more contemporary edition of IFS, conceptually condense the model into five basic steps: (a) Focus, (b) Befriend, (c) Invite (Jesus), (d) Unburden, and (e) Integrate. This 5-step process they call "taking a You-Turn" (Cook & Miller, 2018, p. 9-10), a mimic of the IFS U-turn concept of turning a client's attention to their inner world instead of focusing on others (Herbine-Blank et al., 2015; Pastor & Gauvain, 2020). Referencing Cloud and Townsend's (2017) classic book *Boundaries*, they introduce the notion of *inner boundaries* for parts and provide case vignettes in the third section of their book in a series of "challenging emotions" chapters (Cook & Miller, 2018, p. xi).

Most recently, Riemersma (2020), who's adherence to the IFS model was endorsed in a forward to her book by Richard Schwartz, challenged Christians to get to know and heal their *Spiritualizer* part. By identifying and calling attention to Protectors that use church practices or activities to control (Managers) or create avoidance (Firefighters), Riemersma (2020) helps Christians to examine their inner motivations. The book's chapter outline parallels Schwartz's presentation of the model and utilizes IFS terminology through an unapologetic and distinctly Christian lens. Additionally, multiple experiential exercises of guided mindfulness are included in the text to aid in locating and identifying the reader's Managers, Firefighters, and Exiles.

Commonalities and Differences

What these authors hold in common is their Christ-centered faith and the desire to see it honored within their profession. Specifically, they seek a Christian perspective being represented and accommodated in the IFS model. Ultimately, they each seek to invite God (i.e., Jesus, Holy Spirit) to engage in the therapeutic process, with the expectation of an authentic experiential

encounter with the Divine to guide the work. In turn, each author frames IFS concepts and interventions through the lens of various scriptures and biblical examples to demonstrate Christian accommodation and integration of the model. For example, the multiplicity of God (Father, Son, Holy Spirit; *New International Bible,* 1978/2011, Matthew 28:19) and how we are made in His image (Genesis 1:27) is cited by each to bring understanding to the idea of parts. Likewise, the thematic similarities of the *fruit of the Spirit* and the qualities of the Self are advanced (Galatians 5:22-23).

While they each wrestle with translating and describing into Christian terms the IFS *Self*; they diverge on their conceptualizations of it for the Christian practitioner. This key concept has been described as "the seat of consciousness" with names and descriptions such as "Godseed" and "Inner Light" (Schwartz & Sweezy, 2020, p. 43). Carl Rogers (1980) referred to it as his "transcendental core" and "inner spirit" (p. 129), while Jung is quoted as describing it as "God within us" (Moacanin, 1988, p. 33). (Read Schwartz and Falconer (2017) for a thorough review.) According to Schwartz and Sweezy (2020), "The Self is the centerpiece of the model" and what makes it psychospiritual (p. 54; Schwartz, 2021).

To that end, Riemersma (2020) put forth that the Self is God's fingerprint at the core of every human being. Because we are made "in the image of God" (*New International Bible,* 1978/2011*,* Genesis 1:27), she calls the Self the *God Image* in her book. This may be a theologically based premise; however, the various denominations may want doctrinal review. (Being beyond the purview of this effort, that effort is best left to interested theologians.)

Meanwhile, both Steege (2010) and Cook and Miller (2018) in their writings acknowledge the presence of the Holy Spirit in Christ followers. They refer to the Self as the *Spirit-led Self* in their independent discussions of the model without lengthy explanation. Harris

(2002), however, added a layer of complexity by renaming the Holy Spirit the *Self of Faith* in his model and has it working in tandem with the Self.

Inner Healing Prayer

None of these models explicitly reference Christian Inner Healing Prayer. However, Cook and Miller (2018) with their third step inviting Jesus Christ to "come near" seem to implicitly introduce it, they suggest "it may be helpful simply to pray a new way…Invite Jesus to be near a hurting part, and hold it up to the light" (p. 88). Additionally, they offer a series of questions (p. 90) for "inviting Jesus near" that ostensibly align with Tan's (2011a) model of CIHP:

- Is Jesus near?
- If not, would this part like to invite Jesus to be near?
- Does it have any fears and concerns? Can it tell those things to Him?
- Ask Jesus if He wants to say, do, or give the part anything in response.

Harris (2002) also does not specifically reference CIHP. What he does do is implicitly discuss the importance of Jesus' role in the "healing of a memory", highlighting the safety Jesus creates with His presence in the accessing the painful past (p. 106-107). He conservatively mentions clients "sometimes begin a spiritual journey and encounter Jesus in a transforming and healing new relationship" (Harris, 2002, p. 74).

None of these authors' models has generated empirical research to validate the effectiveness of IFS accommodation of or integration with the Christian faith. Nor has there been any data generated on the effects of the Christian Inner Healing Prayer application as implied by Cook and Miller (2018) and Harris (2002). This study will begin to fill that gap in the literature.

Christian Inner Healing Prayer

Christian Inner Healing Prayer (CIHP) is an overarching designation for a collection of models that implement "a range of 'journey back' methodologies that seek under the Holy Spirit's leading to uncover personal, familial, and ancestral experiences that are thought to contribute to the troubled present" (Hurding, 1995, p. 297). Associated with "spirit filled" or charismatic Christian denominations, CIHP has been considered a grass-roots movement originating with the writings and influence of Agnes Sanford (1947/1972) in the 1950s (Garzon et al., 2009). Since then, CIHP has made its way into mainstream faith denominations (Wilder et al., 2020), clinical Christian psychology texts, (Appleby & Ohlschlager, 2013; Garzon, 2005b; Gingrich & Gingrich, 2017; Worthington et al., 2013), and into clinical practice (Garzon 2005a; Tan, 2011a). It is through the clinical lens that some mental health professionals acknowledge certain CIHP techniques seem "to be similar to psycho dynamic and experiential psychotherapies", with God being the identified change agent (Garzon, 2005a; Garzon et al., 2009, p. 115).

CIHP's foray into clinical practice has not been without controversy (see Hathaway, 2009; Hunter & Yarhouse, 2009). Religion and psychology have a long history (Entwistle, 2015) and ethical practice is vital and required (ACA, 2014; APA, 2017). However, it has been reasonably argued that such "concerns can be taken seriously, without rejecting the models" (Wilder et al., 2020, p. 50). Most CIHP proponents advocate inner healing prayer (i.e., healing of memories) as an intervention in clinical treatment or pastoral care, rather than a comprehensive treatment (Garzon & Burkett, 2002; Garzon, 2005a, 2005b; Gingrich, 2020; Gingrich & Gingrich, 2017; Tan, 2011a). According to Tan (1996):

> Inner healing prayer is particularly relevant in situations where the client has suffered past hurts or childhood traumas (e.g., involving neglect or deprivation, sexual and physical abuse, rejection, abandonment, harsh criticism, or sarcasm, etc.) that are still unresolved and very painful emotionally. (p. 371)

CIHP Diversity

CIHP models universally agree God (Jesus, Holy Spirit) is the mechanism of change (Garzon et al., 2009, Gingrich & Gingrich, 2017, Tan, 2011a). However, stylistic variations exist due to each CIHP model having its own interpretation on *how* to engage with the Divine (DeSilva & Liebscher, 2016; Lehman, 2016; Seamands, 1985/2002; Smith & Smith, 2019a; Tan, 2011a; etc.). CIHP model interaction styles range from nondirective invitations for the Lord to be present and lead "in whatever way is appropriate or needed" (Tan, 2011a; Garzon & Burkett, 2002, p. 44) to structured "maps" with verbatim scripts (Smith & Smith, 2019a, 2019b). Along the continuum of these diverse styles are found the pioneering efforts of Agnes Sanford (1947/1972), the work of Francis MacNutt (1971/1999; Christian Healing Ministries), Ruth Stapleton (1976), David Seamands (1985/2002), John and Paula Sandford's Elijah House model (1982, 2013), and Leanne Payne's Ministries of Pastoral Care (1991; formally called Pastoral Care Ministries). Likewise, are psychologist Siang-Yang Tan's model (2011a) and the contemporaneous models of Ed Smith's Transformation Prayer Ministry (TPM; Smith & Smith, 2019a; previously known as Theophostic Prayer Ministry), Karl Lehman's Immanuel Approach (2016), Chester and Betsy's Restoring the Foundations (2014), and DeSilva and Liebscher's SOZO (2016). For further writings on CIHP, as well as references to other models, see authors Flynn and Gregg (1993), Kraft (2014), Morgan (2013), Richardson (2005), Rustenbach (2011), or Wardle (2001).

CIHP Applied

Because of the diverse spectrum of CIHP models, practitioners' applications present differently according to the version utilized. For clarity in this effort, a brief description of the features of the eclectic style of CIHP (eCIHP) implemented in this study follows.

All Christian Inner Healing Prayer (CIHP) begins with an inquiry: "Is the client willing to invite the Lord (i.e., Jesus, God, Holy Spirit) to be present and guide the session?" This explicit invitation is critical; without it, a CIHP intervention is not possible (Tan, 2011a). Depending on the client, this invitation is obtained immediately or after a brief discussion of session focus.

In eCIHP, the next essential element is determining how the client engages with the Lord. Are they visual, audial, sensory? Is there just a sudden "knowing" after seeking God's perspective? Helping the client differentially identify, or recognize, God's input from their own thoughts is foundational to eCIHP processing (DeSilva & Liebscher, 2016). Clients report a variety of sensory impressions: vivid imagery, warmth or cold, tangible somatic movement, audial reception of the internal ear such as "a still small voice" (*King James Bible*, 1769/2017, I Kings 19:12; Garzon 2005b) or "a voice calling" (*New International Bible*, 1978/2011, 1 Samuel 3:4-11). A common report is of a sense of God's presence or an all-encompassing profound peace (Garzon, 2005b). For the mental health practitioner, it is important to remember God is not static, He acts and can engage in any manner He chooses (*New International Bible*, 1978/2011, Isaiah 64:4; Psalm 115:3). This means from session to session, and even within the same session, the interaction can vary. This results in every client's CIHP session experience being uniquely their own (Garzon & Burkett, 2002).

Once the invitation is extended and the therapist has a general sense of the client's mode of reception of CIHP, the work can ensue. Usually, a direct request for the Lord to lead and

guide the session begins the work, but it is not uncommon for the client to have a specific focus they wish to pursue. Depending on how the session unfolds from there determines the CIHP interventions to be applied.

In eCIHP, there is a general scaffolding derived from Ed Smith's TPM (Smith & Smith, 2019a, 2019b). Fashioned from the components consisting of *emotion*, *memory/representation*, and *belief*, a conceptual structure exists that aids the therapist in facilitation. These same scaffolding components have been identified in empirically validated therapies (e.g., EMDR) and can present somatically (Botha, 2008; Shapiro, 2018).

The eCIHP intervention unfolds with what the client reports they are currently noticing (emotion, memory/representation, belief; Smith & Smith, 2019b), or if they are noticing nothing at all. In eCIHP, noticing *nothing* is something. According to Smith and Smith (2019b), *nothing* would fall under their TPM "solutions" category and has various sources (i.e., fears, anger, beliefs). In other therapy models, it would be called *resistance* (VandenBos, 2007). To address *nothing,* the Lord is asked, "What is blocking, or in the way of, the client's noticing?" The work progresses to address what is reported (i.e., fears, vows, anger, beliefs).

Fears are addressed by asking the Lord to "represent them in any way He chooses, behind a protective glass shield." The client reports what they notice on the other side of the glass (e.g., trash, monsters, blackness, shapes, etc.). The practitioner asks the Lord for His solution of the representation (e.g., trash swept away, monsters eradicated, light shining down and replacing the blackness, shapes erased, etc.), which the client then reports. The client is then asked if they are willing to allow the Lord to do, or act on, the solution. Depending on the willingness, either the client's resistance is addressed, or the client reports the Lord's response. Processing continues with what client notices next.

Vows have a unique role in belief systems. Usually, they are identified by the words "never" and "always" in a belief statement (e.g., "I will always fail," "I never can win"). Anderson's (2004, 2019) method of renunciation of the vow is utilized in this event. A verbal statement is made: "Lord, Jesus, I renounce the vow or belief that 'I will always/never ___.' I break it, Lord, and give it to You to do with as You will." The Lord is then asked for His response. The client reports what they notice. Processing continues.

Permission is a unique concept. Sometimes a client is terribly snarled in the tangle of their emotions and beliefs from their life experiences. Adult survivors who experienced preverbal childhood trauma can sometimes experience this level of entanglement where there is no cognitive ability available for them to get free without Divine help. *Permission* is giving God permission to do what is necessary to help untangle the individual from impossible knots of unreasoning fears in order to help address unmet, often unknown, preverbal needs. It is an intentional override of the client's free will (Stapleton, 1976) and an intentional decision to trust God, in order to allow the Lord to have His way. It allows God to do what the client may not be willing to do if left to their own devices due to paralyzing fears or other overwhelming sensations. *Permission* helps make a way where there seems to be no way (*New International Bible*, 1978/2011, Isaiah 43:15-16).

Anger and *Grief*/*Sadness* are emotions that are often held on to because of underlying beliefs (Smith & Smith, 2019a). Through God's representation of the *Anger* or *Grief/Sadness* (image, memory, sensation, etc.), the question for the client is: "If the (representation) wasn't there, what would happen?" The answer reveals the *belief* anchoring the focus emotion. Process the *belief* (see below), repeating as necessary until all the reasons (*beliefs*) to retain the focus emotion are addressed.

A *Memory/Representation* can be the original event that created the *belief* or a conceptual representation of such an event. The client can be asked questions like: "What feels true because of what happened in the memory?" "What feels true because of the conceptual representation?" or "Because that happened, it means….?" The client's answers will help identify the *belief(s)*.

Once the *belief* is identified (i.e., in EMDR the *negative cognition*; in TPM the *lie*), the practitioner requests God's Perspective or Truth about it (Smith & Smith, 2019b). The client then reports the Lord's response. At this point, it is not uncommon for the client to report various experiential reactions (Garzon & Burkett, 2002) to the resulting shift in emotions and understanding regarding the *belief*. The ability to easily extend forgiveness is often expressed (Smith & Smith, 2019a), although *choosing to forgive* through an act of the will is an available option if necessary (Anderson, 2004, 2019). According to Agnes Sanford (1947/1972), "Forgiveness and healing are one" (p. 60).

Depending on the client and the focus of the work, the intervention could be brought to a close at this juncture. A second option, if there is sufficient time, is to revisit the original focus and check to see if any residual emotions or beliefs still need to be addressed. If so, the new focus is processed utilizing the same scaffold (*emotion*, *memory/representation*, *belief*, or any resistance) in order to request the Lord's Perspective and Truth. Repeating as necessary and as time allows.

Research

Research on Christian Inner Healing Prayer (CIHP) has focused on Francis MacNutt's model (Boelens et al., 2009, 2012; Baldwin et al., 2016; Matthews et al., 2000), Immanuel Prayer (Hattendorf, 2014; Wilder et al, 2020), SOZO (Monroe & Jankowski, 2016; Wattoff, 2015), and Transformation Prayer Ministry (TPM; Botha, 2008; Garzon, 2004, 2008; Garzon &

Poloma, 2003, 2005; Garzon & Tilley, 2009; Ritchey, 2013). Researchers have implemented preliminary (Garzon & Poloma, 2005), descriptive (Garzon & Poloma, 2003; Garzon & Tilly, 2009) and cross sectional (Ritchey, 2013) surveys; single group studies with pre- and post-treatment baselines (Monroe & Jankowski, 2016); a nonrandomized waiting list crossover design model (Matthews et al., 2000); mixed model (Wattoff, 2015); outcome-based case studies (Garzon, 2005, 2008) as well as narrative case studies (Hattendorf, 2014) to add to the body of knowledge and empirical discussion of CIHP.

A significant evidential contribution to the efficacy of CIHP has been provided by Boelens et al. (2009) with their randomized clinical trial on the effects of a CIHP intervention on depression and anxiety. This was their description of the CIHP model:

> The prayers in this study were person-to-person prayers without physical contact. They differ from intercessory prayers in that there is no intercession to God for the healing of depression and/or anxiety but rather they were prayers going back in time asking for God's healing of life stressors combined with prayers of forgiveness. Both of these prayers result in a separation of traumatic memories from their corresponding negative emotions. In addition, various form prayers were utilized where appropriate. (Boelens et al., 2009, p. 379)

Results of the trial indicated significant reduction in depression and anxiety while optimism and spirituality measures increased. Even more significantly, a year later, the levels were maintained (Boelens et al., 2012). Since then, Baldwin et al. (2016) has reproduced the study and results, adding functional magnetic resonance imaging (fMRI) scans pre- and post-prayer intervention to view brain activity. Comparative scan results showed increased activation in the prefrontal cortex after the prayer intervention, which correlated to reductions in depression scores.

Such results are encouraging to CIHP practitioners and professional advocates. However, continued research building a body of evidence regarding CIHP's efficacy is needed (Wilder et al., 2020). Up to now, only a handful of studies have been in a clinical setting (Boelens et al., 2009, 2012; Baldwin et al., 2016; Hattendorf, 2014; Matthews et al., 2000) in that the majority of CIHP studies have focused on lay ministry applications. Clinical studies with a trauma-related focus are even more scarce (Baldwin, 2016). This study investigating the integration of eCIHP with IFS in a clinical setting with adult survivors of ChT will be a contribution to that end.

IFS and CIHP Integrated

IFS and CIHP are complementary methods of intervention. Both use insight to facilitate the work and ask clients to "notice" what is happening within (Schwartz & Sweezy, 2020; Tan, 2011a). Both seek to address the deep wounds of trauma (Anderson, 2021; Tan, 2011a). Both are open to the spiritual (Schwartz, 2021; Wilder et al., 2020). However, for the cultural Christian, the scripture is clear:

> Dear friends, do not believe every spirit, but test the spirits to see whether they are from God, because many false prophets have gone out into the world. This is how you can recognize the Spirit of God: Every spirit that acknowledges that Jesus Christ has come in the flesh is from God, but every spirit that does not acknowledge Jesus is not from God. (*New International Bible*, 1978/2011, 1 John 4:1-3a)

Through the utilization of CIHP and its clear invitation for Jesus to participate and guide the work, an integrated IFS session can accommodate the cultural needs of Christ followers (ACA, 2014; APA, 2017). What follows is a model outline for the religious accommodative integration of IFS with eCIHP.

Integration Model Outline

1. Depending on client preference:
    a. Open with prayer by asking the Lord to guide the work and help focus where to begin.

    OR

    b. Ask client if they know what they want to focus on for the day's session.
2. Once starting point is identified: begin by addressing the Protectors in order to obtain permission to work with the various parts; proceed utilizing IFS protocols.
    a. Insight and Direct access
    b. 6 Fs (Finding, Focusing, Fleshing Out Protectors, Feeling toward, BeFriend, and Exploring Protector's Fears)
    c. Address Polarizations (see Schwartz & Sweezy, 2020, for a description)
3. When working with the various parts, there are opportunities to inquire if inviting the Lord to participate is acceptable to them. When it is, eCIHP is possible.
    a. A part *holding* anger will direct it toward another person, Protector or Exile, who they see as the problem. Asking the Lord to represent, any way He chooses, the anger around the person or part, will aid in the release of anger. Ask what the fears (what feels true?) or beliefs (burdens) are that keep it hanging on to the representation. (If you didn't hold on to the representation [rope, fire, darkness], what would happen?). Ask the Lord for His truth and perspective. Listen for His response. Repeat as many times as necessary to unburden.
    b. Sadness is another emotion that is held onto due to fears or beliefs (burdens). It can use same process as anger above.

4. When working with burdened parts (exiles or protectors), seeking God's truth or solution through eCIHP provides means for parts to unburden from seemingly impossibly entangled historical moments (Double binds, deep emotional wounds, intractable beliefs). Vows and fears are common.
    a. Seeking *permission* to allow the Lord to do what is necessary to help the part (or system) heal is helpful with particularly stuck places (such as with preverbal and somatic parts).
5. Once the part is able to unburden, it is appropriate to ask the Lord for any attributes or blessings He may have for the part now that it is unencumbered. (Frequently the Fruits of the Spirit are mentioned, or a sense of warm sunshine, or overwhelming peace, or the simply the experience of feeling lighter is reported.)
6. Integrate changes. (What does the part want to do? Where does it want to be?)
7. Checking in with the Protectors that made room for the work follows. Often, they are unburdened along with the Exile, and it is appropriate to see if the Lord has any attributes or blessing for them as well. It is not uncommon for Protectors to rest after such interventions.
8. Check in if all parts are ok. (Anyone upset with what we've done today?)
9. Once the work is complete, the client is asked to be intentional in checking back with the various parts to promote strengthening of the neural pathways and the new roles of the parts.
10. Closing with a prayer of appreciation for the work accomplished and for continued healing for the client completes the session.

Summary

This literature review was built on the conceptual framework of cultural accommodation of therapeutic interventions in a clinical setting (ACA, 2014; APA, 2017). IFS is an empirical psychospiritual model of therapy that is open to all spirituality (Schwartz & Falconer, 2017).

However, Christians are called to "test the spirits" (*New International Bible*, 1978/2011, 1 John 4:1). Multiple efforts have attempted to integrate Christianity with IFS for cultural accommodation (Cook & Miller, 2018; Harris, 2002; Riemersma, 2020; Steege, 2010).

The related literature briefly introduced childhood trauma, complex trauma, and touched on the diagnostic comorbidity of anxiety and depression in adult survivors. Childhood trauma and its effect on a survivor's spirituality was introduced. God was explored as an agent of change as was Hope and Forgiveness. The constructs of Self access, Self leadership, Self qualities, love of self, and love of God were explored as possible instruments of, as well as potential indicators and evidence of, positive change. The IFS model was presented, followed by a brief review of published Christian applications with IFS. CIHP was introduced, an integrated model of IFS and eCIHP was described and an outline presented, followed by the chapter summary.

It has been suggested the psychospiritual needs of Christian clients necessitates the development of clinically researched Christ-centered therapies (ACA, 2014; APA, 2017; Wilder et al., 2020; Worthington et al., 2013). Researchers have noted that various CIHP techniques are analogous to those of clinical psychotherapies of experiential and psychodynamic extract, with the critical difference of the identified change agent being God (i.e., Christ, Holy Spirit; Garzon et al., 2009). It has been recommended for clinical researchers to make CIHP the focus of "a major program of emic research" (Wilder et al., 2020, p. 51). This project engages that recommendation and will contribute to the body of research and the ongoing empirical dialogue of CIHP as a potentially valid and viable method of contemporary clinical psychotherapy.

Chapter Three: Methods

Overview

This chapter presents the research project's methods. It begins with an introductory description of the investigative design, followed by the research questions and the subsequent hypotheses. The participants and setting are then presented, with the criteria for inclusion or exclusion outlined. The academic qualifications of the participating clinical therapist are listed, including trainings in the therapeutic models. Each of the instruments utilized in the project are then described and their credentials presented. The procedures are explained as to how the intervention was set up and investigated. The chapter wraps up with an analysis of the data and a final summary.

Design

This research study is a quasi-experimental design utilizing a N of 1 time-series trial on four single-subject clinical participants identifying as cultural Christians with childhood trauma histories to explore the efficacy of Internal Family Systems with Christian Inner Healing Prayer accommodation on the trauma symptoms of posttraumatic stress, anxiety, depression, and on internal and spiritual relations. Multiple base-line measures were documented of the clients' trauma symptoms (depression and anxiety), their access to Self (as defined by IFS), as well as love of God and love of self (as defined by the TSOS) prior to the 8-week intervention series. As a trans-diagnostic approach over the course of eight IFS/eCIHP sessions, weekly measurements prior to each therapy session and multiple post-trial assessments document the effectiveness of the intervention and the potential new baseline for the client(s). Additionally, the PCL-5 to measure post-traumatic stress; the IFS Self subscales for Self leadership, and Self qualities; and

the individual measures for Hope and Forgiveness were taken one time prior and one time post the eight-session intervention for a pre-post comparison.

Research Questions

RQ1: Does Internal Family Systems (IFS) with eclectic Christian Inner Healing Prayer (eCIHP) religious accommodation correlate with a reduction the trauma symptoms of *post-traumatic stress*, *anxiety*, and *depression* in self-identified cultural Christian clients with childhood trauma histories?

RQ2: Does the use of IFS with eCIHP correlate with an increase of *Self access, Self leadership*, and *Self qualities,* as defined by IFS Self Scale, for self-identified cultural Christian clients with childhood trauma histories?

RQ3: Does the use of IFS with eCIHP correlate with an increase of *love of self* and *love of God,* as defined by the Theistic Spiritual Outcome Survey (TSOS), for self-identified cultural Christian clients with childhood trauma histories?

RQ4: Does the use of IFS with eCIHP correlate with an increase of *forgiveness* and of *hope,* as defined by the Heartland Forgiveness Scale (HFS) and Herth Hope Index (HHI) measures, for self-identified cultural Christian clients with childhood trauma histories?

Alternative Hypotheses

Ha1: IFS and eCIHP treatment will correlate with a reduction in *post-traumatic stress, anxiety,* and *depression* symptoms as measured by the PTSD Check List – 5 (PCL-5), Overall Anxiety Severity and Impairment Scale (OASIS), and Overall Depression Severity and Impairment Scale (ODSIS).

Ha2: IFS and eCIHP treatment will correlate with an increase of *Self access, Self leadership,* and *Self qualities* as measured by the IFS Self scale and its Self Leadership and Self Qualities subscales.

Ha3: IFS and eCIHP treatment will correlate with an increase in *love of self* and *love of God* as measured by the Theistic Spiritual Outcome Survey (TSOS) Love of Self and Love of God subscales.

Ha4: IFS and eCIHP treatment will correlate with an increase in *forgiveness* and in *hope* as measured by the Heartland Forgiveness Scale (HFS) and Herth Hope Index (HHI) scales.

Participants and Setting

The participants of this study are adults identifying as cultural Christians with historical trauma seeking clinical mental-health intervention. Candidates of this convenience sample were invited to fill out a screening measures application at a small private-practice mental health clinic located in the southcentral region of the United States (Warner, 2013). The practice was established in 2014 and works with referred individuals with trauma histories and related trauma-based diagnoses. Five individuals meeting all qualifying criteria were selected from the candidate pool of incoming new clients. Participant demographics were documented once volunteers were identified, and they committed to the study by signing consent forms.

Inclusion and Exclusion Criteria

For inclusion, participants met the following criteria: Participants must be 18 or older, identify as cultural Christians, meet trauma screening parameters, able to commit to attending all eight weeks of the intervention as well as participating in pretreatment and post-treatment baselines, weekly measures, and be able to sign the consent forms. Trauma screening parameters are the following: a least one qualifying event from the LEC-5 (either experienced or witnessed),

scoring a least a 4 on the ACES and a minimum of 15 on the Duke University Religious Index (DUREL). Individuals reporting current suicidal intention or plan, active drug or alcohol abuse, use of a current antipsychotic or mood stabilizer prescription, or historical diagnosis of mania or psychosis were excluded from study. Additionally, applicants must not have had previous IFS therapy or CHIP intervention experience.

Therapist Training and Qualifications

The IFS/eCIHP sessions were facilitated by a state Licensed Professional Counselor (LPC) who is also a systems-trained, Licensed Marriage and Family Therapist (LMFT). A non-denominational cultural Christian since 1990, the facilitator has 20-years practical experience with CIHP as both a recipient and practitioner. Initially trained in TPM (Transformation Prayer, then known as Theophostics) in 2002, retrained with the 2007 version, and current with the latest revisions (Smith & Smith, 2019a, 2019b), the practitioner practices eCIHP as outlined in Chapter 2. After introduction to Internal Family Systems in 2017, they participated in the following IFS trainings: Level 1 (2018), Great Lakes Retreat (2019), Deep Exiles Retreat with Dick Schwartz (2020), Level 2 (2020), Level 3 (2021), was a Program Assistant at a Level 1 training in 2021, and was IFS certified in 2022. Currently pursuing a doctorate in Traumatology.

Instrumentation

Assessment Form/Application

An initial assessment/application form was presented to select new clients to determine potential qualification for participation in the study. See Appendix B.

Demographic Questionnaire

As part of the client written consent of participation, a demographic questionnaire was included to obtain basic points of information such as age, sex, ethnicity, and religious affiliation. See Appendix C.

Adverse Childhood Experiences Questionnaire – Amended Version (ACE-Q)

The Adverse Childhood Experiences Questionnaire (ACE) – Amended Version (Tranter et al, 2021; Dube, 2020; Dube et al., 2003; Felitti et al., 1998, Petruccelli et al., 2019) is a 10-category survey designed to measure childhood exposure to traumatic events and correlate to subsequent adult health and behavior outcomes. Questions are answered with a "yes" = 1 or "no" = 0 and are tallied upon completion for a categorical score between 0 and 10. Individuals with high ACE scores (4 or more) are more likely later in life to experience significant mental health issues (e.g., anxiety, depression, PTSD; Sheffler et al., 2020). For participation, a minimal score of 4 or more was required for this study. This measurement is freely available for public access and use for research from PsycTESTS. See Appendix D.

Life Events Checklist for DSM-5 (LEC-5)

The LEC-5 is an instrument designed to identify a client's trauma exposure through various event scenarios. Participants respond to 17 event statements with six possible nominal responses: "Happened to me; Witnessed it; Learned about it; Part of my job; Not sure; and Doesn't apply" (Weathers et al., 2013a). Psychometric properties of the LEC-5 are adequate as an independent assessment of traumatic exposure (Weathers et al., 2013a). There is no scoring as the checklist is an information gathering instrument frequently utilized in client assessment with other measurements. A qualifying event of "experienced" or "witnessed" is a participation

inclusion requirement. The checklist is freely available at the National Center for PTSD. See Appendix E.

Duke University Religious Index (DUREL)

The Duke University Religious Index (DUREL; Koenig & Büssing, 2010; Koenig et al., 1997) is a 5-item instrument designed to be brief and comprehensive in order to measure religious involvement. Three dimensions of religiosity are assessed: organized religious activity (ORA), non-organized religious activity (NORA), and intrinsic (or subjective) religiosity (IR; Koenig & Büssing, 2010). The first subscale measures public attendance in organized religious activities (ORA) on a 6-point Likert scale with "1 = Never; 2 = Once a year or less; 3 = A few times a year; 4 = A few times a month; 5 = Once a week; and 6 = More than once/week." The NORA question asks about private religious activities (bible reading, prayer, etc.) with a six-point Likert scale of "1 = Rarely or never; 2 = A few times a month; 3 = Once a week; 4 = Two or more times/week; 5 = Daily; and 6 = More than once a day." The three IR subscale questions on belief, experience, and personal commitment are rated on a five-point Likert scale with "1 = Definitely *not* true; 2 = Tends *not* to be true; 3 = Unsure; 4 = Tends to be true; and 5 = Definitely true of me." The DUREL scale has a high internal consistency of .78 to .91 with a test-retest reliability score of .91. Scoring is based on each subscale; however, summing the three subscales together is not recommended. Nonetheless, as a screening measure, an overall score of 15 was required for participation in the study. The DUREL has been translated into over 18 languages and was rated the fourth most utilized religious measure worldwide from 2011 to 2016 (Koenig, 2018). The DUREL is available for use in studies and research with citation at PsycTESTS. Written permission was sought and obtained from Dr. Koenig for the study. See Appendix F.

Consent for Treatment

Prior to participation, the purpose of the research study was outlined in a consent form. This consent form was in addition to the clinic's standard consent for services contract. Confidentiality, types of information gathered, risks and benefits, as well as the right to quit the study at any time, were detailed in the document. Informed consent was reviewed in the first session to answer any questions and provide clarity as needed. A signature was required for participation. See Appendix G.

PTSD Checklist for DSM-5 (PCL-5)

The PCL-5 (Weathers et al., 2013b) is a 20-item self-report assessment of the *Diagnostic and Statistical Manual of Mental Disorders'* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) symptoms of Post-Traumatic Stress Disorder (PTSD). A 5-point Likert scale (0 = "not at all" to 4 = "extremely") rates the severity of the experienced symptom statements. Prefaced with "In the past month, how much were you bothered by," symptom statements examples are: "Repeated, disturbing, and unwanted memories of the stressful experience?" and "Loss of interest in activities that you used to enjoy?" (Weathers et al., 2013b). The PCL-5 can be used to monitor symptom change (5 points = minimal threshold response; 10 points = clinically meaningful) during and after treatment, as well as screen for PTSD (31-33 and above on PCL-5; U.S. Department of Veterans Affairs, 2021). Total scoring of the 20-items can range from 0 to 80 and individual item scorings of 2 or higher indicate an endorsed symptom for the *DSM-5* criterion of PTSD (U.S. Department of Veterans Affairs, 2021). The PCL-5 demonstrates solid internal consistency ($\alpha = .95$), test-retest reliability ($r = .82$), with convergent ($rs = .74$ to $.85$) and discriminant ($rs = .31$ to $.60$) validity in trauma-exposed college students (Blevins et al.,

2015). The checklist is freely available at the U.S. Department of Veterans Affairs. See Appendix H.

Internal Family Systems (IFS) Self Scale

The Internal Family Systems (IFS) Self scale was developed by DeLand et al. (2006) to measure an individual's access to Self as conceptualized by the IFS model (Schwartz, 1995). It has been utilized to study depression (Martin, 2014) and has demonstrated associations between Self-leadership, mental health issues, and relationship quality in adults (Fitzgerald, 2022). Two factors are measured: Self-Qualities, evidencing the experiential aspect of Self (i.e., "I feel energetic and joyful") and Self-Leadership, substantiating the functional aspect of Self (i.e., "I feel able to comfort myself when something bad happens" (DeLand et al., 2006). Utilizing a 5-point Likert scale (1 = Never/Almost Never; 2 = Seldom; 3 = Sometimes; 4 = Often, 5 =Always/Almost Always), participants are asked to rate the frequency of experience on each statement. The 25-item scale has internal consistency of (α = .97) with item-to-total correlations range from .58 to .86 (DeLand et al., 2006). A short 9-item scale demonstrates high correlation with the 25-item scale (r = .98, $p < .000$, 1-tailed) making them virtually interchangeable (DeLand et al., 2006). The IFS Scale is available gratis to university-sponsored research projects via approved application from Lia DeLand (*liadeland5@gmail.com*). See Appendix I.

Overall Anxiety Severity and Impairment Scale (OASIS)

The Overall Anxiety Severity and Impairment Scale (OASIS) was designed to meet the need for a brief assessment for a broad spectrum of anxiety disorders (even multiple disorders) while simultaneously gauging the severity and functional impairment experienced from anxiety (Norman et al., 2006). OASIS is a brief, self-report, continuous measure instrument of five questions all reflecting on the past week:

Q1. “In the past week, how often have you felt anxious?” (frequency)

Q2. “…When you have felt anxious, how intense or severe was your anxiety?” (intensity)

Q3. “…How often did you avoid situations, places, objects, or activities because of anxiety or fear?” (avoidance)

Q4. “…How much did your anxiety interfere with your ability to do the things you needed to do at work, at school, or at home?” (interference/function)

Q5. “…How much has anxiety interfered with your social life and relationships?” (interference/relationally).

A 5-point Likert rating scale scores from 0 to 4 with a total summed score ranging from 0 to 20. Higher values indicate more functional impairment and severity due to anxiety symptoms (Norman et al., 2006). Questions #1 and #3: 0 = No anxiety/or None; 1 = Infrequent; 2 = Occasional; 3 = Frequent; and 4 = Constant/All the Time. For questions #2, #4, and #5: 0 = *None*; 1= *Mild*; 2 = *Moderate*; 3 = *Severe*; and 4 = *Extreme*. The OASIS has unfailingly demonstrated a one-factor structure with strong internal consistency with Cronbach’s $\alpha = .80$ to .94, (Hermans et al., 2015; Ito et al., 2014; Norman et al., 2006; Osma et al., 2019), very good test-retest reliability, and good convergent and divergent validity with every replication of research analysis (Bragdon et al., 2016; Campbell-Sills et al., 2009; Gonzalez-Robles et al., 2018; Hermans et al., 2015; Ito et al., 2015; Moore et al., 2015; Norman et al., 2006; Norman et al., 2011; Norman et al., 2013). Utilized to assess treatment progress OASIS has proven useful and demonstrated sensitivity to change (Barlow et al., 2017; Norman et al., 2013; Osma et al., 2015). A reliable change index of 4 points indicates reliable improvement (if decreased) or reliable deterioration (if increased) over the course of treatment (Moore et al., 2015). It is its sensitivity to change and its brevity in assessing anxiety that qualifies the OASIS as a

measurement for this trial. Written permission to use the OASIS was sought and obtained from Dr. Norman. See Appendix J.

Overall Depression Severity and Impairment Scale (ODSIS)

The Overall Depression Severity and Impairment Scale (ODSIS) was designed by Bentley et al. (2014) to replicate the OASIS (Norman et al., 2006). As a result, it is comprised of the same five questions regarding depression with Q3 addressing loss of interest instead of avoidance (Bentley et al., 2014). Likewise, it is scored on a 5-point Likert scale from 0 to 4 with a summed total of 0 to 20. Higher values indicate more functional impairment and severity due to depression symptoms (Bentley et al., 2014). Questions inquire after the previous week's experience with depression:

Q1. "In the past week, how often have you felt depressed?" (frequency)

Q2. "…When you have felt depressed, how intense or severe was your depression?" (intensity)

Q3. "…How often did you have difficulty engaging in or being interested in activities you normally enjoy because of depression?" (loss of interest)

Q4. "…How much did your depression interfere with your ability to do the things you needed to do at work, at school, or at home?" (interference/function)

Q5. "…How much has depression interfered with your social life and relationships?" (interference/relationally).

Questions are measured for Q1 and Q3: 0 = No anxiety/or None; 1 = Infrequent; 2 = Occasional; 3 = Frequent; and 4 = Constant/All the Time. Measurement for questions Q2, Q4, and Q5 are: 0 = *None*; 1= *Mild*; 2 = *Moderate*; 3 = *Severe*; and 4 = *Extreme*. Analysis reports the ODSIS demonstrating a one factor structure with strong internal consistency (Cronbach's $\alpha = .94$) with

excellent reliability and good convergent and discriminate validity (Osma et al., 2019). ODSIS is freely available to non-commercial research and for education purposes at PsycTESTS (Bentley et al., 2014). See Appendix K.

Theistic Spiritual Outcome Survey (TSOS)

The Theistic Spiritual Outcome Survey (TSOS) was developed by Richards et al. (2005) to measure the effects of mental health therapy on client's religiousness and spirituality. Three subscales are measured by assessment statements such as: "I felt there is a spiritual purpose for my life" (Loving God); "I had feelings of love toward others" (Loving Others); and "I felt worthy" (Loving Self; Richards et al., 2005). The 17-item instrument utilizes a 5-point Likert scale to rate the statements (Never = 1, Rarely = 2, Sometimes = 3, Frequently = 4, and Almost Always = 5). Scoring ranges from 5-25 and 6-30 on the subscales, with a total possible score of 17 to 85 for the entire survey. The TSOS has been utilized in studies of eating disordered populations (Richards et al., 2006; Richards et al., 2017); church-based peer-groups (Rogers & Stanford, 2015); and life satisfaction and mental health studies (Jauncey & Strodl, 2018). A clinical population demonstrated a Cronbach alpha reliability of $\alpha = .90$ for the total score of all subscales, with the subscales' reliability: $\alpha = .93$ for Love of God subscale; $\alpha = .71$ for Love of Others subscale, and $\alpha = .77$ for Love of Self subscale (Richards et al., 2005). The survey is freely available for educational and research purposes. Dr. Richards gave permission to publish with citation. See Appendix L.

Heartland Forgiveness Scale (HFS)

The Heartland Forgiveness Scale (HFS) is a rating scale for measuring dispositional forgiveness designed by Thompson et al. (2002). It is an 18-item instrument with three 6-item sub-measures focused on forgiveness of others, self, and situations. Nine items are worded

positively for a forgiveness focus and nine are worded negatively for an unforgiveness focus. A 7-point scale with anchor points of 1 = almost always false of me; 3 = more often false of me; 5 = more often true of me; and 7 = almost always true of me are utilized to score the measure (Thompson & Snyder, 2003). The larger the sum of the scales, the greater the measure of forgiveness. Internal consistency of HFS ranges from .84 to .87 with the other, self, and situations alphas between .71 and .83 (Thompson & Snyder, 2003). Test-retest reliability was .83 for the HSF with the subscales between .72 to .77. The HFS may be used freely for educational purposes and non-commercial research without written permission. See Appendix M.

Herth Hope Index (HHI)

The Herth Hope Index (HHI) is a 12-item instrument designed by Herth (1992) for clinical assessment of hope in adults. It is a brief measurement based on the 30-item Herth Hope Index (HHI; Herth, 1991) and utilizes a 4-item Likert scale with 1 = “Strongly Disagree,” 2 = “Disagree,” 3 = “Agree,” and 4 = “Strongly Agree.” The HHI has an internal consistency of 0.75 to 0.94 with a test-retest reliability ranging from 0.89 to 0.91 (Schrank et al., 2011). The measure produces a single overall score with the option to dimensionally differentiate (a) Inner sense of Temporality and Future, (b) Inner Positive Readiness and Expectancy, and (c) Interconnectedness with Self and Others. Higher scores indicate greater hope. Written permission to use the copyrighted instrument has been obtained from Dr. Kaye Herth. See Appendix N.

Schedule of Measures

Table 1 outlines the schedule of the administration of the measures.

Table 1

Schedule of Measures

Week	Application	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13
Session		Intake	None	1	2	3	4	5	6	7	8	Debrief		
ACE	X													
DUREL	X													
LEC-5	X													
IFS/CIHP				X	X	X	X	X	X	X	X		X	X
IFS Self Scale-9			X	X	X	X	X	X	X	X	X		X	X
OASIS		X	X	X	X	X	X	X	X	X	X	X	X	X
ODSIS		X	X	X	X	X	X	X	X	X	X	X	X	X
TSOS (God, Self: 11)		X	X	X	X	X	X	X	X	X	X	X	X	X
IFS Self Scale-25		X										X		
HFS		X										X		
HHI		X										X		
PCL-5		X										X		
TSOS (Others: 6)		X										X		
Total Items	33	102	30	30	30	30	30	30	30	30	30	102	30	30

Measures giving prior to each session: IFS Self Scale-9, OASIS, ODSIS, TSOS

Note. ACE: Adverse Childhood Expereinces: 10 items; DUREL: Duke Religious Index: 5 items; LEC-5: Life Events Checklist: 17 items; IFS/CIHP: Theraputic Intervention; IFS Self Scale: Internal Family Systems Self Scale: 9 or 25 items; OASIS: Overall Anxiety Severity and Impairment Scale: 5 items; ODSIS: Overall Depression Severity and Impairment Scale: 5 items; TSOS: Theistic Spiritual Outcome Survey: 17 items; HFS: Heartland Forgiveness Survey: 18 items; HHI: Herth Hope Index: 12 items; PCL-5: Checklist for DSM-5: 20 items

Procedures

Upon obtaining committee approval, the research proposal was submitted to the university's Institution Review Board (IRB) application process. Any alterations or refinements

to the proposal, if necessary, were addressed in order to obtain IRB approval. IRB approval was given. Recruitment of participants came from new client intakes at a private practice located in the southcentral region of the USA and/or from individual referrals by the leadership at a local church Celebrate Recovery 12-step program. Candidates were invited to fill out the assessment/application to determine if further screening via the inclusion/exclusion criteria of the ACES, PCL-5, and the LEC-5 was merited (see Appendices D, E, & F).

Once invited to participate in the study, the first of three baseline measures was obtained through the completion of the intake packet and each of the instruments listed above (see Table 1). Participants were allowed to take a short break and to move and stretch if they desired to during the completion of the pre-intervention survey (101 items) to ensure reliable data collection. The second baseline measurement was acquired a week later with the brief 30-item instrument compiled of the OASIS, ODSIS, the IFS Self Scale, and the TSOS subscales Love of God and Love of Self. The third baseline (30-item instrument) was obtained at the time of, just before, the initial intervention session. Likewise, prior to each of the remaining seven intervention sessions of integrated IFS and eCIHP, the brief 30-item instrument was completed via SurveyMonkey.

Sessions were gauged according to client need beginning with an initial 90-minute time slot reserved for the work with the option to maintain it throughout the study or flex to 60-minute sessions as warranted. All sessions were intended for face-to-face interaction in office. However, due to Covid-19, technology assistance via Zoom interface was an option to accommodate quarantine as needed. There was no charge for the psychotherapy sessions to avoid participant exclusion due to financial challenges. Each of the sessions was video recorded and audio recorded as a backup precaution. Recordings were secured on labeled flash-drives, one for each

participant, and stored in accordance with IRB requirements. Written transcripts of the sessions were stored in the participant's clinical file and secured behind two locks in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). During the debriefing session in week 11, participants completed the compiled 30-item instrument along with the PCL-5, IFS Self Scale, HFS, and HHI post-treatment measurements (for a total 101 items). Two more post baseline measures of the 30-item measure were taken: one a week later and the second and final survey on the week following.

Variables

Independent Variables

The independent variables for this study are the treatment condition IFS/eCIHP applied in a series of eight clinical sessions per participant and time.

Dependent Variables

There are 10 dependent variables: PTS, anxiety, depression, access-to-Self, Self leadership, Self qualities, love of self, love of God, forgiveness, and hope. The PTS variable is defined by the PCL-5 scoring. The anxiety variable and the depression variable are defined by the scores of the OASIS and ODSIS, respectively. The Self access, Self leadership, and Self qualities variables are defined by the IFS Self Scale and corresponding subscales. Love of self and love of God variables are defined by the TSOS subscales so titled. Forgiveness is defined by the HFS and hope the HHI. The dependent variables (scored by the OASIS, ODSIS, and TSOS subscales and short IFS scale) were measured every week of the study: at intake and the week prior to treatment (2x), before each of the eight IFS/eCIHP sessions, and then three times (3x) after treatment to determine and record points of change. The PCL-5, IFS Self leadership, IFS

Self qualities, HFS, and HHI were scored once (1x) prior to the intervention and once (1x) after the interventions during the debriefing.

Validity

Internal Validity

Because of the quasi-experimental design of this N of 1 study, a low to moderate amount of internal validity is expected. As a result of not being in a controlled laboratory setting, the possibility of threats to validity must be acknowledged. The treatment protocol of IFS is a model of structured methods that meets clients where they are in a non-directive way. The CIHP element uniformly seeks God's guidance and follows His lead. Both of these elements allow for unique journeys based on the participants' internal parts map. However, to ensure IFS/eCIHP was presented and utilized consistently, the therapist/researcher obtained certification to promote adherence to the IFS model and was the sole provider of the treatment to all participants. To that end, the experimenter, being both therapist and researcher, recognizes personal anticipations for specific results is a potential hazard to validity and must be guarded against. It is expected, due to the acknowledged uncontrolled factors, both causality and the ability to generalize beyond this sample will be limited. Possible correlations between independent and dependent variables will be sought.

External Validity

Overall, the external validity is expected to be higher because the study was conducted in an authentic clinical setting (not a laboratory) with an experienced licensed therapist and with actual mental health clients seeking authentic treatment as the participants. However, the pre-, during, and post-assessments are potential threats to external validity. Participants' responses could affect the treatment findings by trying to report the "desired" results. Additionally,

potential heterogeneity of the participants due to previous therapies or personal meditation practices or conversely, the lack thereof, could affect outcomes. The homogeneity of the sample will increase the validity; however, it also decreases the ability of the results to be generalized to other populations.

Data Analysis

Analysis of the data from this set of N-of-1 cases occurred through the following statical procedures: visual inspection of the graphical data; time series analysis for each participant; and both within subject and between subject analysis. Through the utilization of the ABA time-series design, the treatment phases (pre-treatment baseline, treatment, and post-treatment baseline) provide several points of evaluation before, during, and after the application the IFS/eCIHP intervention for comparison. Descriptive analysis is important due to the limited statistical power of single-subject studies (Heppner et al., 2015). By visually depicting the data, analysis is possible of the pre-baseline condition through the treatment phases to the post-baseline results. Likewise, the within the phases slopes (r^2), the range and standard deviations, the treatment immediacy, and the consistency of patterns of data across the various participants can be examined (Ray, 2015).

Because of the low data size garnered from this N of 1 study design, utilizing parametric analyses would not be appropriate as some researchers consider the requirements not met for inferential statistics (i.e., the assumptions of observations and normal distributions of data; Ray, 2015). Subsequently, the effect size estimations were determined when inspection of the data suggests a positive or negative effect has occurred. This was done through a hand calculation of nonoverlapping data analysis. Because of the presence of potential outliers in the baseline data, the Points Exceeding the Median (PEM) method was utilized (Lenz, 2013). To avoid creating a

Type 2 error from the use of a solitary data point for baseline, three data points were collected to produce the baseline: one at intake, the second a week later with no session, and the third prior to first treatment (Lenz, 2013).

Summary

This chapter presented the methods of the research project. It began with an introductory description of the investigative design, followed by the research questions and the subsequent hypotheses. The participants and setting were presented, with the criteria for inclusion or exclusion outlined. The academic qualifications were listed of the participating clinical therapist, including trainings in the therapeutic models. Each of the instruments utilized in the project were described and their credentials presented. The procedures were then explained as to how the intervention was set up and investigated. The chapter wrapped up with how the analysis of the data will be performed, followed by the summary.

The purpose of this study is to investigate the integration of Internal Family Systems (IFS) and eclectic Christian Inner Healing Prayer (eCIHP) and to begin to address the gap in research regarding their combined effectiveness as a Christian culturally accommodative model to treat posttraumatic stress disorder (PTSD), anxiety, and depression as well as improve internal and spiritual relations for adult survivors of childhood trauma (ChT). The instruments and methods described in this chapter represent an initial step in empirically evaluating this model.

Chapter Four: Findings

Overview

Chapter four begins with a restatement of both the research questions and the alternative hypotheses, followed by a reporting of the descriptive statistics and participant descriptions. The rest of the chapter consists of the study results organized by each of the four research questions and their coordinating alternative hypothesis. Each instrument is unpacked and whether it supported or did not support the pertinent hypothesis is stated. Clinical results are provided in the form of a transcript of the intervention from one of the study sessions, followed by brief participant narrative results. A short summary brings the chapter to a close.

Research Questions

Four research questions guided the study.

RQ1: Does Internal Family Systems (IFS) with eclectic Christian Inner Healing Prayer (eCIHP) integration correlate with a reduction of trauma symptoms of *post-traumatic stress*, *anxiety*, and *depression*, in self-identified cultural Christian clients with childhood trauma histories?

RQ2: Does the use of IFS and eCIHP correlate with an increase of *Self access, Self leadership*, and *Self qualities* as defined by the IFS Self Scale, for self-identified cultural Christian clients with childhood trauma histories?

RQ3: Does the use of IFS and eCIHP correlate with an increase of *love of self* and *love of God,* as defined by the TSOS, for self-identified cultural Christian clients with childhood trauma histories?

RQ4: Does the use of IFS and eCIHP correlate with an increase of *forgiveness* and of *hope,* as defined by the HFS and HHI, for self-identified cultural Christian clients with childhood trauma histories?

Alternative Hypotheses

The alternative hypotheses (Ha0) explored in the study were:

Ha1: IFS and eCIHP treatment will correlate with a reduction in *PTS, anxiety,* and *depression* symptoms as measured by the PCL-5, OASIS, and ODSIS scales.

Ha2: IFS and eCIHP treatment will correlate with an increase of *Self access, Self leadership,* and *Self qualities* as measured by the IFS Self scale and its Self Leadership and Self Qualities subscales.

Ha3: IFS and eCIHP treatment will correlate with an increase in *love of self* and *love of God* as measured by the TSOS Love of Self and Love of God subscales.

Ha4: IFS and eCIHP treatment will correlate with an increase in *forgiveness* and in *hope* as measured by the HFS and HHI scales.

Descriptive Statistics

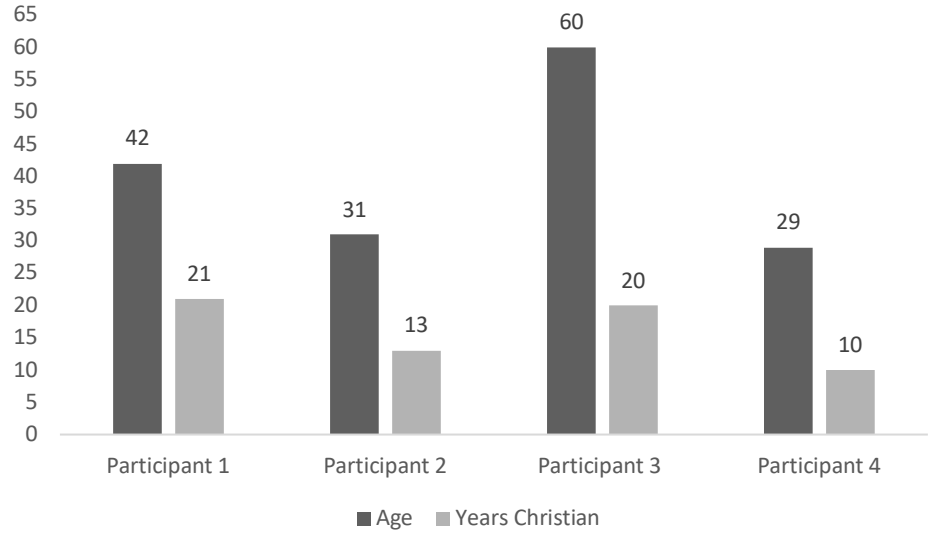
There were five candidates initially identified for participation in this N of 1 time series study. All met the minimum requirements of one qualifying traumatic event from the LEC-5; scoring a 4 on the ACES for adverse childhood experiences; and at least a 15 on the DUREL to measure for religiosity. Although all participants completed the study, one participant was disqualified from inclusion in the results phase after disclosing an overlap of parallel therapy during the study. The confounding of the data rendered it ineligible for the final findings.

Of the remaining four participants, three identified themselves as Caucasian, one identified as Hispanic, and two of the four acknowledged English as a second language (Central

American and Eastern European origins). All listed anxiety, depression, and mood swings as issues they struggled with in their intake paperwork. Of the one man and three women participants in the study, all were married and between the ages of 29 and 60. Their incomes ranged from $0 - $15,000 to $36,000 - $45,000, with three having obtained high school diplomas and one a master's degree. All identified as lifestyle Christians, ranging from 10 to 21 years since their decision to follow Christ (see Figure 1); two identifying as non-denominational, one as Episcopalian, and one as Southern Baptist. None of the participants reported previously experiencing IFS or CIHP therapies.

Figure 1

Participant Age and Years a Christian



Participant Descriptions

The following qualitative descriptions are provided to give context to the findings from this small trauma population (see Table 2 for demographics). Racial, religious, and gender information is intentionally withheld to prevent inadvertent identification. Additionally, some of the information has been altered to maintain anonymity.

Participant 1

The first participant contacted the office seeking help for "excessive anxiety, fear, and worry." At 42 years old, they have been a practicing Christian 21 years. Married 16 years with one child under age 10, Participant 1 is self-employed with a high school education. For the past 5 years, they report struggling with the ongoing debilitating health issues of chronic pain, fatigue, physical weakness, loss of weight, and overall loss of strength, along with other immunocompromised symptoms. Their childhood history includes having experienced extreme poverty, multiple traumatic events, and harsh physical punishment. Participant 1 attended all appointments. At the study's start, they reported experiencing intrusive thoughts, deep hopelessness, and expressed the belief that "God has failed me." Of note: during the last week of the study, they reported a significant event, which is reflected in their post-survey data.

Participant 2

The second participant contacted the office after doing a search online for a therapist who worked with complex trauma. A 31-year-old college graduate with a master's degree, they are employed by a local church. Participant 2 has been a practicing Christian for 13 years. Married for 10 years, they have no children. Seeking symptom relief for depression, ADHD, dissociating, excessive stress, and internal conflict, they report having experienced suicidal thoughts; however, they report having no plans to act on the ideations. Participant 2 reports no previous therapy. Their childhood history consists of parents divorced when they were very young resulting in multiple back and forth living situations with multiple family members throughout childhood. Participant 2 described their mother as "an alcoholic" and their father "had severe untreated mental illness." Additionally, their childhood history includes having experienced extreme poverty, multiple traumatic events, harsh physical punishment, and sexual abuse.

Participant 2 attended all appointments. Note: A significant event occurred in week 7, which is reflected in their time series data.

Participant 3

The third participant was referred to the office by a former client. At 60 years old, they report being a Christian for "20 plus years." A high school graduate, they are employed with a local healthcare provider. They been married 42 years and have two adult children and several grandchildren. Participant 3 contacted the office seeking help for "uncontrollable habits" (eating, alcohol [sober more than a year], sleep medications), depression, guilt, and shame. They reported experiencing suicidal thoughts, but no plans. Childhood history consists early adult responsibilities, multiple traumatic events, multiple stepfathers, harsh physical punishment, and ongoing sexual abuse. They attended all appointments. At the start of the study, they reported intrusive thoughts and feelings of hopelessness and worthlessness. Previous counseling was for grief after parents' deaths. Of note: During weeks 6 and 7, a significant event occurred, which is reflected in their time series data.

Participant 4

The fourth participant was referred to the office by a relative. They called seeking help for PTSD, anxiety, depression, hypervigilance, and rage. Participant 4 is 29 years old and reports being a Christian for 10 years. A high school graduate, they work at a local business. Married five years, they have stepchildren and one birth child who was under two years old at the start of the study. They sought counseling help for excessive anger, "I want to be the best [parent] I can be for my child." Their childhood history included multiple traumatic events and years of childhood sexual abuse by a stepfather. They attended all sessions with a 2-week gap between sessions 4 and 5 due to their child being ill. Previous counseling consisted of a year of

counseling the participant stated was "helpful but stalled out and plateaued." Note: a significant event occurred in week 8, which is reflected in their time series data.

Table 2

All Participant Demographics

Demographics	Participant 1	Participant 2	Participant 3	Participant 4
Age	42	31	60	29
Years Christian	21	13	20+	10
Married	16	10	42	5
Children	1	0	2	3
Education	High School	Masters	High School	High School
Employment	Self Employed	Local Church	Healthcare	Local business
Diagnoses	PTS*/GAD	PTSD/GAD/ MDD	PTSD/GAD/ MDD	PTSD/GAD/ MDD

Note. GAD = generalized anxiety disorder; MDD = major depressive disorder; PTSD = post-traumatic stress disorder; PTS* = post-traumatic stress *no diagnosis.

Results

What follows are study results organized by research question, hypotheses, and the individual instrument utilized to collect the data. Each data analysis is outlined with the results evaluated as supporting or not supporting the pertinent hypothesis. This section addresses the overall group data; the individual participants' data are charted in Appendix O.

Research Question 1

Research Question 1 seeks to investigate a possible correlation of the application of integrated Internal Family Systems (IFS) and eclectic Christian Inner Healing Prayer (eCIHP) with a reduction of trauma symptoms of *post-traumatic stress (PTS)*, *anxiety*, and *depression* in Christian clients with trauma histories. To obtain baseline measures of PTS, anxiety, and depression, each participant completed the PTSD Checklist for *DSM-5* (PCL-5), the Overall Anxiety Severity and Impairment Scale (OASIS), and the Overall Depression Severity and

Impairment Scale (ODSIS) surveys at intake. The PCL-5 was administered a second time in the exit survey after the eight-week intervention to measure any change in the participants' experience of PTS. The OASIS and ODSIS were surveyed each week of the study and prior to therapy to quantify and track the ongoing experience of anxiety and depression.

Hypothesis 1

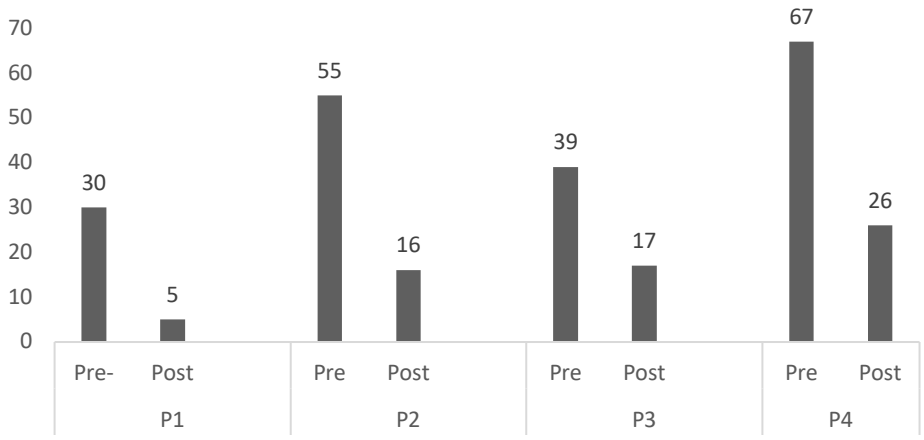
The PCL-5, OASIS, and ODSIS were analyzed to test the hypothesis that integrated IFS and eCIHP treatment will correlate with a reduction in *PTS, anxiety,* and *depression* symptoms in Christian recipients with childhood trauma histories.

PCL-5

The PCL-5 pre-treatment totals for the four participants ranged from a score of 30 to 67 and post-treatment totals spanned scores ranging from 5 to 26 as shown in Figure 2.

Figure 2

PCL-5 Totals



The visual inspection of the bar graph of this measure exhibits the significant decreases in total PTS for all four participants from their baseline scores to their post-treatment scores. The range of scores for the baseline measure was 30-67 with a mean baseline of 47.75 for all

participants. The post-treatment measurement scores ranged from 5-26 with a mean of 16 for all participants. The mean difference in scoring was a decrease of 31.75 (clinically meaningful) for all participants, confirming visual inspection (See Table 3).

Table 3

PTSD Checklist for DSM-5 (PCL-5)

Participant	Pre-Intervention	Post-Intervention	Difference
P1	30	5	25
P2	55	16	39
P3	39	17	22
P4	67	26	41
Combined	47.75	16	31.75

Note: +5 points = minimal threshold response; +10 points = clinically meaningful change (Weathers et al., 2013b).

A 5-point change indicates a minimal threshold response; a 10-point change indicates clinically meaningful change (Weathers et al., 2013b). Scoring for the PCL-5 also includes a screening for a diagnosis of PTSD (according to the *DSM-5* criteria) starting at 31-33 and above. The PCL-5 results from the pre-treatment baseline measure have 3 of the 4 participants scoring over 31 (PTSD diagnosis) and the 4th a close 30 (no PTSD diagnosis). In the post-treatment measure, none of the participants scored over 31 (no PTSD diagnosis).

These results support Hypothesis 1, which states integrated IFS with eCIHP correlates with a decrease in PTS for Christian clients with childhood trauma histories. Both individual scores and the mean score of all participants decreased by more than 10 points (clinically meaningful change). All participants scored less than 30 (does not screen for PTSD) on the PSTD post-treatment screening measure.

OASIS

The OASIS is a measure that gauges the severity and functional impairment experienced by anxiety. Its scores are expected to decrease in correlation with the application of integrated IFS/eCIHP with Christian clients with histories of childhood trauma. All four participants reported experiencing anxiety. The OASIS was scored each week of the study and prior to sessions (during the treatment phase): 3 measures to establish baseline, 7 during the treatment phase, and 3 in the post-treatment phase for a total of 13 scores. To analyze for effect size, the results were compared within subject and between subjects. The baseline scores ranged from 5.00 to 13.67 with a mean baseline of 9.42 for all participants combined, a standard deviation (*SD*) of 0.53, and a standard error of the mean (*SEM*) of 0.31. The mean of the individual coefficients of determination (r^2) scores for the treatment phase was 0.45. The treatment scores ranged from 3.00 to 6.43 with a combined mean of 5.18 for all participants, an *SD* 2.36, and a *SEM* of .89. Additional assessment of the effect sizes was implemented through calculations of nonoverlap methods. Specifically, by the Percentage Exceeding the Median (*PEM*) statistic to address the small sets of data being generated by the N of 1 case studies (Lenz, 2013). The PEM scores effect sizes range from 0.00 to 1.00, with 0.00 listed as not effective and 1.00 as very effective. Specifically, PEM scores are rated on a scale with 0.90 and greater indicating very effective treatments, 0.70 to 0.89 are considered moderate effectiveness in treatment, 0.50 to 0.69 minimal effectiveness, and 0.49 or less suggesting the treatment is not effective. The PEM score for the mean of the participants was 0.93 (very effective). Post-treatment mean of all participant scores was a 2.83 decrease from a range of 0.00 to 4.67, a *SD* of 1.09, and *SEM* of 0.63. Table 4 displays the mean scores of each individual participant, the combined mean, *SD*, *SEM*, r^2, and PEM for the OASIS.

Table 4

Overall Anxiety Severity and Impairment Scale (OASIS)

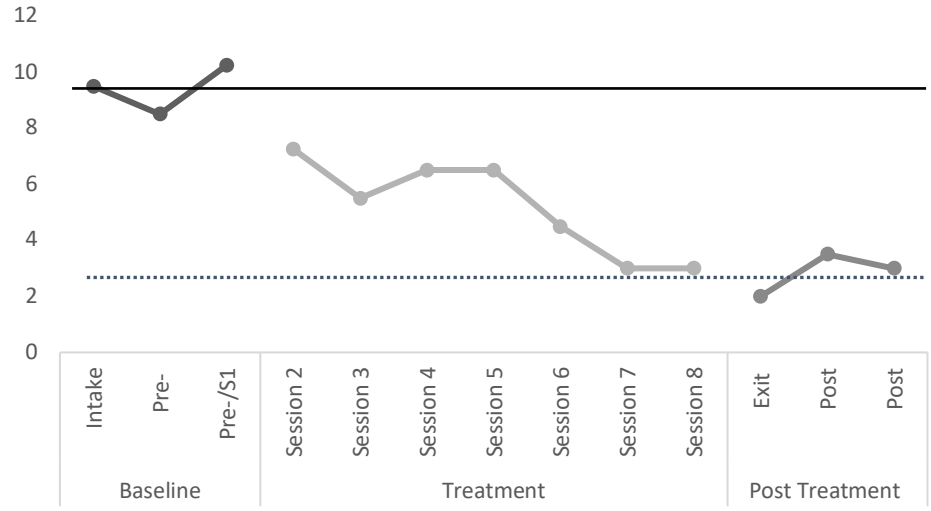
Participant	Baseline			Treatment					Post-Treatment		
	Mean	*SD*	*SEM*	Mean	*SD*	*SEM*	r^2	PEM	Mean	*SD*	*SEM*
P1	5.00	0.00	0.00	3.00	1.41	0.53	0.15	0.86	4.00	2.65	1.53
P2	11.67	0.33	0.19	6.43	2.37	0.90	0.51	1.00	4.67	1.15	0.67
P3	7.33	0.33	0.19	4.86	3.34	1.26	0.48	0.86	0.00	0.00	0.00
P4	13.67	1.45	0.84	6.43	2.30	0.87	0.45	1.00	2.67	0.58	0.33
Combined	9.42	0.53	0.31	5.18	2.36	0.89	0.40	0.93	2.83	1.09	0.63

Note: Change index of 4 points indicates reliable improvement (if decreased) or reliable deterioration (if increased; Moore et al., 2015). *SD* = Standard Deviation; *SEM* = Standard Error of the Mean; r^2 = Coefficient of Determination; PEM = Points Exceeding the Median. PEM Scores: 0.90 and greater = very effective; 0.70 to 0.89 = moderate effectiveness; 0.50 to 0.69 = minimal effectiveness; 0.49 or less = not effective.

Visual inspection of the data (see Figure 3) demonstrates a decrease in scores over time. The difference of the combined mean of the baseline phase (9.42, shown in black line) and the combined mean of the post treatment phase (2.83, shown in dashed line) is a decrease of 7.75, confirming visual inspection. These results support Hypothesis 1 stating the use of IFS with eCIHP correlates to a reduction of anxiety in Christian clients with histories of childhood trauma.

Figure 3

OASIS – Mean of All Participants



ODSIS

The ODSIS, like the OASIS, is designed to measure the severity and level of impairment due to depression. Similarly, its scores are expected to decrease with the utilization of integrated IFS with eCIHP for Christian clients with histories of childhood trauma. At the study's start, three of the four participants reported experiencing depression, while one reported experiencing no depression. The ODSIS was scored each week of the study and prior to session (during the treatment phase): 3 measures to establish baseline, 7 during the treatment phase, and 3 in the post treatment phase for a total of 13 scores. To analyze for effect size, the results were compared within subject and between subjects. The baseline individual mean scores of the three that reported experiencing depression ranged from 8.33 – 13.67 with a combined mean score of 10.89, a *SD* of 1.01, and *SEM* of 0.58. The treatment phase individual mean scores ranged from 4.86 – 6.71 with a combined mean of 6.00, *SD* of 2.31, and *SEM* of 0.87. The mean of the individual r^2 scores for the treatment phase was 0.32. The mean PEM scored for all participants was 0.90 (very effective). The post-treatment phase individual means ranged from 0.67 to 3.33 with a combined mean of 2.25, *SD* of 1.25, and *SEM* of 0.72. See Table 5.

Table 5

Overall Depression Severity and Impairment Scale (ODSIS)

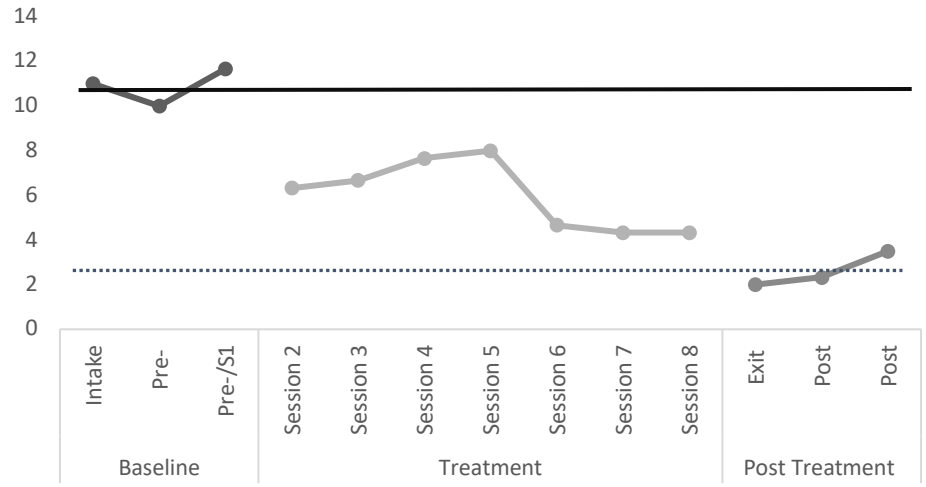
Participant	Baseline			Treatment					Post-Treatment		
	Mean	*SD*	*SEM*	Mean	*SD*	*SEM*	r^2	PEM	Mean	*SD*	*SEM*
P1	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0.67	1.15	0.67
P2	10.67	0.67	0.38	4.86	2.48	0.94	0.43	1.00	3.33	1.15	0.67
P3	8.33	0.33	0.19	6.71	2.93	1.11	0.03	0.71	2.33	1.53	0.88
P4	13.67	2.03	1.17	6.43	1.51	0.57	0.51	1.00	2.67	1.15	0.67
Combined	10.89	1.01	0.58	6.00	2.31	0.87	0.32	0.90	2.25	1.25	0.72

Note: SD = Standard Deviation; *SEM* = Standard Error of the Mean; r^2 = coefficient of determination; PEM = Points Exceeding the Median. PEM Scores: 0.90 and greater = very effective; 0.70 to 0.89 = moderate effectiveness; 0.50 to 0.69 = minimal effectiveness; 0.49 or less = not effective

Visual inspection of the plotted data reveals a decrease over time in the treatment phase (see Figure 4). The difference in the mean baseline (10.89, shown in black line) and the mean of the post-treatment phase (2.25, shown in dashed line) is a decrease of 8.64 confirming visual inspection. These results support Hypothesis 1 stating the use of IFS with eCIHP correlates to a reduction of depression in Christian clients with histories of childhood trauma.

Figure 4

ODSIS - Mean of All Participants



Research Question 2

The second research question seeks to investigate if there is a correlation in the use of integrated IFS and eCIHP with an increase of *Self access* as defined by the IFS Self Scale and its subscales for Christian clients with childhood trauma histories. The IFS Self Survey and the IFS Self subscales measuring Self Leadership and Self Qualities were scored at both intake and exit. By gauging the functional aspect of Self and the experiential aspect of Self, respectively, they provide comparative measures of the availability of the Self through the lenses of both facets.

The more the Self is observed as present through its leadership and its qualities, the more access is available to it (Schwartz & Sweezy, 2020). A short form of the IFS scale was administered each week of the study to quantify and track change in the ongoing experience of one's Self and Self access as a result of the treatment over time of integrated IFS/eCIHP for Christian clients with childhood trauma histories.

Hypothesis 2

Hypothesis 2 states IFS and eCIHP treatment will correlate with an increase of *Self access, Self leadership,* and *Self qualities,* as defined by the IFS Self scale and its Self Leadership and Self Qualities subscales. The data of IFS Self Scale with its subscales of Self Leadership and Self Qualities was obtained at both pre- and post-treatment and the 9-item Self scale data was taken weekly to provide a method of assessment of this hypothesis. The first 3 measures of the 9-item Self scale established the baseline, there were 7 measures during the treatment phase, and 3 in the post treatment phase for a total of 13 scores.

IFS Self Leadership Subscale

The IFS Self Leadership subscale is expected to increase with effective treatment. The baseline scores ranged from 23 to 31, with a combined mean baseline of 28 for all participants. The post-treatment scores ranged from 31 to 39, with a combined mean of 35.75 (see Figure 5).

Visual inspection of the pre- and post-treatment bar graph demonstrates a universal increase in Self Leadership for all four participants. Likewise, comparison of the combined mean of the pre-treatment scores (28) and the post-treatment combined mean (35.75) validates the visual inspection with a 7.75 increase in score for the Self Leadership subscale. See Table 6. These results support Hypothesis 2.

Figure 5

Self Leadership Subscale Totals

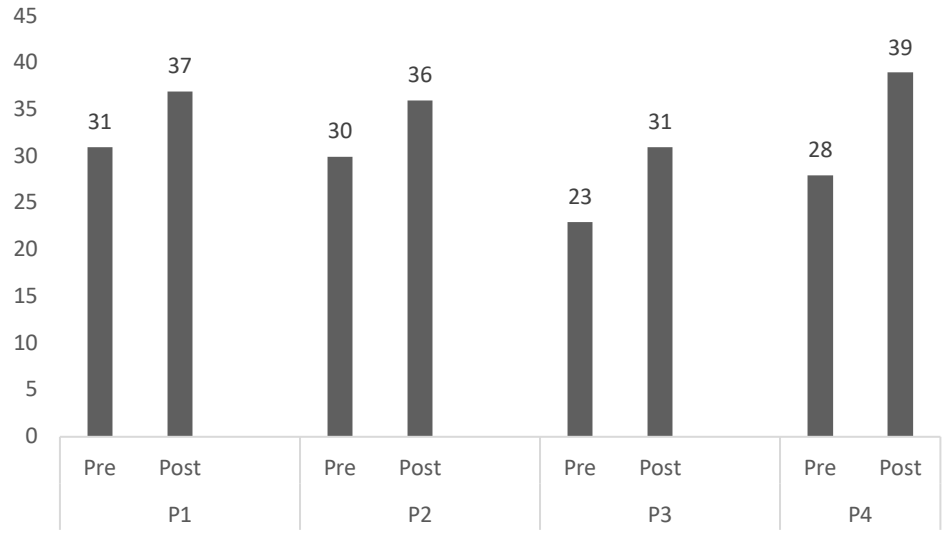


Table 6

IFS Self Scale – Self Leadership

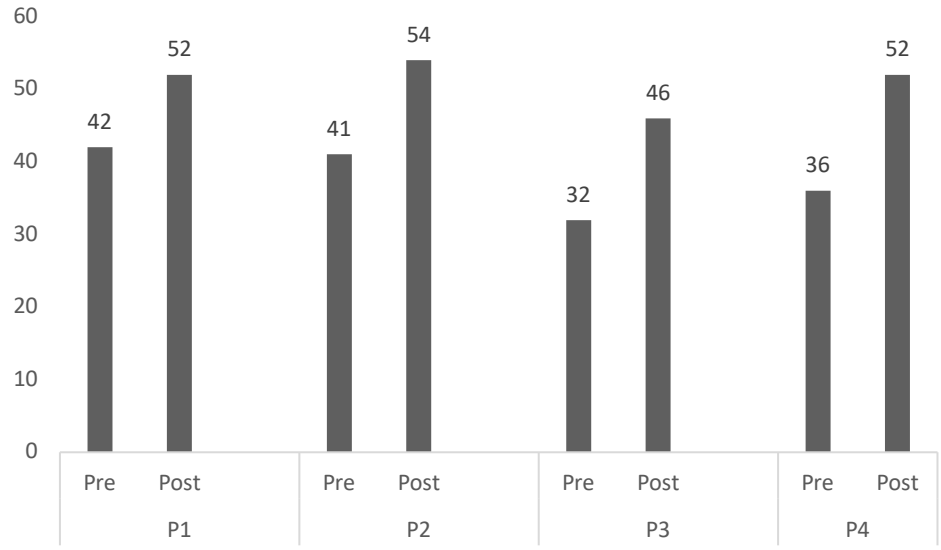
Participant	Pre-Intervention	Post-Intervention	Difference
P1	31	37	6
P2	30	36	6
P3	23	31	8
P4	28	39	11
Combined	28	35.75	7.75

IFS Self Qualities Subscale

Likewise, the IFS Self Qualities Subscale is expected to increase in response to effective treatment. The baseline individual mean scores ranged from 32 – 42, with a combined mean of 37.5 for all participants. The post-treatment individual mean scores ranged from 46 – 54, with a combined mean of 51 for all participants. See Figure 6.

Figure 6

Self Qualities Subscale Totals



Visual inspection of the pre- and post-treatment bar graph validates increases of Self qualities in each of the four participants. The comparison of the combined pre-treatment mean (37.75) with the combined mean of post-treatment (51) confirms a combined mean increase of 13.25, validating visual inspection. See Table 7. These results support Hypothesis 2.

Table 7

IFS Self Scale – Self Qualities

Participant	Pre-Intervention	Post-Intervention	Difference
P1	42	52	10
P2	41	54	13
P3	32	46	14
P4	36	52	16
Combined	37.75	51	13.25

IFS Self Subscale

The IFS Self subscale is expected to increase with effective treatment. The scale was administered each week of the 13 weeks of the study. The first 3 scores comprise the baseline,

the next 7 cover the treatment phase, and the last 3 are post treatment. To analyze for effect size, the results were compared within subject and between subjects (see Table 8).

Table 8

IFS Self – Short Scale

Participant	Baseline			Treatment					Post-Treatment		
	Mean	*SD*	*SEM*	Mean	*SD*	*SEM*	r^2	PEM	Mean	*SD*	*SEM*
P1	27.33	1.67	0.96	29.29	1.25	0.47	0.64	1.00	28.00	5.29	3.06
P2	26.67	0.33	0.19	29.86	2.04	0.77	0.47	1.00	32.00	1.73	1.00
P3	22.33	1.86	1.07	26.43	3.31	1.25	0.49	0.86	32.67	3.51	2.03
P4	27.00	1.73	1.00	37.29	4.79	1.81	0.87	1.00	41.67	4.16	2.40
Combined	25.83	1.40	0.81	30.72	2.85	1.08	0.62	0.96	33.58	3.67	2.12

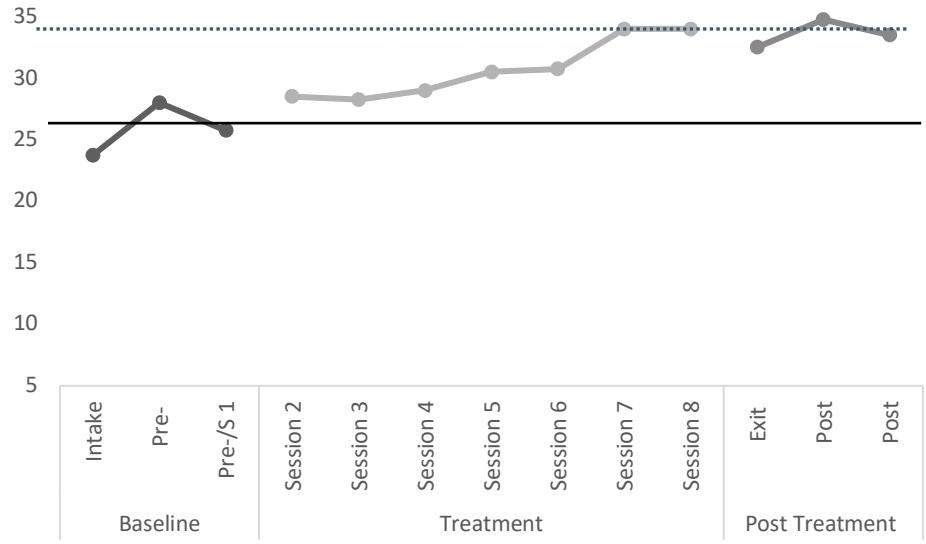
Note: SD = Standard Deviation; *SEM* = Standard Error of the Mean; r^2 = coefficient of determination; PEM = Points Exceeding the Median. PEM Scores: 0.90 and greater = very effective; 0.70 to 0.89 = moderate effectiveness; 0.50 to 0.69 = minimal effectiveness; 0.49 or less = not effective.

The baseline range of individual mean scores was 22.33 – 27.00 with a combined mean of all participants of 25.83, with a *SD* of 1.40, and *SEM* of 0.81. The range of individual mean scores of the treatment phase was 26.43 – 37.29 with a combined mean score of 30.72, with a *SD* of 2.85, and *SEM* of 1.08. The mean of the r^2 was 0.62 in the treatment phase. Effect size determined by utilizing PEM was 0.96 (very effective). The post treatment individual mean scores were from 28.00 – 41.67 with a combined mean of 33.58 for all participants, with a *SD* of 3.67 and a *SEM* of 2.12.

Visual inspection of the graph shows the combined mean increased over time from the baseline to post treatment (see Figure 7). The combined mean difference between baseline (25.83, shown in black line) and the post treatment mean of all participants (33.58, shown in dashed line) is an increase of 7.75, confirming the visual inspection increase. These results support Hypothesis 2.

Figure 7

IFS Self – Mean of All Participants



Research Question 3

Research question 3 seeks to investigate if there is a possible correlation of the application of integrated IFS and eCIHP treatment and an increase of *love toward self* and *love toward God* as defined by the Theistic Spiritual Outcome Survey (TSOS) for self-identified cultural Christian clients with childhood trauma histories. The TSOS subscales identified as Love of Self and Love of God were surveyed each week of the study and prior to therapy (in the treatment phase) to quantify and track the ongoing experience of love toward oneself and love toward God. The first 3 measures established the baseline, there were 7 measures during the treatment phase, and 3 in the post treatment phase for a total of 13 scores.

Hypothesis 3

Integrated IFS and eCIHP treatment will correlate with an increase in *love of self* and *love of God* as measured by the TSOS Love of Self and Love of God subscales.

TSOS – Love of Self

To analyze for effect size, the results were compared within subject and between subjects. The mean individual scores of the baseline ranged from 14.00 – 19.00 with a combined mean of 16.33 for all participants, with a *SD* of 0.75 and *SEM* of 0.43. In the treatment phase, the mean individual scores ranged from 16.29 – 22.43, with a combined mean of 18.97, *SD* of 1.53, and *SEM* of 0.58. The mean of the r^2 was 0.59 in the treatment phase. The PEM measured 0.79 (moderate effectiveness). In the post-treatment phase, the individual means ranged from 18 – 24 with a combined mean of 20.42, the *SD* was 2.30 and the *SEM* was 1.33. See Table 9.

Table 9

Theistic Spiritual Outcome Survey (TSOS) – Love of Self

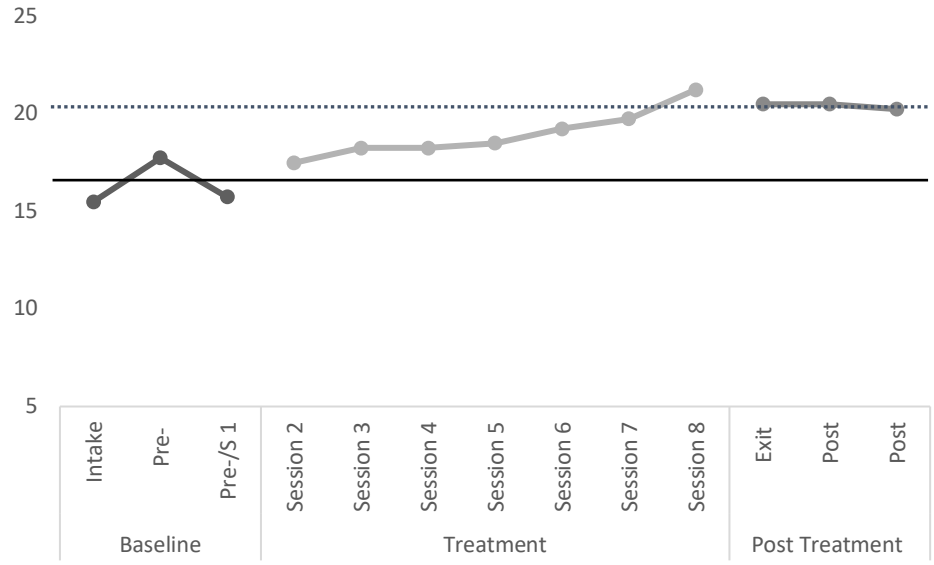
Participant	Baseline			Treatment					Post-Treatment		
	Mean	*SD*	*SEM*	Mean	*SD*	*SEM*	r^2	PEM	Mean	*SD*	*SEM*
P1	19.00	0.00	0.00	19.29	0.49	0.18	0.63	0.29	18.00	2.65	1.53
P2	16.00	0.00	0.00	17.86	1.57	0.59	0.19	0.86	19.33	2.31	1.33
P3	14.00	1.15	0.67	16.29	1.50	0.57	0.68	1.00	20.33	2.52	1.45
P4	16.33	1.86	1.07	22.43	2.57	0.97	0.86	1.00	24.00	1.73	1.00
Combined	16.33	0.75	0.43	18.97	1.53	0.58	0.59	0.79	20.42	2.30	1.33

Note: SD = Standard Deviation; *SEM* = Standard Error of the Mean; r^2 = coefficient of determination; PEM = Points Exceeding the Median. PEM Scores: 0.90 and greater = very effective; 0.70 to 0.89 = moderate effectiveness; 0.50 to 0.69 = minimal effectiveness; 0.49 or less = not effective.

Visual inspection of the plotted data shows an increase of the combined mean of all participants during the treatment phase over time (see Figure 8). The difference between the combined mean baseline (16.33, shown in black line) and the combined mean of the post treatment (20.42, shown in dashed line) is 4.09, validating the visual inspection increase. These results support Hypothesis 3.

Figure 8

TSOS – Self – Mean of All Participants



TSOS - Love of God

To analyze for effect size, the results were compared within subject and between subjects. The mean individual scores of the baseline ranged from 19.33 – 24.33 with a combined mean of 21.25 for all participants, with a *SD* of 1.01, and *SEM* of 0.58. In the treatment phase, the mean individual scores ranged from 21.43 – 24.29, with a combined mean of 23.36, *SD* of 2.10, and *SEM* of 0.79. The combined mean of r^2 for all participants was 0.79 in the treatment phase. The PEM measured 0.64 (minimal effectiveness). In the post-treatment phase, the individual means ranged from 18 – 24 with a combined mean of 20.42, the *SD* was 2.30 and the *SEM* was 1.33. See Table 10.

Visual inspection of the plotted data indicates an increase over time in the combined means of all participants during the treatment phase. See Figure 9. The difference between the combined mean baseline (21.25, shown in black line) and the combined post-treatment mean

(26.00, shown in dashed line) is 4.75, validating the visual inspection increase. These results support Hypothesis 3.

Table 10

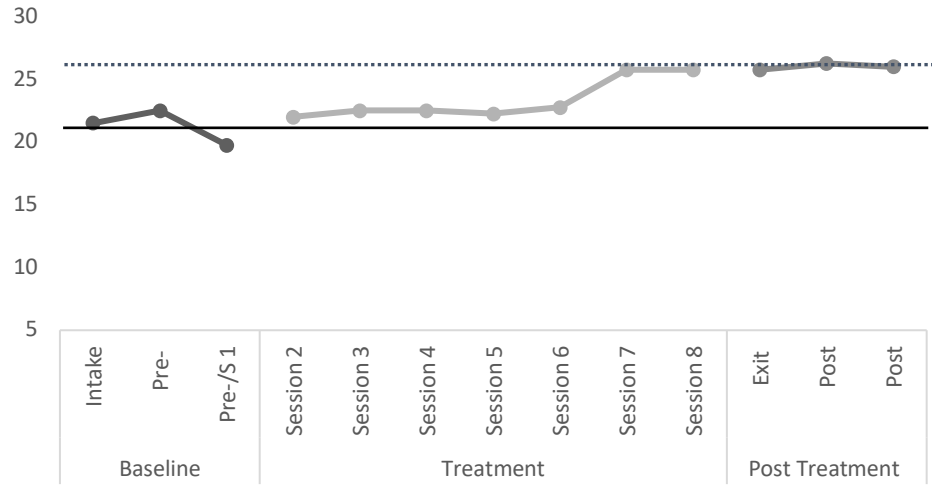
Theistic Spiritual Outcome Survey (TSOS) – Love of God

Participant	Baseline			Treatment					Post-Treatment		
	Mean	*SD*	*SE* Mean	Mean	*SD*	*SE* Mean	r^2	PEM	Mean	*SD*	*SE* Mean
P1	24.33	0.33	0.19	24.00	0.00	0.00	0.00	0.00	23.66	0.58	0.33
P2	22.00	1.53	0.88	24.29	2.21	0.84	0.35	0.86	25.33	2.31	1.33
P3	19.33	1.86	1.07	21.43	2.99	1.13	0.52	0.71	27.67	1.53	0.88
P4	19.33	0.33	0.19	23.71	3.20	1.21	0.42	1.00	27.33	2.08	1.20
Combined	21.25	1.01	0.58	23.36	2.10	0.79	0.32	0.64	26.00	1.62	0.94

Note: SD = Standard Deviation; *SEM* = Standard Error of the Mean; r^2 = coefficient of determination; PEM = Points Exceeding the Median. PEM Scores: 0.90 and greater = very effective; 0.70 to 0.89 = moderate effectiveness; 0.50 to 0.69 = minimal effectiveness; 0.49 or less = not effective.

Figure 9

TSOS – God – Mean of All Participants



Research Question 4

Research question 4 seeks to investigate a possible correlation of the application of integrated IFS and eCIHP with an increase of *forgiveness* and of *hope* as defined by the Heartland Forgiveness Scale (HFS) and Herth Hope Index (HHI) for self-identified cultural

Christian clients with childhood trauma histories. To obtain baseline measures of Forgiveness and of Hope, each participant completed both the HFS and HHI surveys at intake. The measures were administered a second time in the exit survey to measure any change in the participants' experiences of Forgiveness and of Hope after the eight-week intervention.

Hypothesis 4

IFS and eCIHP treatment will correlate with an increase in *forgiveness* and in *hope* as measured by the HFS and HHI scales.

Heartland Forgiveness Scale

Visual inspection of the pre- and post-comparison scores of the Heartland Forgiveness Scale show there is no consensus of results after the 8-session treatment. See Figure 10. Half of the participants maintained or increased their scores and the other half decreased.

Although the comparison of the difference of the mean of all participants' pre-treatment scores and the mean of their post-treatment scores reflect a minute increase of 0.25, it does not validate the visual inspection nor support Hypothesis 4. See Table 11.

Figure 10

Heartland Forgiveness Totals

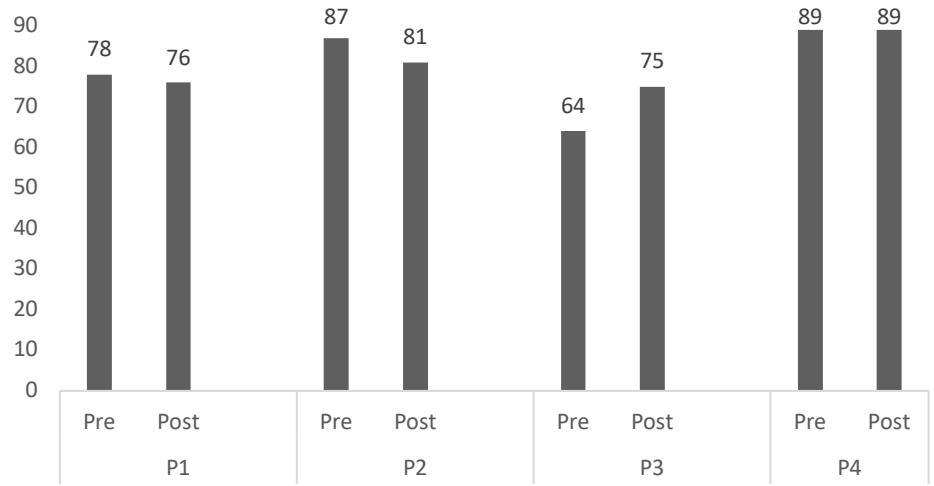


Table 11

Heartland Forgiveness Scale

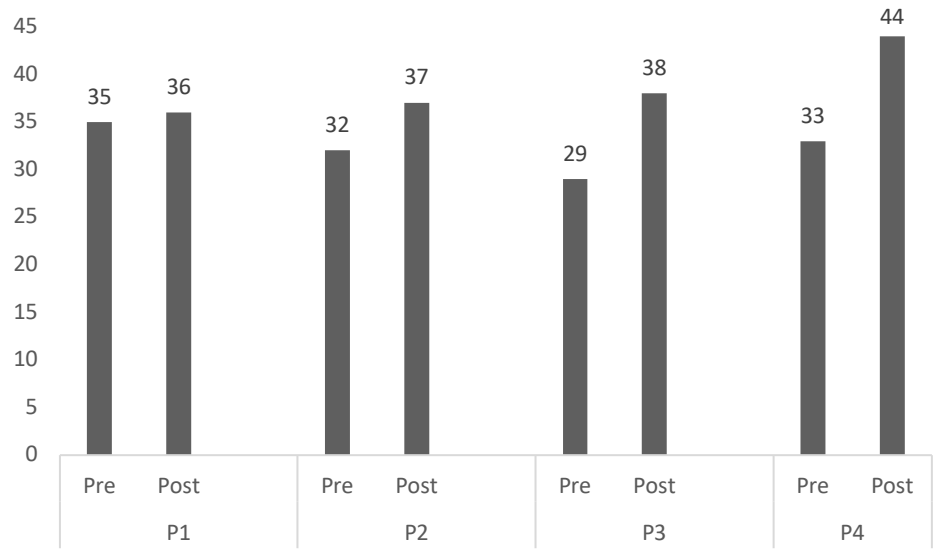
Participant	Pre-Intervention	Post-Intervention	Difference
P1	78	76	-2
P2	87	81	-6
P3	64	75	9
P4	89	89	0
Combined	79.5	80.25	0.25

Herth Hope Index

Visual inspection of the comparison scores of the Herth Hope Index show there is a consensus of results after the 8-week treatment indicating an increase in Hope. See Figure 11.

Figure 11

Herth Hope Totals



Comparing the difference of the mean of the individual baseline scores and the mean of the post-treatment scores generated a 6.5 mean increase in Hope, validating the visual inspection and supporting Hypothesis 4. See Table 12.

Table 12

Herth Hope Index Totals

Participant	Pre-Intervention	Post-Intervention	Difference
P1	35	36	1
P2	32	37	5
P3	29	38	9
P4	33	44	11
Combined	32.25	38.75	6.5

All Measures

For clarity of comparisons between participants, the PEM treatment effect sizes for all participants and the IFS Self, OASIS, ODSIS, TSOS-Love of self, and TSOS-Love of God instruments are compiled in Table 13. Likewise, the pre- and post-descriptives for all participants for the PCL-5, IFS Self Qualities, IFS Self Leadership, Herth Hope Index and Heartland Forgiveness instruments are compiled in Table 14.

Table 13

PEM Treatment Effect Sizes for All Measures

Measure	Participant 1	Participant 2	Participant 3	Participant 4
OASIS	0.86	1.00	0.86	1.00
ODSIS	n/a	1.00	0.71	1.00
IFS Self	1.00	1.00	0.86	1.00
TSOS -Self	0.29	0.86	1.00	1.00
TSOS -God	0.00	0.86	0.71	1.00

Note. OASIS = Overall Anxiety Severity and Impairment Scale; ODSIS = Overall Depression Severity and Impairment Scale; IFS Self = Internal Family Systems Scale; TSOS = Theistic Spiritual Outcome Survey. PEM Scores: 0.90 and greater = very effective; 0.70 to 0.89 = moderate effectiveness; 0.50 to .69 = minimal effectiveness; 0.49 or less = not effective.

Table 14

Pre & Post Descriptives for All Measures

Measure	Participant 1		Participant 2		Participant 3		Participant 4	
DSM-5 Diagnoses	GAD/PTS*		GAD/MDD/ PTSD		GAD/MDD/ PTSD		GAD/MDD/ PTSD	
	Pre	Post	Pre-	Post	Pre-	Post	Pre-	Post
PTSD Checklist-5	30	5	55	16	39	17	67	26
IFS -Self Qualities	42	52	41	54	32	46	36	52
IFS -Self Leadership	31	37	30	36	23	31	28	39
Herth Hope Index	35	36	32	37	29	38	33	44
Heartland Forgiveness	78	76	87	81	64	75	89	89

Note. GAD = generalized anxiety disorder; MDD = major depressive disorder; PTSD = post-traumatic stress disorder; PTS* = post-traumatic stress *no diagnosis.

Model Integration Results

What follows is a portion of a transcript from a session with a participant from the study. The session ran 50 minutes, and the transcript is from a 20-minute section that demonstrates the integration of IFS and CIHP. The transcript was altered in that affirmations and repeated words were removed for clarity.

Therapist: Well, thoughts on any kind of activation or trigger this week? Or just allowing the Lord to lead? Or what do you think?

Client: I think we need to just let the Lord lead. Cuz…. I have NO idea.

Therapist: Absolutely.

Client: I mean, I get triggered… by the littlest thing.

Therapist: Okay. So, we're just going to, however you need to… turn inward, however… if you need your eyes shut… if you need to… whatever you need… [IFS – invitation to turn inside] (pause) [CIHP invitation to Christ] – "Lord Jesus, we are so grateful that we can call upon you. We are so grateful that you are our healer, our protector, our provider, our Savior. And, while I know you're here, you are always welcome in this space. [The client] is willing to invite you on this journey with them. So, Lord, you know where we need to begin. You know where this journey starts, and you know the end from the beginning. So, Lord, you stir up the thoughts, the feelings, the emotions, just the body sensations, whatever it is that needs to be present and to be made aware of. And we will follow you, Lord." (To

client) -And you just notice, [Client's name]…. allow yourself to feel what you need to feel, to think what you need to think…. And just notice. And as you…. focus in, just report what it is that it is you're noticing…. It does not have to make any sense…. You don't have to try to reason it out. Just notice.

Client: <eyes closed> Just remembering when I was young and, uh, we were in Washington state. My mother was married for the third time and her, um, her husband sexually abused me, but what I am remembering is even before that.

Therapist: Okay.

Client: I'm thinking about a… particular memory.

Therapist: Yeah. So, as you focus on that particular memory… you can share, or you don't have to share. -You don't have to go into much detail. But as you think, and you notice that…. as you notice that memory, what stands out?.... (softly). How do you notice?… [CIHP source]

Client: That I'm chubby. [CIHP – Belief]

Therapist: Mm-hmm. <affirmative>. Yeah….. And because "I'm chubby," what feels true?.... -It means that I am…. -fill in the blank…. -First thought.

Client: Sad. [CIHP – Emotion]

Therapist: Mm-hmm. <affirmative>. Yeah.

Client: Trying to fill up something… and it's never full.

Therapist: Yeah… "Fill up something that's never full." Yeah. All right… So, is it okay if we ask the Lord about that? [CIHP – Permission]

Client: Yeah.

Therapist: "Lord Jesus, there she has that moment, that memory… and she's chubby and such sadness, Lord. … That emptiness, that's never full... Lord Jesus, what's your response? What's that little chubby one need there, Lord?" [CIHP – Seeking Truth]

Client: (Extended long pause) Acceptance.

Therapist: And as you hear Him say acceptance, what do you notice? How's that feel for Him to say you needed acceptance?

Client: That I felt very alone… nobody cared. [CIHP – Belief/ IFS – Exiled part]

Therapist: Yeah. So, as you look at that little one… that's alone, nobody cared. How do you feel towards her? Do you get it? [IFS – Feel Toward-6 Fs]

Client: (Nods) Yeah.

Therapist: Yeah... Can you let her know? Can you just extend… that knowledge to her… that you get it? (Long pause) How's she receiving that? [IFS – BeFriend-6 Fs]

Client: (Nods) Cuddled up in my lap. <laughs>

Therapist: <laugh>. Yeah, absolutely!

Client: Like I used to do… "With my mama." [Young Parts voice]

Therapist: Yeah. So, there she is cuddled up in your lap.

Client: Yeah.

Therapist: Yeah…and you just respond to her however you need to. You just cuddle her in. Snuggle her in. (pause) What does she need you to know? What does she want to share with you? As she snuggles in your lap? [IFS – Self to part relationship building]

Client: (Long pause) <shakes head> I don't know. [IFS – Protector part/CIHP blocking belief]

Therapist: It's okay! So, I'm going to ask the Thinker, the one that's trying to reason through "And what would she say? What would she need to show me?" I'm going to ask that Thinker/Reasoner, (who's trying to help so hard!), if it could just step back and let you have this moment with this Young One. Can it do that? (pause) -And if it can't, it's okay. We can talk about it.

Client: (Long pause) <shakes head> I don't know. [IFS – Protector part]

Therapist: <laugh>, So, I'm going to ask the Thinker and the one that "doesn't know" ….

Client: mm-hmm. <affirmative>.

Therapist: Yeah… This is kind of strange, isn't it? [IFS – Direct Access to Protector part] To have a little part of you sitting in your lap, cuddled in… Yeah…. It is very strange. And that's okay. It's okay. And [the parts are] getting to know me. They're getting to learn that… I'm kind of walking them on this path. -And if we're going too fast, we can slow down… What would help that Thinker and the ones that need to know… what would help them feel more safe and secure here? ... What would help them? [IFS – Aligning with Protector part]

Client: This was before I knew Jesus. [IFS – Protector part/CIHP - Belief]

Therapist: Yeah.

Client: And… just… the acceptance of God.

Therapist: Mm-hmm. <affirmative> Yeah…

Client: But then, whenever I asked my mother about why there weren't any more miracles. Why people didn't do miracles anymore… She said that was, uh, back in the Bible days. It didn't happen anymore. [Young Part speaking in Childish voice] [IFS – Protector's Fear/CIHP – Fear or Belief]

Therapist: Anymore. Yeah. And yeah. So, they're wondering about that. Is this a miracle? Is this…? -Mom said that this "wasn't but the in the old days." [IFS -Direct Access with Protector]

Client: <nodding>

Therapist: Yeah. Yeah. That's a logical question. That's a great question! "Lord Jesus, what's, what do they need to know? Are miracles just back in the olden days?" [CIHP – Seeking God's truth for IFS – Protector part]

Client: (Long pause) No.

Therapist: How about that? Are they hearing Him say 'no'? [IFS – Direct Access to Protector(s)]

Client: Yeah.

Therapist: Yeah…. "Thank you, Lord." [CIHP] (Long pause) I don't want your Knowers and your Thinker to go away. We're not asking them to disappear. We just ask them to make a little bit of space. Maybe they can sit next to you there on the couch or by me in this chair over here. -And they are welcome to speak up whenever they need to. Whenever they have a concern or a question. …They are welcome to speak up. 'Cause that was an important question. "Are miracles only in the olden days?" -and they got to hear the Lord answer them… -Where would they be comfortable to be in this space with you? [IFS – Indirect Access - Unblending Protector part(s)]

Client: Just right here. <indicates space to their left>

Therapist: Yeah. Fantastic... I'm so glad they are. Now what are you noticing?

Client: Just that it feels weird… <laughs> to have your personalities all over the place.

Therapist: <laugh>. Yeah. Yeah, it is. But they each get to speak up and be heard. They each get to have the attention that they need and not be ignored or pushed away or pretended like we don't see them <laugh>. Yeah. [IFS – Psychoeducation]

Client: You push them down. -So you don't remember…

Therapist: Yeah, so you don't remember. You don't go there again. Yeah. Makes a lot of sense, doesn't it?... How's that little one doing in your lap? [IFS – Building Self to part relationship]

Client: She's Happy.

Therapist: Yeah. Yeah…. Is there anything she needs to share now?... Anything he/she wants you to know? [IFS invitation to Unburden Exile]

Client: Just that she likes to be held.

Therapist: Yeah. How about that? Absolutely. That's wonderful.

Client: I have a younger sister. (Part in a young childlike voice.)

Therapist: Mm-hmm. <affirmative>.

Client: And she gets all the attention… Cause she's still a baby. [Part Unburdening]

Therapist: Yeah. And you want to be held too, just like little sis. Yeah. That makes so much sense, huh? [IFS -Direct Access] <client nods> Yeah. (pause) –"So, Lord Jesus, what do you have for this one? This Little One that's got a baby sister that's getting all the attention." [CIHP – Seeking God's guidance/solution]

Client: (Long pause) She gets to go and sit in Jesus's lap. <laughs> <tears>

Therapist: How about that? Yeah. How's that feel for her to be able to crawl right up into Jesus' lap?

Client: It's pretty good.

Therapist: Yeah. It's really good. That's wonderful.... Let her soak that up… You know the cool thing about climbing up into Jesus's lap? She doesn't ever have to get down. He will cuddle them for the rest of forever. How's she feel about that?

Client: Pretty Awesome.

Therapist: Yeah. It's really awesome. Yeah.

Client: (extended pause) <client shrugs>

Therapist: Now what are you noticing?

Client: <client opens eyes> Nothing.

Therapist: Okay. Can you still see her in Jesus' lap?

Client: Mm-hmm. <affirmative>.

Therapist: Yeah. How's that feeling?

Client: Good.

Therapist: Yeah. So, I'm going to have you go back to the original memory. What do you notice now in the original memory -when she was chubby, -what do you notice? (Long pause) Uh, is she still there? [CIHP checking the memory]

Client: Yeah.

Therapist: She's still in Jesus' lap or she's still in the memory?

Client: She's still in the memory *and* in Jesus' lap. <laughs>. [IFS – Reporting 2 parts]

Therapist: How about that?

Client: Yeah. Kind of interesting. (pause) She's gonna stay there. [First Part]

Therapist: Yeah. She's going to stay in the memory or in Jesus' lap? [Seeking clarity]

Client: In Jesus' lap. <laugh>. [First Part]

Therapist: Does she want to leave that old memory? [IFS – Indirect Access to Second part in Memory]

Client: Yeah. [Second Part]

Therapist: Yeah. (Pause) So, “Lord, how does she get to leave that old memory? What would that look like for them, Lord?”

Client: (Long pause) <Shakes head> No idea. [Protector part]

Therapist: Yeah. So, I'm going to ask the Thinker and the Reasoners… -I promise them that if they could have figured it out, they would've already. They would've! Because this isn't… this isn't a human question. This is a God question. Are they okay letting the Lord show the way… back to those miracles today? [IFS -Direct Access to Protector part]

Client: I see them [miracles] all over.

Therapist: Yeah. Uh-huh <affirmative>. Yeah. (pause) Are they able to stand back? Do they have a question they need to ask? [IFS – Unblending protectors]

Client: I don’t know, they're just sitting here <laugh>.

Therapist: Ok. And I'm glad they spoke up. Like I said, they're always welcome to speak up. Are they ready to hear God's answer? [IFS – Direct Access permission/CIHP permission for God to guide/His truth]

Client: Yeah.

Therapist: Yeah. –"Lord Jesus, that Little One…. How does she get to leave that old place? What would that look like, Lord?"

Client: (long pause) It's not coming.

Therapist: <laugh> It's not coming. That's okay. That's okay.

Client: I think He just wants to sit and hug her for a while. <laugh>.

Therapist: Yeah. Absolutely. (Pause) So the part of her that's *in* that memory.. [CIHP – shifting to IFS - specifying Second Exiled part]

Client: Mm-hmm. <affirmative>

Therapist: As you focus on the part that's *in* the memory [Second Part], *not* the one that's in His lap [First Part]. -What does *she* want to share? [CIHP & IFS – switching to Second Part in memory – Indirect Access]

Client: (Extended long pause) She just… Doesn't like… She doesn't like the… atmosphere at home.

Therapist: Mm-hmm.<affirmative> Yeah. It doesn't feel right, does it? [IFS – Direct Access]

Client: <shakes head> It's not right.

Therapist: Yeah. Can you let her know that you get that? How you understand… [IFS – beFriending part -6Fs]

Client: (pause) And that she's not guilty cause of what he [stepfather] does. [IFS – Client Updating part]

Therapist: No. How about that?... (pause) So, is there any reason why she *has to* stay there? Ask her. Is there a reason why she's stuck there?

Client: (extended long pause conferring with Second Exiled part) I've never let her out.

Therapist: Ah. Would she be interested in being let out?

Client: I've no idea. <laugh> [IFS Protector part]

Therapist: <laugh>. Yeah. Understand. So, we're going to ask the one to step back again and we can ask her directly. Does she want to stay there? [IFS – Unblending/Direct Access]

Client: (long pause) No. She's gonna go with Jesus.

Therapist: Yeah. She wants to go with Jesus, too.

Client: Yeah.

Therapist: Are you good with her going with Jesus, too?

Client: Yes.

Therapist: Yeah. –"Lord, does she ever have to go back there ever again… about that? [CIHP] <shakes head no> -So, Lord, what is she going to share with you? What does she get to leave behind?" [IFS – Unburdening with CIHP – Christ leading]

Client: Sadness and the… Aggravation.

Therapist: Mm-hmm. <affirmative>. Yeah. All that negativity. All that yuck.

Client: Yeah.

Therapist: "Lord… what do you have for her? What do you want to give to her? Now that she leaves all that sadness and negativity behind." [IFS invitation for positive attributes/CIHP – seeking Christ's blessings/gifts of the Spirit]

Client: Peace.

Therapist: Yeah. Is she good? Receiving that peace? <client nods> Yeah. Soak it up. (long pause) Keep soaking it up. Keep noticing... (Extended long pause) Now what's happening?

Client: She's going with Him. <tears>

Therapist: Yeah.

Client: So, she'll be living my heart, too. <laugh>.

Therapist: Yeah. How about that? That feels good to know. She's going to be in your heart there with Him. [IFS – Retrieval/CIHP – Healing of Memory]

Client: Yep.

Therapist: Yeah.

Client: Okay. Sorry. <mopping up tears and blowing nose>

Therapist: No, please. I should have invested stock in this stuff [Kleenex]. <laugh>. Use them up. Use them up. How's that feeling?

Client: Much better.

*Please note, the session continues beyond this portion; therefore, the closing steps of the model are not represented here.

Narrative Results

What follows are the participants' words in response to their experience of the IFS/eCIHP treatment when asked what they have noticed since the previous session.

Mind

- "In the past, I had ruminations in the background all the time, you know, thinking about [everything] all the time. Now I am able to have more quiet. I'm not thinking about stuff all the time. Just focusing on what I'm doing; more like in the moment. The ruminations have stopped."

- "I don't think I noticed before how much that kind of within-self fighting was affecting me. Because I've noticed there being less of it and some things just being much easier. <laugh> Like, yeah. Just the idea of like, "Oh, I'm not fighting myself. I'm just dealing with what's going on around me." That's huge. That's amazing. When we're not having to do this battle before; we can deal with everything else."

- "It's interesting because I feel like I'm just being able to be really honest. Yeah. And that's good. To be honest with myself and to be honest with the people around me."

- "I used to think I was hiding mental illness, because my parts were fighting all the time. I liked to put it down to being part Irish and part Scottish. A natural conflict. Then I learned that all people have fighting or secret parts. God made us this way for a reason."

- "There's been a new thought. 'Okay, this thing feels personal, but maybe it's not about me. Maybe it's about the other person involved.' Yeah. You know, like, it doesn't always have to be about me."

- "Helped me in general being less anxious and worried."

- "If someone irritates me or you know, like with [my child], who's been really like, been testy. <laugh>. I'm able to sit down, and I'm like, 'okay, this is why.' Or I'm able to be curious, if I don't know."

- "I'm checking in with reality of how it is now. And knowing/feeling like I've had a lot of like, bad ideas and thoughts, like really harmful ideas and thoughts about myself and just finding moments where I can pause and be like, "oh, that's not really true." <laugh> What a concept!"

- "I'm not internalizing other people's opinions."

Emotions

- "I talked to my mom, and she [mentioned] it was the 2nd anniversary of my grandpa's death. I haven't felt, like bad or nothing, like grief. Yeah. Before it was too much. I

haven't felt like that. And I remembered we did the work on funerals and death the other week. And so, that reminder didn't bring the grief up. So, [I] just thought, you know, it's kind of was more like normal, without the emotions coming in. It's good. Yeah, and I guess more focused."

- "Things that hurt are still happening. And I feel like there is, I don't know, maybe more of a sense of peace even in the midst of that. At least, I feel like I understand what's happening. I think it's more of like a consciousness of what's going on there. There's another layer of experience there."

- "Just kind of like mood-wise being better. The mad still is there. It didn't just poof. But like trying to have more patience with my [child]. Um, which has been actually better. To a certain extent because… <laugh> It's been better! So that's been a little bit easier."

- "I have noticed an improvement in really chronic depression. A big improvement. Depression is not being an obstacle."

- "It is going better [with mother-in-law]. That is, it is very, very much more calming whenever I go up there. It's usually I'm just aggravated from the time I get there to the time I go home and it's just horrible. But these last few times I've been up there, it's been a lot different. From my perspective. But of course [my spouse] doesn't experience it differently. [My spouse's] still activated and yet I can walk through this now and not fly up into the trees. <laughter>"

- "I've been finding ways just to be happy. Like taking everything just like you can't do anything about it. And then just roll with it. So, it's been nice."

- "[It's been] Mixed, very mixed <laugh>. There were some low lows, but there were also high highs. And so, Okay. You know, I think that's worth noting, both times, where I'm like, "Oh, I feel terrible. This is not feeling good." And then, then also moments where like, "you know what? I can move on from that." And that being really freeing. Yeah. Just like the possibility of like, "that hurt!," and yet I can move on. There is more to life <laugh> than the hurt. That's really, you know, that's a big thing that I really had not wrapped my head around, - there is more to life than being hurt. And that's huge! That's super huge because when we're stuck being the one receiving all of this pain and hurt. What's the point? That makes life really hard and really a struggle."

Body

- "I feel like I've been able to feel like I can actually take on things that I want to, you know? I feel like when something is difficult, I don't feel like totally smacked in the face by it."

- "Since the study, I notice I can talk myself out of depression. Some of the things that I would normally do, I could figure out a way to make sense of it, so I don't have to. For example, I could easily call in sick for a day, just because I was getting depressed. Or

not praying and just getting worse, giving up; finding a way to get out of doing what I should do. Instead, have been able to go and do."

- "The first session, for example, you know, I think it's maybe one of the most powerful sessions for me. Since then, that pain in the back of my neck, it has never been bad how it was. Yeah. So that's amazing."

- "I've had a lot of extra energy to devote to things. I feel like I've been like getting everything done I need to with energy left over, which is awesome. <laugh>."

- "It was specifically in those parts, you know, when I felt the [emotional] pain that I carry in my body; well, I guess like the physical too. But I also see that when I am with more stress and just worry, [it] increase[s] the pain more, you know, makes it worse. It's like there is some connection to it too. [What] I'm trying to say is that I remember both pains as physical, but the other one was not related to any type of stress or nothing. It was like a fault [a belief] that I have. And it did kind of heal, you know, that pain is less somehow and hopefully maybe getting better."

- "I'm able to function in spite of stuff coming up. It's all "life happens." It's always around us, constantly going, but can I actually get through it and be able to do what I need to do."

Spirit

- "I was just feeling this beautiful thing. And then I just started crying and I, kind of, was all peaceful."

- "I've been talking to God more, I feel like, just randomly throughout the day. So, I mean, that's changed. 'Cause, like, I'm really trying to let Him in more."

- "I felt a touch from God during the sessions."

- "[God has] been really present in my mind. Like Yeah. Just some of the images and some of the feelings. I feel like it's an experience."

- "I am inviting Jesus into my day and checking in [with my parts] when things come up."

- "I have noticed that my relationship with God has grown. I think I understand Him a lot more than I ever did before. My faith that He really has a plan for ME, has grown exponentially."

Overall

- "I learned so much. I wish I had the ability to write this down well. To tell you how very helpful this program has been."

- "With this [work], I see more as transformational, you know, more like being healed."

- “I had kind of been noticing this, but it became really clear when I was doing the survey earlier. Was like, “Yeah, there's stuff going on, but I actually am functioning pretty well, <laugh> in spite of stuff going on.” <laugh> Which is not how I'm used to things being. I've constantly been fighting this, trying to work on mental health and, you know, being in therapy, and being on antidepressants, and all this stuff, and still having a really hard time. And it's like, “I'm not having a hard time.” But it's like [on] some of those [survey questions] I was like, “Can I actually mark mild?” <laugh> That was mild! Yes! <laugh> Fantastic! Yeah.”

- “It really helped me get closure on a lot of things and really helped me get closer to God. This experience has truly helped me – You have no idea! Truly has been a blessing. I’ve even got my spouse saying we can start going to church.”

Summary

The purpose of this study is to investigate the religious accommodation of Internal Family Systems (IFS) with eclectic Christian Inner Healing Prayer (eCIHP) and to begin to address the gap in research regarding their united effectiveness as a Christian accommodative model to treat symptoms of posttraumatic stress, anxiety, and depression, as well as improve internal and spiritual relations for adult survivors of childhood trauma (ChT). This chapter began with a restatement of both the research questions and their alternative hypotheses, followed by a reporting of the descriptive statistics and participant descriptions. The rest of the chapter discussed the study results systematically in the order of the four research questions and their coordinating alternative hypotheses. Each instrument was unpacked and whether it supported or did not support the pertinent hypothesis was stated. Model integration results were provided in the form of a transcript of the intervention from one of the study’s participant’s sessions, and by brief participant narratives of their experience. In summary, this presentation of the data has begun filling the previously identified gap in the research regarding the effectiveness of IFS and eCIHP as Christian accommodative model.

Chapter Five: Conclusions

Overview

Chapter five begins with a discussion reviewing the purpose of this study and an analysis of each of the research questions in light of the results from the 8-week intervention; both comparisons to other studies and the relevant literature are explored. The implications for therapeutic practice and how this study effects the existing body of knowledge are presented, followed by its limitations. The chapter closes with recommendations for future research and conclusions.

Discussion

The purpose of this study was to explore the cultural accommodation of Internal Family Systems (IFS) with eclectic Christian Inner Healing Prayer (eCIHP) and investigate its effectiveness as a model of therapy for adult survivors of childhood trauma (ChT). This initial inquiry begins to address the gap in IFS research regarding an accommodative model for some cultural Christians concerned about the model's undefined spirituality. Psychology and religion have a long history of animosity that must be overcome for many modern-day Christians before they will consider clinical counseling (Corey, 2109; Entwistle, 2015; Hathaway & Tan, 2009; Hathaway & Yarhouse, 2021; Gingrich, 2020). Because IFS has empirically demonstrated effectiveness with adult survivors of childhood trauma and clients with depression and anxiety, it behooves Christian clinical mental health therapists to be able to provide the model for their Christian clients (Anderson, 2021; Anderson et al., 2017; Haddock et al., 2017; Hodgdon et al., 2021; Matheson, 2015; ACA, 2014; APA, 2017). Nevertheless, the undefined spirituality, acknowledged as a core tenet of the IFS model, necessitates accommodation for cultural Christians who are instructed to "test the spirits" (*New International Bible*, 1978/2011, 1 John

4:1-3a; ACA, 2014; APA, 2017; Schwartz & Falconer, 2017; Schwartz & Sweezy, 2020). CIHP specifically invites Jesus Christ to be present and lead at the beginning of each therapy session. When eCIHP is integrated with IFS, concerned Christians can know Who is spiritually present in their clinical sessions. Scripture is clear; "Where two or three gather in My name, there I am with them" (*New International Bible*, 1978/2011, Matthew 18:20). The Duke University Religion Index (DUREL; Koenig & Büssing, 2010) helped identify cultural lifestyle Christians for this study. Using an integrated model of IFS/eCIHP as the independent variable, the dependent variables of post-traumatic stress, anxiety, Self access, Self-leadership, Self-qualities, hope, forgiveness, love of self, and love of God were measured to determine the effect of an IFS culturally accommodated clinical intervention for the needs of some of the cultural Christian population.

The study's results demonstrated IFS/eCIHP significantly correlated with a decrease in post-traumatic stress, anxiety, and depression symptoms in a sample of N-of-1 Christian clients with histories of childhood trauma. Simultaneously, in that same group of participants, an increase in Self access, Self-leadership, Self-qualities, hope, love of self, and love of God was documented after eight sessions of treatment. However, IFS/eCIHP did not correlate with evidenced increased forgiveness for the participants. What follows is a discussion of those results for each hypothesis in turn.

Research Question 1

Does Internal Family Systems (IFS) with eclectic Christian Inner Healing Prayer (eCIHP) religious accommodation correlate with a reduction the trauma symptoms of *post-traumatic stress*, *anxiety*, and *depression* in self-identified cultural Christian clients with childhood trauma histories?

Because adults with historical childhood trauma (ChT) have some of the most intractable symptomology sequalae (Ford & Courtois, 2020; Herman, 1992a) that affect all aspects of their lives, including their spirituality (Walker et al., 2015), providing effective therapeutic interventions is a critical need. Diagnoses of complex post-traumatic stress disorder (CPTSD) and comorbid symptoms of anxiety and depression are prevalent in this population (Cloitre et al., 2020) necessitating treatments that are multifaceted in their application. In the literature, IFS is touted as an effective trauma intervention for clients with childhood trauma histories (Anderson, 2021; Hodgdon et al, 2021; van der Kolk, 2014). CIHP is a culturally specific intervention for some Christian denominations and lay practitioners. Both IFS and eCIHP use insight to facilitate the work and ask clients to "notice" what is happening within (Schwartz & Sweezy, 2020; Tan, 2011a); both seek to address the deep wounds of trauma (Anderson, 2021; Tan, 2011a) and both are open to the spiritual (Schwartz, 2021; Wilder et al., 2020). Studies on the effectiveness of each of the models have focused on populations struggling with anxiety (Boelens et al., 2009; Boelens et al., 2012; Baldwin et. al., 2016; Fitzgerald, 2022; Shadick et al., 2013), depression (Boelens et al., 2009; Boelens et al., 2012; Fitzgerald & Barton, 2022; Haddock et al., 2017; Hodgdon et al., 2021; Shadick et al., 2013), and post-traumatic stress (Baldwin et al., 2016; Hodgdon et al., 2021) with promising results. Hypothesis 1 proposed IFS with eCIHP treatment would correlate with a reduction in *PTS, anxiety,* and *depression* symptoms as measured by the PCL-5, OASIS, and ODSIS scales. The overarching results acquired from the study gave strong support for this hypothesis on each point, building on the literature and aligning with results from previous studies.

Post-Traumatic Stress

The PCL-5 (Weathers et al., 2013b) baseline measure screened three of the four participants as qualifying for a PTSD diagnosis (*DSM-5*; APA, 2014) at study intake, with the fourth participant just one point shy of a possible PTSD diagnosis. According to Weathers et al. (2013b), a 5-point change in scoring indicates a minimal threshold response while a 10-point change is considered to indicate clinically meaningful change. After the 8-session series of IFS/eCIHP treatments, every participant individually reported a minimum of a 22-point decrease in scoring; twice the measure of what is considered to be clinically meaningful according to the instrument (Weathers et al., 2013b). Additionally, it must be noted one participant tripled and another quadrupled the 10-point meaningful change gauge in their score's reductions. These substantial decreases in score suggested a remission of symptoms consistent for PTSD diagnosis for all participants at study's end.

These encouraging results are not without precedence in PTSD literature. Hodgdon et al. (2021) acknowledged larger results than typically observed in their pilot study of IFS for PTSD with survivors of multiple childhood trauma in a non-Christian specific group. While Hodgdon et al.'s (2021) study was 16 sessions of IFS treatment and this study was half that, the large change effect is duly recorded with comparable treatment dosage of session duration (90 minutes) and trauma population. Similarly, a significant portion of their participants (90%) no longer qualified for the *DSM-IV*-R PTSD diagnosis at study's end (Hodgdon et al, 2021). These documented large effect changes with populations with childhood trauma are hopeful for adult survivors with PTS, warranting further investigation.

Anxiety

The OASIS is a measure that gauges the severity and functional impairment experienced by anxiety (Norman et al., 2006). Both IFS and CIHP have studies in the literature on their effectiveness with anxiety (Boelens et al., 2009; Boelens et al., 2012; Baldwin et al., 2016; Shadick et al., 2013). In this culturally accommodative study, the OASIS scores were expected to decrease in correlation with application of integrated IFS/eCIHP with Christian clients with histories of childhood trauma. All participants reported experiencing anxiety at intake. After eight IFS/eCIHP sessions, the decreased OASIS score results supported the hypothesis with a combined median PEM score of 0.93 (very effective) for all participants, with one participant reporting no anxiety symptoms at study's end.

These encouraging findings align with the evidentiary literature of both models regarding anxiety symptom reduction. Boelens et al. (2009, 2102) produced similar findings of significant improvement for anxiety symptoms in a randomized cross-over clinical trial of six sessions of CIHP. Moreover, Baldwin et al. (2016) reproduced the Boelens et al. (2009, 2012) CIHP studies and findings. Meanwhile, in 2015, the National Registry for Evidence-based Programs and Practices (NREPP; Matheson, 2015, para. 5) determined IFS showed "promising outcomes for: 1) reducing anxiety disorders and symptoms" based on an independent review of a randomized control trial of IFS proof of concept study by Shadick et al. (2013).

Depression

The ODSIS is similar to the OASIS in that it is designed to measure the severity and level of impairment due to depression (Bentley et al., 2014). Likewise, its scores were expected to decrease with the utilization of integrated IFS with eCIHP for Christian clients with histories of childhood trauma. At the study's start, three of the four participants reported experiencing

depression, while one reported experiencing no depression. The post-treatment combined mean PEM score for the three depressive participants was 0.90 (very effective).

Again, similar findings of significant improvement for depression were produced in a randomized cross-over clinical trial of six sessions of CIHP in a clinical setting utilizing the Hamilton Rating Scales by Boelens et al. (2009). These results also align with a random control trial conducted of IFS by Haddock et al. (2017) with a sample of female college students with depressive symptoms. The trial results substantiated the effectiveness of IFS in reducing depression symptoms equally as well as the comparative "gold standard" therapies of CBT (cognitive-behavioral therapy) and IPT (interpersonal psychotherapy; Haddock et al., 2017). More recently, Hodgdon et al.'s (2021) IFS study on childhood trauma demonstrated significant reductions in depression, as did Fitzgerald and Barton's (2022) study on childhood maltreatment, depression, and relationship quality. Once more, this study's promising results are in accord with the evidentiary literature of both models.

Research Question 2

Does the use of IFS with eCIHP correlate with an increase of *Self access, Self leadership*, and *Self qualities*, as defined by the IFS Self Scale, for self-identified cultural Christian clients with childhood trauma histories?

Self access is a primary instrument of change in the IFS model (Schwartz & Sweezy, 2020). According to Quirin and Kuhl (2018), conceptually, *self access* is an individual's ability to be aware of internal aspects (i.e., beliefs, needs, emotions, memories, future hopes) and to assist in the utilization and application of that self-knowledge. They specify that *Self access* is different than self-consciousness or self-reflection. According to Schwartz and Sweezy (2020), Self access is an action accomplished by helping parts create space to access the Self. They hold

that a healthy balanced system is Self-led with the Self-qualities of Compassion, Curiosity, Calmness, Courage, Clarity, Connectedness, Creativity, and Confidence (the Eight Cs) in evidence. According to Christian IFS authors and practitioners (Cook & Miller, 2018; Harris, 2002; Riemersma, 2020; Steege, 2010), the qualities of the Eight Cs align with the Fruit of the Spirit (*New International Bible*, 1978/2011, Galatians 5:22-23) thereby making increased Self access desirable for Christ followers.

In a recent study by Fitzgerald (2022) on adult mental health, Self-Leadership was found to be significantly associated with lower levels of dissociation, anxiety, depression symptoms, and fewer sleep disturbances. Another study with adult clients with histories of childhood mistreatment specifically identified Self-Qualities, not Self-leadership, as significantly "associated with depressive symptoms and relationship quality" (Fitzgerald & Barton, 2022, p. 155). By measuring aspects of Self leadership and Self qualities, the IFS Self scale measures how much access is available to the seat of consciousness, which is what IFS calls the Self (Schwartz & Falconer, 2017).

All participants took the IFS Self Scale twice: once at intake and again after completing the intervention. Additionally, each week the short 9-item IFS Self Scale was completed prior to the IFS/eCIHP treatment session in the 30-item survey thereby giving data over time. The comparative scores from the Long IFS Self Scale pre- and post-measure showed increases for all participants with a combined mean increase of 13.25 points for the Self Qualities subscale and a combined mean increase of 7.75 for the Self Leadership subscale. These scores, with more change evidenced on the Self qualities scale, align with the Fitzgerald and Barton's study (2022). The combined means of the short IFS Self Scale over time produced a PEM of .96 (very effective) with all participants increased in their ability to access Self, supporting the hypothesis.

Research Question 3

In investigating a cultural accommodation IFS for concerned Christians, it is germane to measure faith outcomes, especially in a study inviting the Divine to explicitly participate in the intervention of mental health clients through eCIHP. In no way should a client's faith be hindered or negated by a therapeutic intervention (ACA, 2014; APA, 2017). For Christians, the greatest commandment is to love God with all you are and the second is to love others as you love yourself (*New International Bible*, 1978/2011, Matthew 22:37-40). To that end, research question 3 asks: Does the use of IFS with eCIHP correlate with an increase of *love of self* and *love of God,* as defined by the TSOS, for self-identified cultural Christian clients with childhood trauma histories?

Love of God

As an instrument of change, *love of God* is all about one's connectedness (or closeness) with God and how we feel toward Him (Richards et al., 2005). Studies have shown individuals who report experiencing more closeness with God and feelings of love toward Him tend to prioritize their religion and faith beliefs, identifying their *love of God* as a source of comfort and encouragement (Richards et al., 2005). Additionally, support was found for improved outcomes in clients' spiritual emotional connectedness with God. Jauncey and Strodl (2018), in investigating the mental health of Christians, identified increased *love of God* as associated with increased life satisfaction; a recognized factor in anxiety and depression reduction (Lopez & Nihei, 2021).

The Theistic Spiritual Outcome Survey (TSOS; Richards et al., 2005) subscale *love of God* was administered each week of the study resulting in a combined mean PEM of .64 (minimal effectiveness) that marginally supported the hypothesis. Yet, individual results

demonstrated that three of the four participants evidenced a comparative pre- and post-treatment increase in score of at least three points. In fact, a significant 8-point increase was experienced by two of the three participants but is not reflected in the combined mean PEM results in that the fourth participant's zero PEM result skewed the findings. Additionally, documented life circumstances produced fluctuations in the individual participant scores that are observed in the data, which also had bearing on the final PEM score. Further research is indicated.

Love of Self

Love of self is an implicit biblical directive. In the New Testament, Jesus teaches the second greatest law is to "love your neighbor, as you love yourself," indicating a tacit expectation of an existing *love of self* (*New International Bible*, 1978/2011, Matthew 22:39). Considering God is love (1 John 4:16) and He made us in His image (Genesis 1:27), it can be argued *love of self* is a demonstrative reflection of loving God (Garrity, 2021)—perhaps even the ultimate expression of loving God (Garrity, 2021). Conversely, *love of self* is *not* pride (Psalms 10:4) nor conceit (Philemon 2:3), as Jesus would never instruct one to sin (1 John 3:5) or do something contrary to God's will (John 5:19).

From a clinical perspective and understanding, *love of self* is contrary to narcissism's entitled exploitive-ness (APA, 2103) and separate from self-esteem's worth measurements (van Tuijl et al., 2020; Henschke & Sedlmeier, 2021). Moreover, Neff (2003, 2011) insists it is not to be confused with self-compassion, which can be understood best as a gentle response to personal suffering (Henschke & Sedlmeier, 2021; Wallace, 2010). *Love of self* has been described as having a curative effect (Henschke & Sedlmeier, 2021; Irvani, 2007; Orbanic, 2001) and it is recognized as a strength that can promote personal growth (Patrick, 1982). Jauncey and Strodl (2018) identified a direct correlation between increased *love of self* and increased life

satisfaction. Additionally, an inverse relationship was found to exist between one's *love of self* and symptoms of anxiety and depression (Jauncey & Strodl, 2018).

The TSOS (Richards et al., 2005) subscale of *love of self* was administered each week of the study. The combined mean of the post treatment PEM for *love of self* was .79 (moderate effectiveness) in support of the hypothesis. Similar to the results with the *love of God* subscale, the individual scores reveal that a near zero scoring participant skewed the significant scores of the other three participants resulting in the final overall PEM. Likewise, the documented life circumstances are observed in the findings, contributing to the final complied mean PEM score. However, it is of note that the demonstrated reduction in anxiety and depression by the OASIS and ODSIS scores is reflected in the individual TSOS *love of self* subscale findings, aligning with the research of Jauncey and Strodl (2018).

Research Question 4

Does the use of IFS with eCIHP correlate with an increase of *forgiveness* and *hope* as defined by the HFS and HHI for self-identified cultural Christian clients with childhood trauma histories?

Hope and forgiveness are at the heart of the Christian faith, embodied in our Savior, Jesus Christ (*New International Bible*, 1978/2011, 1 Timothy 1:1, Acts 2:38, Luke 23:34). IFS professes to teach their practitioners to be *hope* merchants (Pastor & Gauvain, 2020). To obtain baseline measures of forgiveness and of hope, each participant completed both the Heartland Forgiveness Scale and Herth Hope Index surveys at intake. The measures were administered a second time in the exit survey to measure any change in the participants' experiences of forgiveness and of hope after the 8-week intervention.

Forgiveness

Forgiveness has been identified as a predictor of posttraumatic growth (Heintzelman et al., 2014; Schultz et al., 2010; Wusik et al., 2015) as well as predicting increased meaning making of the original trauma (Van Tongeren et al., 2015). For those who have experienced multiple offenses, research indicates that by *not* stockpiling unforgiveness, the intentional action of perpetually offering forgiveness is protective (Schultz et al., 2014; Van Tongeren et al., 2015). Studies on forgiveness interventions indicate efficacy in anxiety and depression reduction while promoting the development of forgiveness (Wade et al., 2014). Additionally, forgiveness interventions have exhibited posttraumatic growth in religious faith and or spirituality (Luskin et al., 2005; Rye & Pargament, 2002).

Visual inspection of the pre- and post-comparison scores of the Heartland Forgiveness Scale show there is no consensus of results after the 8-week treatment. Half of the participants maintained or increased their scores and the other half decreased thereby creating results not in support the hypothesis. However, it is interesting to note that the half of participants that increased in forgiveness had previous therapy or recovery work that was helpful, while the other half that decreased did not report effective previous interventions.

Hope

The second part of research question 4 sought to determine if IFS/eCIHP increases *hope* in lifestyle of cultural Christians with historical childhood trauma. Visual inspection of the pre- and post-comparison scores of the Herth Hope Index show there is a consensus of results after the 8-week treatment, indicating an increase in hope. These results align with a recent study on hope by Koenig et al. (2020) where an inverse relationship to symptoms of PTSD, anxiety, and depression was evidenced. With the findings of all participants indicating increases in hope, the

data supports that aspect of hypothesis 4. This is encouraging for Christian clients "because we know that suffering produces perseverance; perseverance, character; and character, *hope*. And *hope* does not put us to shame, because God's love has been poured out into our hearts through the Holy Spirit, who has been given to us" [emphasis added] (*New International Bible*, 1978/2011, Romans 5:3-5).

Implications

The data generated by this study begins to address the gap in clinical research for the religious accommodation of IFS for concerned cultural Christians regarding the model's undefined spirituality. This section focuses on what the data and results can mean for the therapeutic community.

Research question 1 focused on the efficacy of a Christian accommodated version of IFS in a Christian clinical sample with histories of childhood trauma to examine whether adapting this evidence-based treatment model to the participants' worldview would result in equivalent or potentially increased treatment effects of the original model. Based on the encouraging results of this study, IFS/eCIHP was at least as effective as the certified application of IFS in a parallel, non-Christian specific, childhood trauma population. The implication of this, within a Christian-specific sample, is that the religiously accommodated IFS/eCIHP can produce equally noteworthy reductions in the trauma symptoms of PTS, anxiety, and depression as compared to empirically supported certified IFS. What this means for therapists who serve cultural Christians is there is a clinical treatment model in IFS/eCIHP with preliminary support they can offer that accommodates and honors their clients' faith.

Research question 2 sought to determine if a cultural Christian population with childhood trauma histories could engage in Self access as taught by the IFS model and increase its

measurement through the implementation of religiously accommodative IFS/eCIHP. That the scores of the IFS Self Scale and its subscales of Self leadership and Self qualities each increased for all participants over the course of the treatment gives indication that lifestyle cultural Christians are able to access IFS defined Self and increase in Self qualities and Self leadership. An implication of the ability to access Self is that, as a central change agent of IFS, it helps promote mind renewal. Romans 12:2 (*New International Bible*, 1978/2011) instructs: "Do not conform to the pattern of this world, but be transformed by the renewing of your mind." An implication of being able to increase in Self qualities is that Christians can acquire IFS's Eight Cs, which have been perceived and presented as to mirror the *fruit of the Spirit* (an evidence of Christian spiritual growth). "But the fruit of the Spirit is love, joy, peace, forbearance, kindness, goodness, faithfulness, gentleness and self-control" (Galatians 5:22-23a). Additionally, an implication for Self leadership is increased self-control and inner peace. "And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus" (Philippians 4:7). Potential spiritual growth while working with an evidenced-based model of therapy creates the possibility of increased personal relational faith and trust in God for clients while addressing the mental health symptoms for which they have sought treatment.

Research question 3 sought to determine if IFS/eCIHP would increase *love of oneself* and *love of God* as defined by the TSOS over the course of the treatment with cultural Christians with trauma histories. The increases within the participant population were not as large as some of the other results obtained in the study, with the *love of self* subscale and its 0.79 PEM (moderate effectiveness) making more measured change than the *love of God* subscale and its 0.64 PEM (minimal effectiveness). However, these lower PEM scores may be accounted for by a couple of factors. Multiple external events occurred during the study (documented) that

increased anxiety and depression for several of the participants and is reflected in their scoring timelines. Also, the minimal movement on the *love of God* subscale score could be due to the participants already having had a strong relationship or connectedness with God as lifestyle Christians prior to the study. One of the participants stated, "I wish there was a place to mark between the scores. Because there is change… growth, but the other answer is not fully true. So, I can't check it."

However, what is particularly noteworthy is there is not a *decrease* in *love of oneself* nor in *love of God* with the faith accommodation of IFS: this is significant in that it is at the heart of this study. God is acknowledged and honored in the clinical therapeutic setting utilizing IFS/eCIHP. The application of IFS and its undefined spiritually, with the use of distinctly Christian IHP, is providing preliminary results that indicate Christians defined *love of God* and *love of self* (according to the TSOS) are not hindered by the integration of the two models. In fact, there are indications of growth. This is reassuring for both concerned Christian therapists as well as their faith-oriented clients.

The fourth and final research question's results were split; an increase in *forgiveness* was not supported by the HFS data, while an increase in *hope* was supported by the HHI data. These results make sense within this participant population of cultural Christians with historical childhood trauma. These individuals have experienced long-term, reoccurring, relational, and interpersonal traumas, with both financial and family instability throughout. An 8-session intervention is simply not enough internal restructuring to combat the years of physical, emotional, sexual, and spiritual abuses that shaped their early childhood. Their need to survive their childhoods structured their protective internal worlds. Eight weeks of treatment is only touching the metaphorical tip of the iceberg of their historical trauma.

The depth and breadth of their historical trauma is why the findings of increased hope for all the participants is so encouraging. Scripture tells us, “Hope deferred makes the heart sick, but a longing fulfilled is a tree of life” (*New International Bible*, 1978/2011, Proverbs 13:12). The documented increases in hope after the IFS/eCIHP treatment could potentially provide renewed strength for a client’s healing/recovery journey. Isaiah 40:31 states “those who hope in the LORD will renew their strength. They will soar on wings like eagles; they will run and not grow weary; they will walk and not be faint.” For adult survivors of ChT, the journey has been long. They have lived an entire lifetime to get to this point with still more work to be done; increased hope is potential fuel for the course. Furthermore, increasing hope can help cultivate a spiritual relationship with God, which is desirable for the cultural Christian. “May the God of hope fill you with all joy and peace as you trust in Him, so that you may overflow with hope by the power of the Holy Spirit” (Romans 15:13). A final thought on hope for adult survivors of ChT is stated in Job 11:18; “You will be secure, because there is hope; you will look about you and take your rest in safety.” For the ChT survivor, security, rest, and safety are beautiful gifts indeed. The implications of increased hope provide many opportunities to draw near to God.

The mixed results of the Heartland Forgiveness Scale, however, may be dependent on how much personal work was individually done prior to the study. Half the participants increased; half decreased. Those who had little or no previous counseling or ineffective previous interventions decreased in their forgiveness score, which could indicate these clients may have never confronted their core anger at their abuse before. It is possible as these clients *got real* or more honest with themselves and their true ability to forgive their abusers, the “correct” Christian answers regarding forgiveness could be discarded thereby producing the observed decrease in scoring. This would be consistent with Enright and Fitzgibbons’ (2000) initial

uncovering phase of forgiveness in their empirically supported Process Model of Forgiveness (PMF). Another possibility is the standard intake "it'll get worse before it gets better" discussion when preparing new clients for the therapeutic journey. Facing old traumas that have been pushed down and managed with any manner of distractions or controls could stir up old resentments and hurts that make forgiveness of perpetrators that much less possible until resolved. Meanwhile, those participants who had done previous 12-step work or effective counseling maintained or increased their forgiveness scores aligning with the forgiveness model phases of *decision* and *work* (Enright & Fitzgibbons, 2000). The alignment of the mixed results of the HFS with the PMF potentially indicates that IFS/eCIHP treatment could be helpful in aiding clients move through the forgiveness phases outlined by Enright and Fitzgibbons (2000). The implication of this observation is that forgiveness may be an appropriate long-term goal and potentially possible by working through the phases of the PMF with IFS/eCIHP for survivors of childhood trauma. Further investigation is warranted.

The use of IFS with eCIHP in clinical settings offers a culturally accommodative integrated model that may effectively address PTS, anxiety, and depression symptoms while simultaneously promoting the increase of hope, love of self, love of God, Self access, Self qualities, and Self leadership for Christian clients. These outcomes not only address mental health but spiritual health as well. The use of IFS/eCIHP in clinical sessions with its intentional invitation of the Divine could potentially contribute to a renewed faith and provide opportunity to cultivate a deeper spiritual walk with God for Christian clients.

Limitations

There are several inherent limitations related to the quasi-experimental design of this N of 1 study. The first is an expectation of a low to moderate amount of internal validity because

the study was not performed in a controlled laboratory setting. Therefore, possibility of threats to validity by confounding variables in a real-world setting must be acknowledged. In addition, the treatment protocol of IFS is a model of structured methods that meets clients where they are in a non-directive way. Likewise, the CIHP element uniformly seeks God's guidance and follows His lead. Both treatments allow for unique journeys based on the participants' internal parts map, preventing cookie-cutter uniformity of the independent variable. However, to ensure IFS/eCIHP was presented and utilized consistently, the participants' treatment was administered by the same researcher/therapist, who in turn, pursued higher training and certification to promote adherence to the IFS model. To that end, the experimenter expectations for specific results from the treatment are a potential additional threat to validity. To avert such, measurement instruments were administered through Survey Monkey and accessible prior to and outside the therapy sessions. This allowed the participants the ability to answer without experimenter influence. The voluntary nature of participation was communicated at several points, reassuring them that should they decide to leave the study, regardless of when, their treatment could continue without penalty. It is accepted that because of the acknowledged uncontrolled factors, both causality and the ability to generalize beyond this sample are limited. Nevertheless, correlations between the independent variable of IFS/eCIHP treatment and the dependent variables of PTS, anxiety, depression, Self access, Self-leadership, self-qualities, hope, love of self, and love of God can be made.

Overall, the external validity of the study is expected to be higher due to the study being conducted in an authentic clinical setting (not a laboratory), with an experienced licensed therapist, and with actual mental health clients seeking treatment as the participants. However, the pre-, during, and post-assessments are potential threats to external validity. Participants'

responses could affect the treatment findings by trying to report the "desired" results. Additionally, potential heterogeneity of the participants due to previous therapies or personal meditation practices or, conversely, the lack thereof, could affect outcomes. The homogeneity of the childhood trauma sample of lifestyle cultural Christians will increase the validity; however, it also decreases the ability of the results to be generalized to other populations. In addition, because of the en vivo element of the office setting, variabilities in clients' life circumstances during the course of treatment can cause (and did) both increases and decreases to be experienced as a result of the external stress of those events. This limits internal validity but simultaneously increases external validity in that this is the actual therapy or "treatment as usual" for this setting. Another clinical population could expect to have similar variances.

A final limitation was found in the instruments used to measure the variables. Participants wanted more points of measurement on the surveys to reflect their experience more accurately. A scale of 1 to 10 was recommended in the exit interviews. Also, a more formal exit interview would have increased the validity of the qualitative data at study's end.

Recommendations for Future Research

There are multiple recommendations for future research. The encouraging results of this study warrant a randomized trial to verify outcomes. Likewise, a randomized control group study with just a control could provide a more robust data set. A dismantling style study of the difference between CIHP and pure IFS would be valuable. A randomized comparative study of Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), or Prolonged Exposure (PE) could give a more complete picture of IFS/eCIHP's efficacy. Having non-Christian therapists utilize the model for Christian clients is also a potential investigation. Does the therapist's faith or lack thereof factor in client outcomes? Future research of IFS/eCIHP will

contribute to the body of knowledge of religiously accommodative models, trauma therapies, and IFS research.

Summary

The current study indicates the cultural religious accommodation of IFS with eCIHP can maintain the integrity and efficacy of IFS treatment while specifying Christian spirituality. It has never been the intent of this study to change or "improve" the IFS model. By utilizing eCIHP and inviting Jesus to be present and involved in the IFS process, the undefined spiritual aspect of the model can be known. IFS/eCIHP gives the Christian mental health therapist a frame for presenting IFS to their Christian clients in the terms and language of their faith. The most beautiful benefit is the opportunity for Christian clients to bring their faith out into the open in their clinical sessions and give God the glory for the experiences and changes brought about by the work.

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Appendices

Appendix A

IRB Exemption Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

May 17, 2022

Kharma Parker
Fernando Garzon

Re: IRB Exemption - IRB-FY21-22-852 A CLINICAL N OF 1 TIME SERIES STUDY ON THE EFFICACY OF INTERNAL FAMILY SYSTEMS AND CHRISTIAN INNER HEALING PRAYER WITH ADULT SURVIVORS OF CHILDHOOD TRAUMA

Dear Kharma Parker, Fernando Garzon,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at [redacted].

Sincerely,
G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Appendix B

Initial Assessment/Interview Form

Please provide the following information as an initial assessment of your appropriateness for participation in the study. This information will be kept confidential, unless ethical guidelines present a limit to confidentiality, such as in the case of reported suicidal or homicidal intention. If you do not understand any question, please leave it blank and contact the researcher.

Name: _____

Date of Birth: _____ / _____ / _____ Age: _____

Phone: _____ May I call you? (Y / N) May I text you? (Y / N)

Email: _____ May I email you? (Y / N)

1. Are you a practicing Christian? (Y / N)
   If yes, please specify denomination: _____
2. Did you experience childhood trauma or adverse experiences? (Y / N)
3. If yes, please specify: _____
4. Are you currently experiencing any mental health concerns? (Y / N)
   If yes, please specify: _____
5. Are you experiencing any physical health concerns? (Y / N)

   If yes, please specify: _____
6. Are you currently experiencing *thoughts* of suicide or homicide? (Y / N)
7. Are you currently experiencing *plans* of suicide or homicide? (Y / N)
8. Are you currently abusing drugs or alcohol? (Y / N)
9. Are you currently prescribed an antipsychotic or mood stabilizing medication? (Y / N)
10. Have you been diagnosed with mania or psychosis in the past? (Y / N)
11. Are you experiencing any condition or life circumstance that would hinder your participation in 8 weeks of intervention and 4 weeks assessments? 12 total weeks. (Y / N)
12. Have you ever experienced Inner Family Systems therapy? (Y / N)
13. Are you willing to complete an initial assessment that will include the completion of a psychometric inventory for investigating exclusion criteria? (Y / N)

Please direct any questions about this interview form to the researcher via:

[redacted] or [redacted]

Appendix C

Demographic Questionnaire

Personal Information

Name: _____ Today's Date: _____
(Last) (First) (M Initial)

Address: _____
(PO Box or Street) (City) (State) (Zip)

Telephone: _____ (Home/Cell)

Date of Birth: _____/_____/_____ Age: _____ Gender: M___ F___ Identify as _____

Marital Status: Single / Living with Partner / Married / Separated / Divorced / Widowed

Place of Employment: _____

Income Level: $0-$15,000 / $16,000-$25,000 / $26,000-$35,000 / $36,000-$45,000 / $46,000-$55,000 / $56,000 & Above (Annual Funds in US Dollars)

Race: African American / Asian / Caucasian / Latino / Native American / Other _____

Highest Education Level: High School /College Freshman / Sophomore / Junior / Senior / Associate degree / Bachelor's degree / Master's degree / Doctoral degree

Medical Insurance Coverage: Yes ____ No ____

In Case of Emergency Contact: _____

Phone: _____ Relationship: _____

How long have you been a practicing Christian? _____

Appendix D

ACE Questionnaire – Amended Version

PsycTESTS®

Adverse Childhood Experiences Questionnaire--Amended Version

PsycTESTS Citation:
Tranter, H., Brooks, M., & Khan, R. (2021). Adverse Childhood Experiences Questionnaire--Amended Version [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t82522-000

Instrument Type: Inventory/Questionnaire

Test Format:
The items are scored as 0 (no) or 1 (yes), with the highest possible score being 16.

Source:
Tranter, Heidi, Brooks, Matthew, & Khan, Roxanne. (2021). Emotional resilience and event centrality mediate posttraumatic growth following adverse childhood experiences. Psychological Trauma: Theory, Research, Practice, and Policy, Vol 13(2), 165-173. doi: https://dx.doi.org/10.1037/tra0000953

Appendix E

Life Events Checklist – DSM 5 (LEC-5)

Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M. (2013). *The Life Events Checklist for DSM-5 (LEC-5)*. Instrument available from the National Center for PTSD at https://www.ptsd.va.gov/professional/assessment/documents/LEC5_Standard_Self-report.PDF

Appendix F

Duke Religion Index (DUREL)

Koenig, H. G., Meador, K., & Parkerson, G. Religion Index for Psychiatric Research: A 5-item Measure for Use in Health Outcome Studies. American Journal of Psychiatry 1997; 154:885-886

https://dx.doi.org/10.1037/t04429-000

PsycTESTS®

Duke Religion Index

PsycTESTS Citation:
Koenig, H., Parkerson, G. R., Jr., & Meador, K. G. (1997). Duke Religion Index [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t04429-000

Instrument Type: Index/Indicator

Test Format:
Responses to the items of the organizational and non-organizational subscales are rated on a six-point frequency scale: (1) = never, (2) = once a year or less, (3) = a few times a year, (4) = a few times a month, (5) = once a week, (6) = several times a week. Responses on the items of the intrinsic subscale are rated on a five-point frequency scale anchored by (1) = definitely not true and (5) = definitely true.

Source:
Supplied by author.

Original Publication:
Koenig, Harold, Parkerson, George R., & Meador, Keith G. (1997). Religion index for psychiatric research. The American Journal of Psychiatry, Vol 154(6), 885-886. doi: https://dx.doi.org/10.1176/ajp.154.6.885b

Permissions:
Contact Corresponding Author.

Duke Religion Index Permission

From: "Harold Koenig, M.D." <[redacted]>
Subject: [External] RE: Permission to utilize the Duke Religion Index
Date: March 20, 2022 at 6:11:36 AM CDT
To: "Parker, Kharma" <[redacted]>

Yes, you have permission to use the Duke religion Index. Dr. K

Harold G. Koenig, M.D.
Professor of Psychiatry & Behavioral Sciences
Associate Professor of Medicine
Director, Center for Spirituality, Theology and Health Duke University Medical Center, Durham, North Carolina
Adjunct Professor, Dept of Medicine, King Abdulaziz University, Jeddah, Saudi Arabia
Visiting Professor, Shiraz University of Medical Sciences, Shiraz, Iran
Editor-in-Chief, *International Journal of Psychiatry in Medicine*

From: Parker, Kharma <[redacted]>
Sent: Sunday, March 19, 2022 9:03 PM
To: Harold Koenig, M.D. <[redacted]>
Subject: Permission to utilize the Duke Religion Index

Dr. Koenig,

I am a graduate student of the School of Behavioral Sciences at Liberty University, I am conducting research as a part of the requirements for a doctoral degree in Community Care and Counseling with a Traumatology emphasis. The title of my research project is: An N of 1 Times Series of the Efficacy of Internal Family Systems and Christian Inner Healing Prayer with Adult Survivors of Childhood Trauma. I am writing you to seek permission to utilizing the Duke Religion Index in my study.

Respectfully,

Kharma K. Parker
MS, LMFT, LPC

Doctoral Candidate
Liberty University,
Lynchburg, VA

Appendix G

IRB Stamped Consent

Consent

Title of the Project: An N of 1 Time Series on the Efficacy of Internal Family Systems (IFS) and Christian Inner Healing Prayer (CIHP) with Adult Survivors of Childhood Trauma.

Principal Investigator: Kharma Parker, M.S., L.P.C., L.M.F.T., Level 3 IFS Trained, Doctoral Candidate of the School of Behavioral Sciences at Liberty University.

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be a self-identified practicing Christian, at least 18 years of age, who experienced adverse experiences in childhood, and meet the trauma screening parameters for this study. Individuals reporting current suicidal intention or plan, active drug or alcohol abuse, current use of a antipsychotic or mood stabilizer prescription, or historical diagnosis of mania or psychosis will be excluded from the study. You must not have had previous Internal Family Systems (IFS) therapy experience. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to investigate the use of the Christian cultural-accommodation intervention of Inner Healing Prayer with the evidenced-based Internal Family Systems therapy model in a clinical setting. Christian Inner Healing Prayer is a method that some churches use in their Care Ministries. This study will investigate how effective the Christian accommodation of Internal Family Systems is with a licensed professional therapist and self-identified practicing Christian clients who have a history of childhood trauma.

What will happen if you take part in this study?

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

1. Respond to *all* the questions or statements on the questionnaires:
    a. There will be a compilation of 7 pre-intervention questionnaires which will take anywhere from 50 minutes to 60 minutes (1 hour) to complete.
    b. There will be a 30-item survey that must be completed prior to each therapy session and for the pre- (1x) and post- (2x) base-line measures which will take *at least* 15 minutes to complete.
    c. There will be a compilation of 7 post-intervention questionnaires which will take anywhere from 50 minutes to 60 minutes (1 hour) to complete.

2. Arrive early *at least* **20 minutes** before each of your scheduled appointments to answer a 30-item pre-session questionnaire. Please set aside 2 hours in your schedule for all appointments.

3. Attend and participate in person: the intake interview appointment and pre-intervention survey; a psychoeducational pre-intervention appointment with the shorter pre-intervention survey; all eight (8) 60- to 90-minute IFS/eCIHP therapy sessions; and the

three (3) post-intervention appointments. Zoom will be available *only* for Covid-19 quarantine, if necessary. Please be aware that these sessions will be video recorded and have an audio recording backup in the event of technology failure.

How could you or others benefit from this study?

The direct benefits participants should expect to receive from taking part in this study are the potential benefits of psychotherapy and therapeutic interventions that address historical and emotional trauma symptoms. This can be seen in such things as a reduction of the various symptoms and behaviors or experiencing more internal calm or peace. Studies have shown that simply having a therapeutic relationship with a mental health professional can be helpful.

Benefits to society include potentially introducing a new clinical intervention for historical trauma that takes into consideration the faith of the self-identified evangelical Christian client. Reduction of trauma symptoms in individuals means potential improved social and community functioning and interface. This can be seen in such things as better work attendance and community involvement.

What risks might you experience from being in this study?

The risks involved in this study are minimal, meaning they are equal to the risks you would encounter in everyday life. The risks involved in this study include the potential to initially feel worse before feeling better. This risk is acknowledged for most forms of psychotherapy. Feelings of fear, anxiety, sadness, pain, anger, and "yucky" will be intentionally engaged in the work. There is potential to activate old memories and emotions which may cause uncomfortable or confusing reactions to be experienced as sensations in the body or mental images or as emotional flooding. Feelings of being tired or "wiped out" after a session are common. A possible sense of time distortion during a session as either super-fast or super slow can occur. These are not unusual experiences when working with historical trauma. There is a risk you may experience the dread of the next session and be tempted to not finish the study. This work is not easy, and avoidance can be a way to cope. Additionally, risk must be acknowledged due to the required reporting of any disclosed current child abuse or neglect, elder abuse or neglect, or any intent to harm oneself or others.

How will personal information be protected?

The records of this study will be kept private. Published reports 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. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Participant responses will be kept confidential through the use of pseudonyms. Sessions will be conducted in a private, clinical location where others will not easily overhear.
- Data will be stored on a password-locked computer and may be used in future presentations. Hard copy data will be stored in a locked filing cabinet. After three years, all electronic records will be deleted, and any hard copy data will be shredded.

- Sessions will be recorded and transcribed. Recordings and transcripts will be stored on a password-locked computer for three years and then erased. Only the researcher will have access to these recordings and documents.
- Confidentiality cannot be guaranteed if mandatory reporting requirements for child abuse/neglect, elder abuse/neglect, intent to harm self or others are disclosed.

What are the costs to you to be part of the study?

To participate in the research, you will need to potentially take time from work which could mean a reduction in your paycheck. Otherwise, regardless of your insurance coverage, or if you do not have insurance at all, there will be no other requests for payment of any kind.

Does the researcher have any conflicts of interest?

The researcher serves as a therapist at Elemental Counseling and will be facilitating the IFS/CIHP sessions. Payment for counseling services is a normal practice for a mental health office. To avoid conflict of interest, all accounting information will be handled by the office manager and not factored into the study data. 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 or not participate in this study.

Is study participation voluntary?

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

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address or phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Kharma Parker. You may ask any questions you may have now. If you have questions later, **you are encouraged** to contact her at [redacted] or [redacted]. You may also contact the researcher's faculty sponsor, Dr. Garzon, at [redacted].

Whom do you contact if you have questions about your rights as a research participant?

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, [redacted] or email at [redacted].

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

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.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio- and video-record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

Appendix H

The PTSD Checklist for *DSM-5* (PCL-5)

Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for *DSM-5* (PCL-5). Scale available from the National Center for PTSD at https://www.ptsd.va.gov/professional/assessment/documents/PCL5_Standard_form.PDF .

Appendix I

IFS Self Scale

DeLand, L., Strongin, D. L., Schwartz, R. C. (2006). The development of a personality scale based on the Internal Family Systems Model. *Journal of Self Leadership*, *2*(1), 1-14.

https://www.ifs-scale.com/

IFS Self Scale Permission

From: Lia DeLand <[redacted]>
Subject: [External] Re: Permission to use IFS Scale
Date: May 26, 2022 at 8:32:10 PM CDT
To: "Parker, Kharma" <[redacted]>
Cc: "Research[redacted]" <[redacted]>

Dear Ms. Parker,

We're very happy to support you with your project. If you'd like to have the convenience of the computer-scored profiles we can provide you with a password that will allow your participants to take the test for free. They can bookmark the results page or take a screenshot of it and send to you.

If you'd rather do a paper-and-pencil scoring I can send you the e-files. Just let me know what you'd prefer.

Best wishes, Lia

Lia DeLand, LCMHC, NCC
Licensed Clinical Mental Health Counselor
National Certified Counselor
[redacted]

> **From:** "Parker, Kharma" <[redacted]>
> **Date:** Saturday, May 21, 2022 at 8:14 AM
> **To:** "[redacted]
> **Cc:** Ilanit Tal <[redacted]>
> **Subject:** Permission to use IFS Scale
>
> Greetings,
>
> I have received IRB approval of my study titled: An N of 1 Time Series on the Efficacy of Internal Family Systems and Christian Inner Healing Prayer with Adult Survivors of Childhood Trauma.
> I am seeking permission to use the IFS Scale in my research.
> I am attaching the Application Form you sent me in January and my IRB approval letter.
> Please let me know if you need any further information.
>
> Respectfully,
>
> Kharma Parker
> MS, LMFT, LPC

Appendix J

Overall Anxiety Severity and Impairment Scale (OASIS)

Norman, S. B., Cissell, S. H., Means-Christensen, A. J., & Stein, M. B. (2006). Development and validation of an overall anxiety severity and impairment scale (OASIS). *Depression and Anxiety, 23*(4), 245-249. https://doi.org/10.1002/da.20182

OASIS Permission

From: "Norman, Sonya" <[redacted]>
Subject: [External] Re: OASIS
Date: April 12, 2022 at 11:08:38 AM CDT
To: "Parker, Kharma" <[redacted]>

Hi Kharma,

You are welcome to use the OASIS. Good luck with your dissertation.

Sonya Norman

On Apr 6, 2022, at 1:51 AM, Parker, Kharma <[redacted]> wrote:

> Greetings, Dr. Norman,
>
> I am a graduate student at the School of Behavioral Sciences at Liberty University. I am conducting research as part of the requirements for a doctoral degree in Community Care and Counseling with a Traumatology emphasis. The title of my research project is: An N of 1 Time Series on the Efficacy of Internal Family Systems and Christian Inner Healing Prayer with Adult Survivors of Childhood Trauma. I am writing you to seek permission to utilize the OASIS in my study.
>
> Respectfully,
>
> Kharma Parker,
> MS, LPC, LMFT

Appendix K

Overall Depression Severity and Impairment Scale (ODSIS)

Bentley, K. H., Gallagher, M. W., Carl, J. R., & Barlow, D. H. (2014). Overall Depression Severity and Impairment Scale [Database record]. PsycTESTS. https://dx.doi.org/10.1037/t36137-000

PsycTESTS®

Overall Depression Severity and Impairment Scale

PsycTESTS Citation:
Bentley, K. H., Gallagher, M. W., Carl, J. R., & Barlow, D. H. (2014). Overall Depression Severity and Impairment Scale [Database record]. Retrieved from PsycTESTS.

https://dx.doi.org/10.1037/t36137-000

Instrument Type: Screener

Test Format:
For each of the 5 items, respondents are asked to endorse one of five different response options (coded from 0 to 4); higher scores are indicative of greater depression-related severity and impairment.

Source:
Bentley, Kate H., Gallagher, Matthew W., Carl, Jenna R., & Barlow, David H. (2014). Development and validation of the Overall Depression Severity and Impairment Scale. Psychological Assessment, Vol 26(3), 815-830. doi: https://dx.doi.org/10.1037/a0036216.

Appendix L

Theistic Spiritual Outcome Survey (TSOS)

Richards, P. S., Smith, T. B., Schowalter, M., Richard, M., Berrett, M. E., & Hardman, R. K. (2005). Development and validation of the Theistic Spiritual Outcome Survey. *Psychotherapy Research, 15 (4)*, 457-469.

Theistic Spiritual Outcome Survey (TSOS)

Directions: Please help us understand how you have been feeling spiritually this past week, including today. Carefully read each item below and fill in or mark the circle that best describes how you felt.	Name _____ ID # _____ Age: _____ Gender: F M Religious Preference: _____				
Session # _____ Date __/__/__	Never	Rarely	Sometimes	Frequently	Almost Always
1. I had feelings of love toward others.	0	0	0	0	0
2. I felt there is a spiritual purpose to my life.	0	0	0	0	0
3. I felt good about my moral behavior.	0	0	0	0	0
4. I yearned to make the world a better place.	0	0	0	0	0
5. I felt peaceful.	0	0	0	0	0
6. I felt appreciation for the beauty of nature.	0	0	0	0	0
7. I felt like praying.	0	0	0	0	0
8. I felt spiritually alive.	0	0	0	0	0
9. I felt worthy.	0	0	0	0	0
10. My behavior was congruent with my values.	0	0	0	0	0
11. I felt love for all humanity.	0	0	0	0	0
12. I had faith in God's will.	0	0	0	0	0
13. I felt like helping others.	0	0	0	0	0
14. I felt God's love.	0	0	0	0	0
15. I praised and worshipped God.	0	0	0	0	0
16. I felt forgiveness toward others.	0	0	0	0	0
17. I loved myself.	0	0	0	0	0

Theistic Spiritual Outcome Survey (TSOS) Permission

From: P Scott Richards <[redacted]>
Subject: [External] Re: TSOS Permission to PUBLISH
Date: March 10, 2023 at 11:46:28 AM CST
To: "Parker, Kharma" <[redacted]>

Dear Kharma,

Congratulations on successfully defending your doctoral dissertation! What an important accomplishment! Would you send me the reference or a link and perhaps the abstract of your dissertation? I would like to read it. It sounds very interesting!

And yes, I give you permission to include a copy of the TSOS in the Appendix of your dissertation. The only stipulation I would request is that you provide the full reference to the original published article (see reference below) about the TSOS in a footnote at the bottom of the page or pages on which the TSOS appears in your dissertation.

Richards, P. S., Smith, T. B., Schowalter, M., Richard, M., Berrett, M. E., & Hardman, R. K. (2005). Development and validation of the Theistic Spiritual Outcome Survey. *Psychotherapy Research, 15 (4)*, 457-469.

Thanks.

Scott

--
P. Scott Richards, Ph.D.
Richards Research Consulting, LLC
Bridges Institute for Spiritually Integrated Psychotherapies
Editor: Handbook of Spiritually Integrated Psychotherapies
Saint George, Utah 84770

On Fri, Mar 10, 2023 at 5:35 AM Parker, Kharma <kparker4@liberty.edu> wrote:
Dear Scott Richards,

I have successfully defended my dissertation titled: An N of 1 Times Series of the Efficacy of Internal Family Systems and Christian Inner Healing Prayer with Adult Survivors of Childhood Trauma.

In my study I utilized the Theistic Spiritual Outcome Survey (TSOS) as allowed for research through the APA PsycTests database. I am currently preparing to submit the final dissertation document to the Liberty University library.

Copyright laws being what they are, Liberty is very clear that permission to *use* and permission to *publish* are two very different things. I am writing today to seek permission to **publish** the TSOS instrument, as presented in the APA PsycTest database, in the appendix of my study document.

Respectfully,

Kharma Parker
EdD, LPC, LMFT

Liberty University
Lynchburg, Virginia

Appendix M

Heartland Forgiveness Scale (HFS)

Thompson, L. Y., Snyder, C. R., Hoffman, L., Michael, S. T., Rasmussen, H. N., Billings, L. S., Heinze, L., Neufeld, J. E., Shorey, H. S., Roberts, J. C, & Roberts, D. E. (2005). Dispositional forgiveness of self, others, and situations. *Journal of Personality*, 73, 313-359.

Freely available at https://www.heartlandforgiveness.com/

Appendix N

Herth Hope Index (HHI)

Herth, K. (1992). Abbreviated instrument to measure hope: development and psychometric evaluation. *Journal of Advanced Nursing, 17*, 1251–1259.

HERTH HOPE INDEX

Listed below are a number of statements. Read each statement and place an [X] in the box that describes how much you agree with that statement right now.

Study No. _____

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I have a positive outlook toward life.				
2. I have short and/or long range goals.				
3. I feel all alone.				
4. I can see possibilities in the midst of difficulties.				
5. I have a faith that gives me comfort.				
6. I feel scared about my future.				
7. I can recall happy/joyful times.				
8. I have determiner strength.				
9. I am able to give and receive caring/love.				
10. I have a sense of direction.				
11. I believe that each day has potential.				
12. I feel my life has value and worth.				

1999 items 1 & 3 reworded

Herth Hope Index Permissions

From: "Herth, Kaye A" <[redacted]>
Subject: [External] RE: Herth Hope Index Permission for Dissertation PUBLISHING
Date: March 10, 2023 at 8:21:38 AM CST
To: "Parker, Kharma" <[redacted]>

Dear Kharma,
Congratulations on successfully defending your dissertation; a very significant achievement. I look forward to receiving a summary of the study results once it has been accepted by the Liberty University library. You have my permission to include the Herth Hope Index in your dissertation but ask that you place a diagonal mark across the document with the words copyrighted. Please let me know if that is not possible.

Best wishes as you continue your life journey; I am sure you are going to do great things.
Sincerely,
Kaye Herth PhD, RN, FAAN
Dean Emerita, Minnesota State University, Mankato

From: Parker, Kharma <[redacted]>
Sent: Friday, March 10, 2023 2:21 AM
To: Herth, Kaye [redacted]
Subject: Herth Hope Index Permission for Dissertation PUBLISHING

Dr. Kaye Herth,

I have successfully defended my dissertation titled: An N of 1 Times Series of the Efficacy of Internal Family Systems and Christian Inner Healing Prayer with Adult Survivors of Childhood Trauma.

I thank you, again, for your permission to utilize the Herth Hope Index (HHI) in the study. I will be sending you a summary of the results once the final dissertation document is accepted by the Liberty University library.

Copyright laws being what they are, Liberty is very clear that permission to *use* and permission to *publish* are two very different things. I am writing today to seek permission to **publish** the HHI instrument in the appendix of my study document.

Respectfully,

Kharma Parker
EdD, LPC, LMFT

Liberty University
Lynchburg, Virginia

From: "Herth, Kaye A" <[redacted]>
Subject: [External] RE: Herth Hope Index Permission
Date: May 23, 2022 at 6:17:27 AM CDT
To: "Parker, Kharma" <[redacted]>

Dear Kharma,
I appreciate your interest in the Herth Hope Index (HHI). I have attached the HHI, scoring instructions, and two reference lists of published articles on hope.

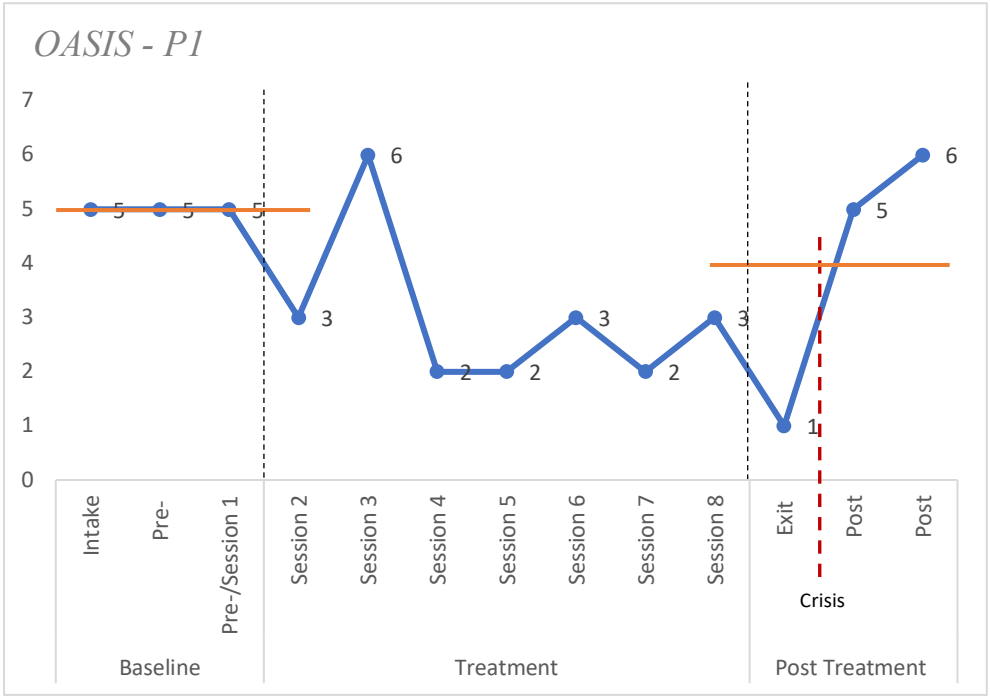
You have my permission to use the HHI in your research project as described in your email message. Please send me a summary of your study findings upon completion.
Best wishes in your educational journey and highly important research study.
Sincerely,
Kaye Herth PhD, RN, FAAN
Dean Emerita
Minnesota State University, Mankato

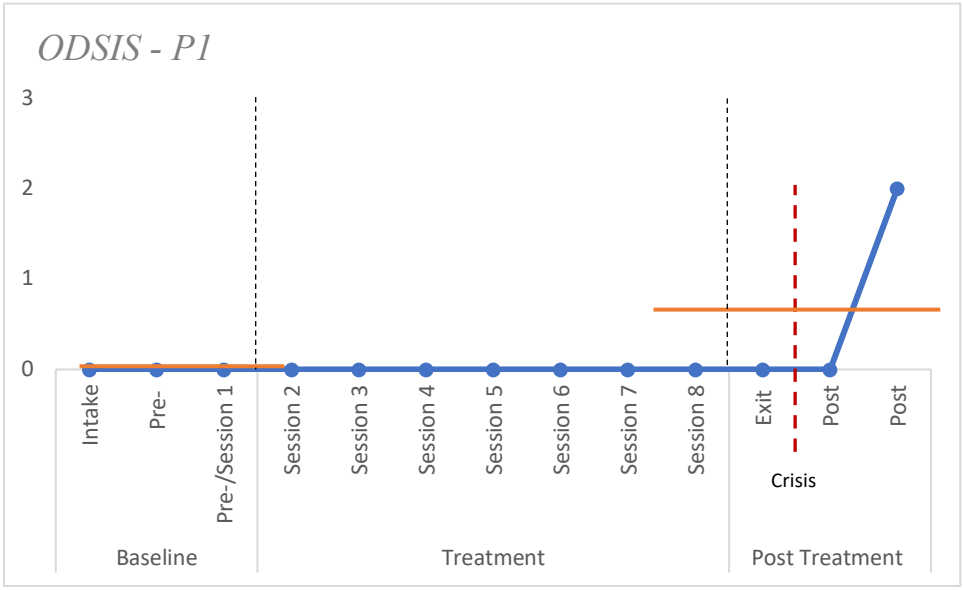
From: Parker, Kharma <[redacted]>
Sent: Sunday, May 22, 2022 9:25 PM
To: Herth, Kaye A <[redacted]>
Subject: Herth Hope Index Permission

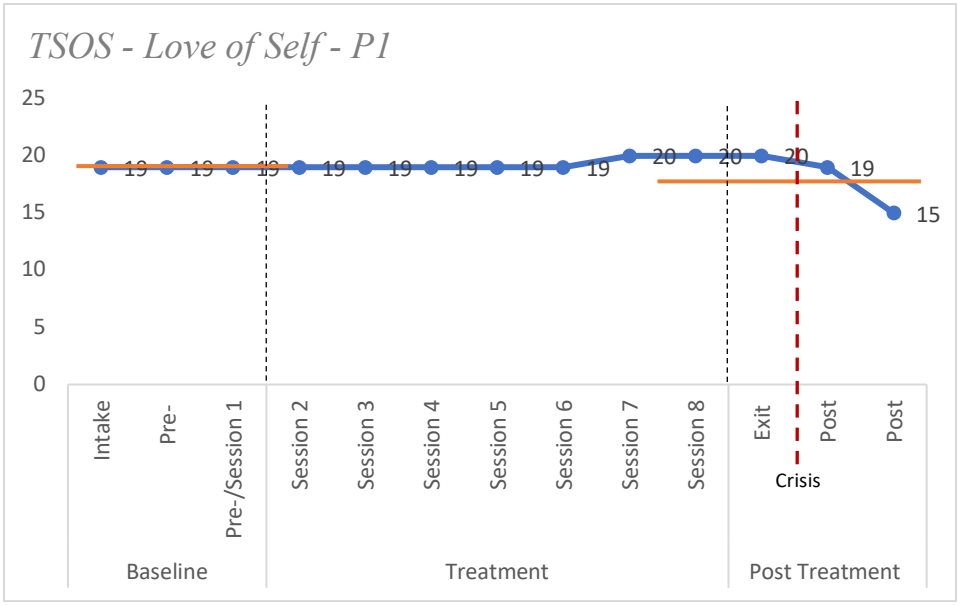
> Dr. Kaye Herth,
>
> I am a graduate student at the School of Behavioral Sciences at Liberty University, I am conducting research as a part of the requirements for a doctoral degree in Community Care and Counseling with a Traumatology emphasis. The title of my research project is: An N of 1 Times Series of the Efficacy of Internal Family Systems and Christian Inner Healing Prayer with Adult Survivors of Childhood Trauma. I have received IRB approval on 5/17/22. I am writing you to seek permission to utilizing the Herth Hope Index in my study.
>
> Respectfully,
>
> Kharma K. Parker
> MS, LMFT, LPC
>
> Doctoral Candidate
> Liberty University,
> Lynchburg, VA

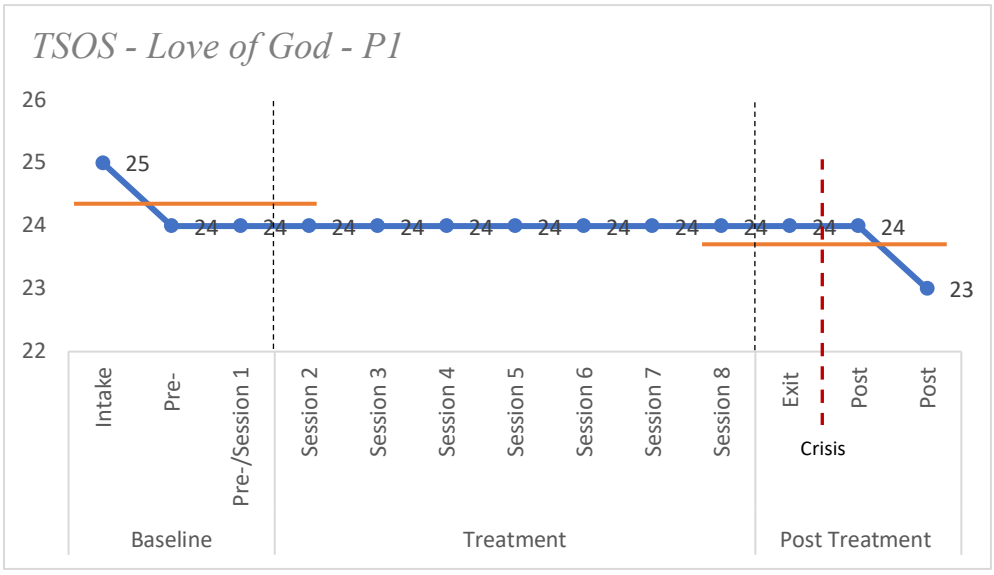
Appendix O

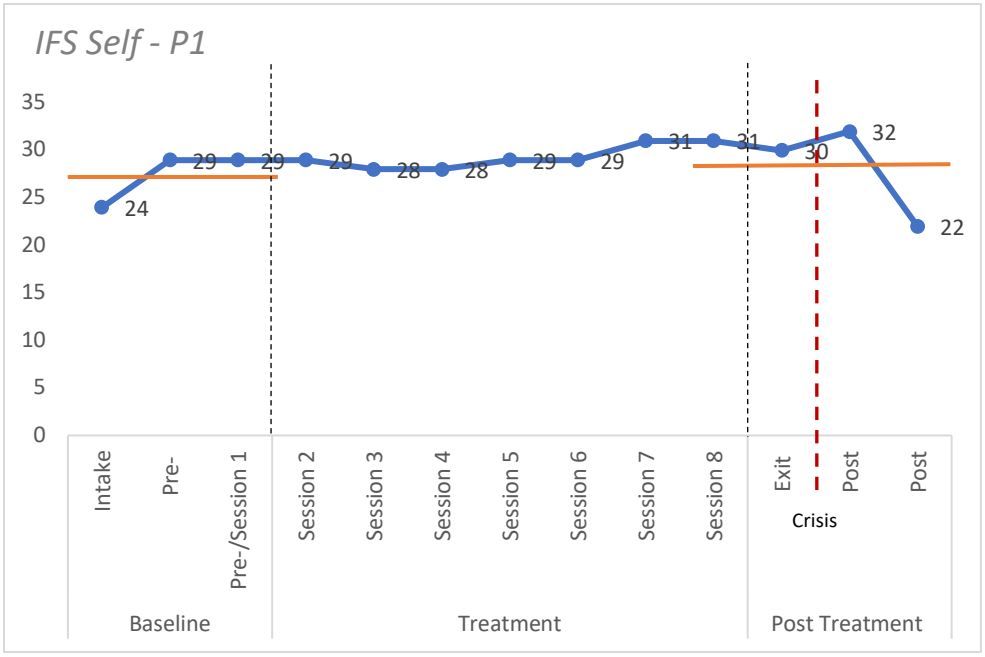
Individual Results






TSOS - Love of Self - P1
25
20
15
10
5
0
19 19 19 19 19 19 19 19 20 20 20 19 15
Intake
Pre-
Pre-/Session 1
Session 2
Session 3
Session 4
Session 5
Session 6
Session 7
Session 8
Exit
Post
Post
Crisis
Baseline
Treatment
Post Treatment


TSOS - Love of God - P1
26
25
24
23
22
25 24 24 24 24 24 24 24 24 24 24 24 24 23
Intake
Pre-
Pre-/Session 1
Session 2
Session 3
Session 4
Session 5
Session 6
Session 7
Session 8
Exit
Post
Post
Crisis
Baseline
Treatment
Post Treatment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Intake
Pre-
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Session 2
Session 3
Session 4
Session 5
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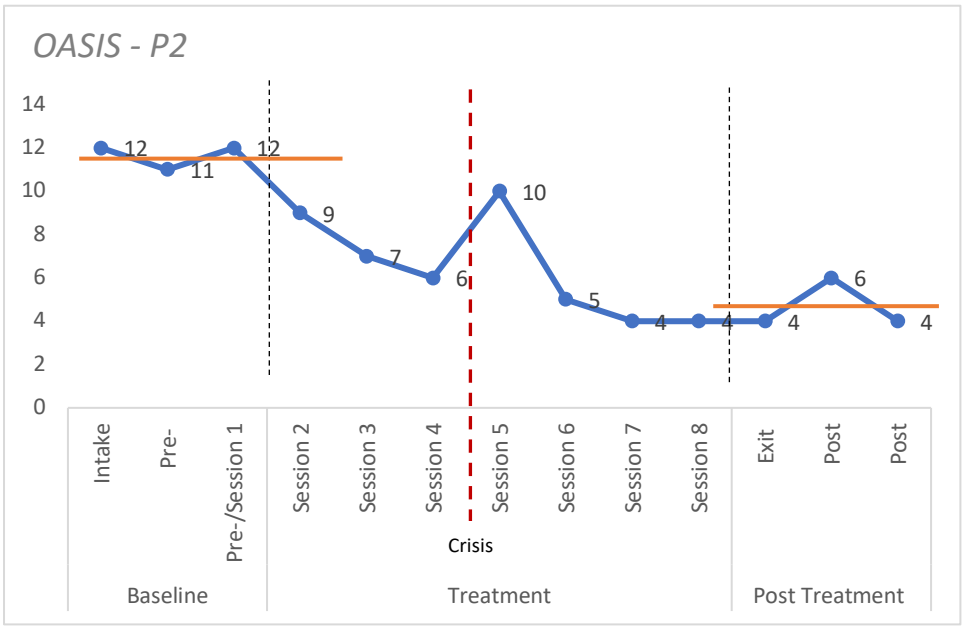
Session 7
Session 8
Exit
Post
Post
Crisis
Baseline
Treatment
Post Treatment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Intake
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Session 3
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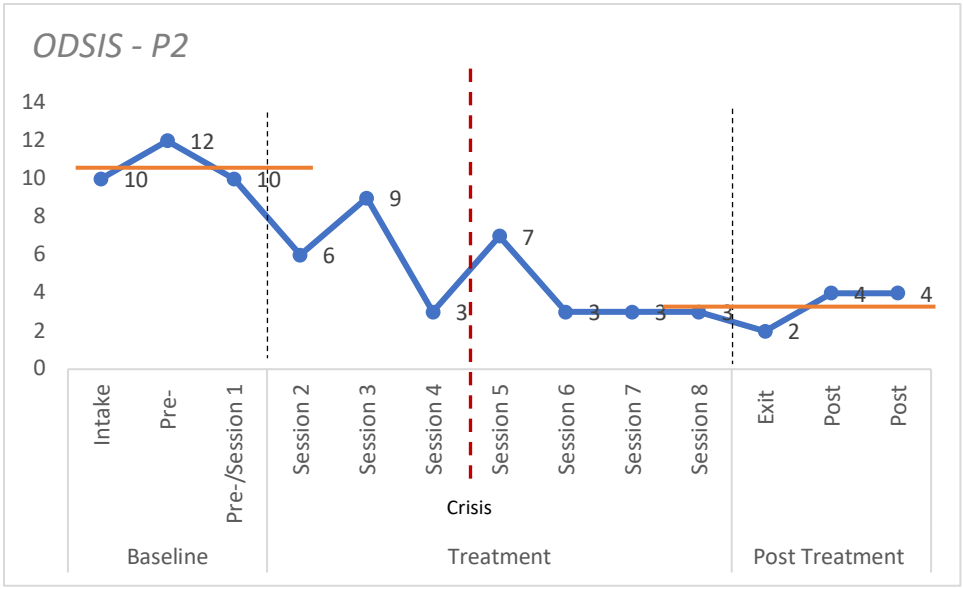
Session 7
Session 8
Exit
Post
Post
Crisis
Baseline
Treatment
Post Treatment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Intake
Pre-
Pre-/Session 1
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Session 3
Session 4
Session 5
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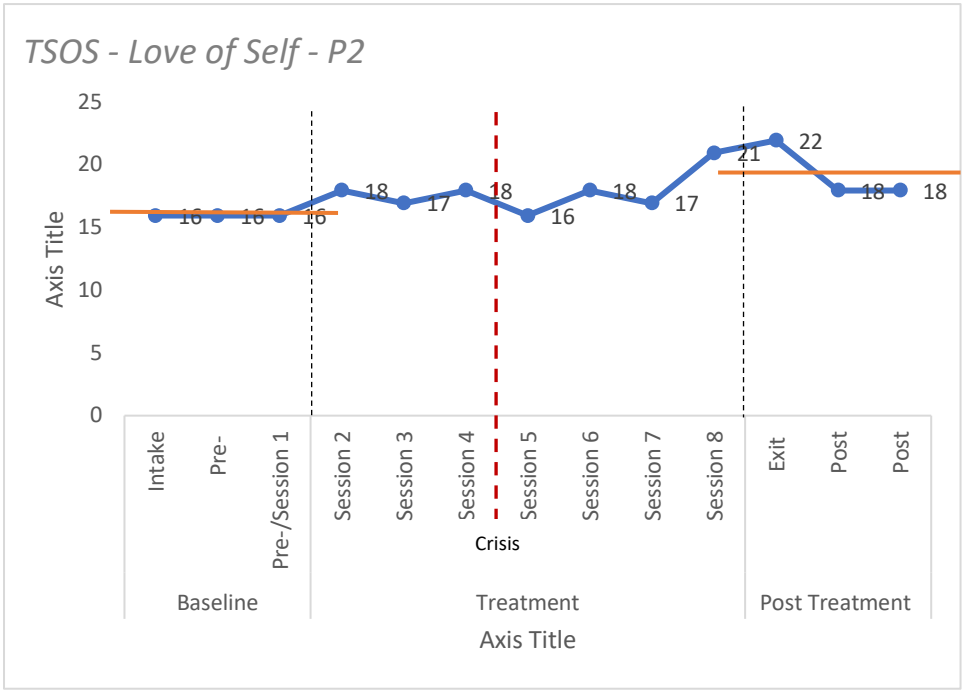
Session 7
Session 8
Exit
Post
Post
Crisis
Baseline
Treatment
Post Treatment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Axis Title
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Intake
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Exit
Post
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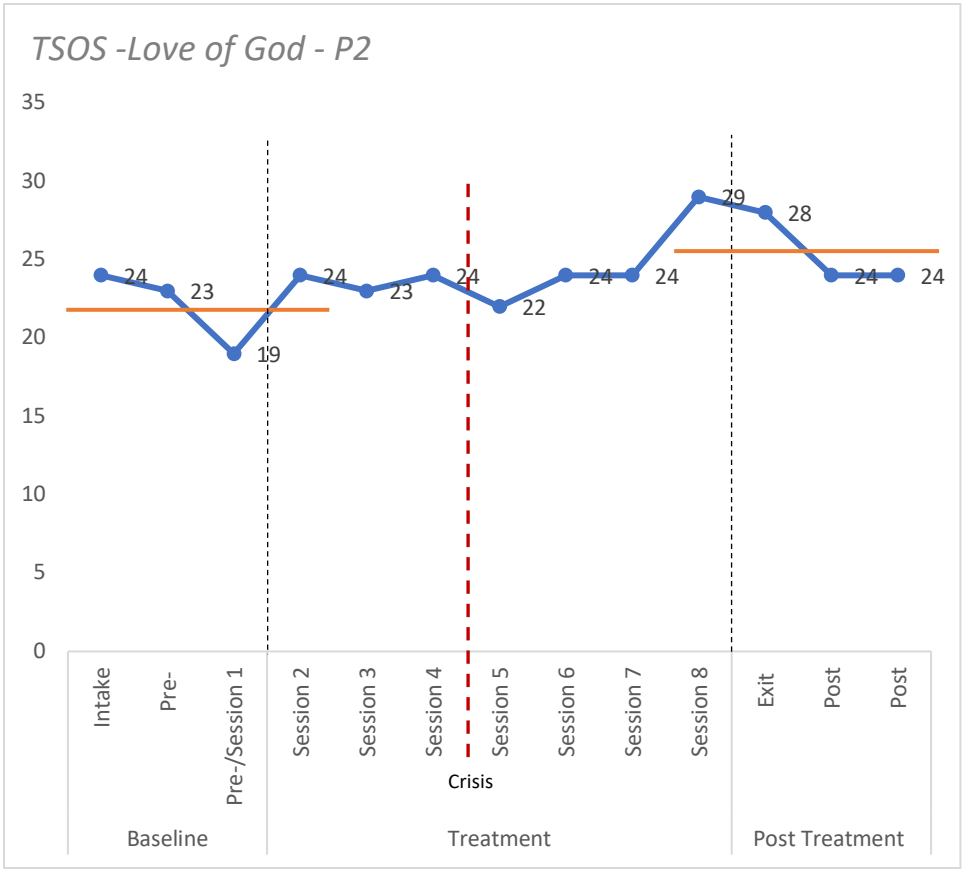
Crisis
Baseline
Treatment
Post Treatment
Axis Title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Intake
Pre-
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Session 7
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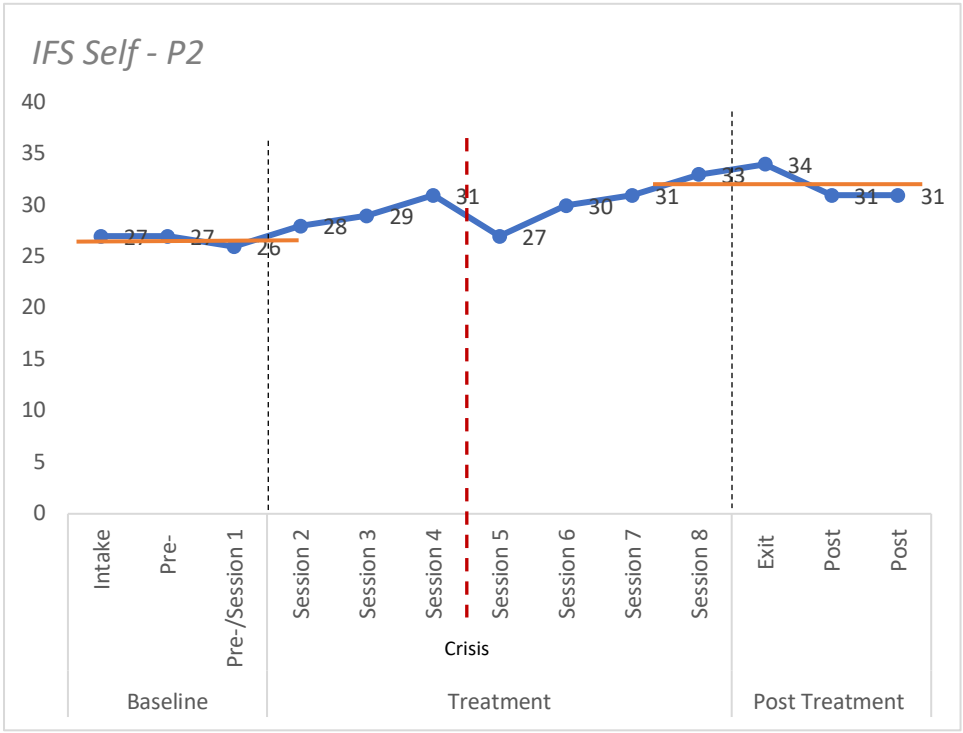
Exit
Post
Post
Crisis
Baseline
Treatment
Post Treatment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Intake
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Exit
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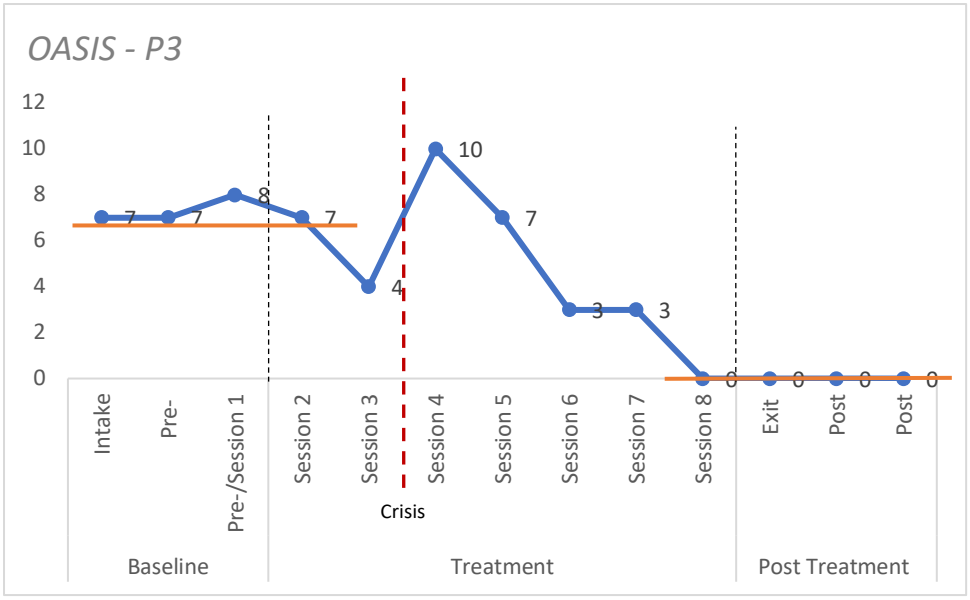
Post
Crisis
Baseline
Treatment
Post Treatment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Intake
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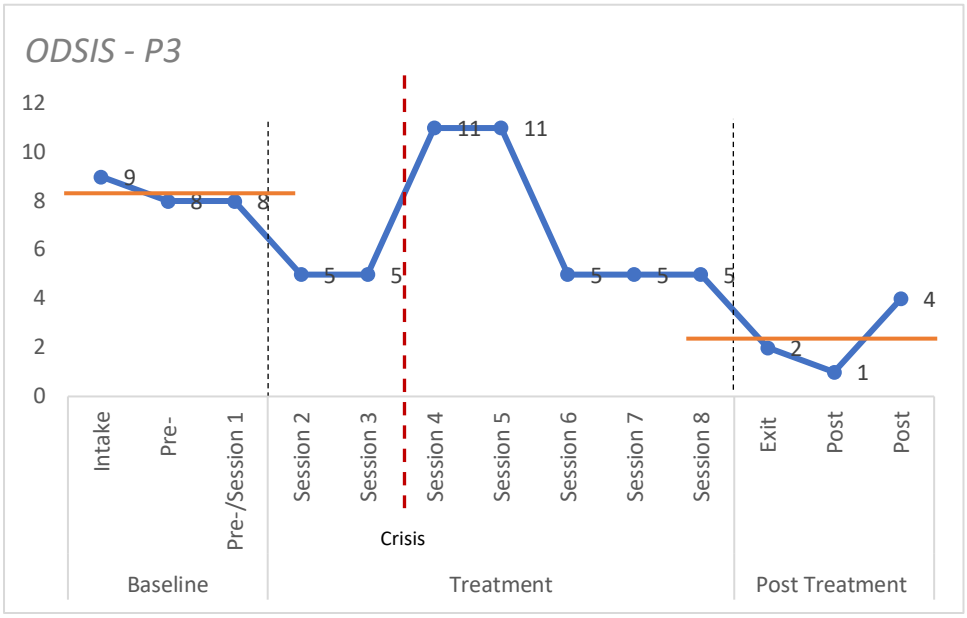
Crisis
Baseline
Treatment
Post Treatment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Intake
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Crisis
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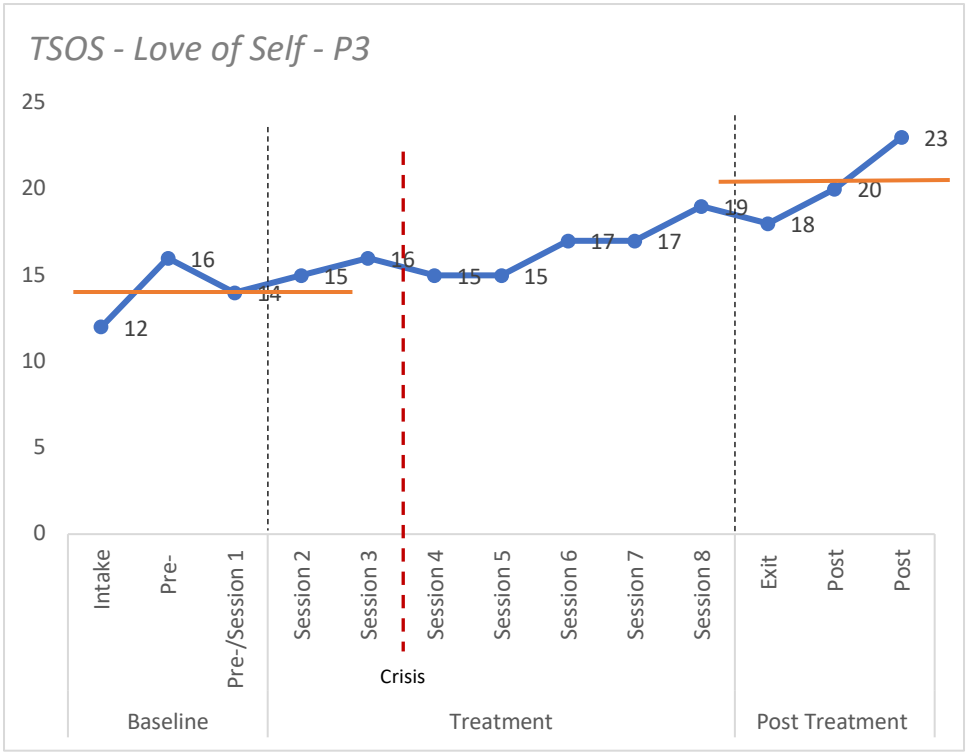
Treatment
Post Treatment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Intake
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Crisis
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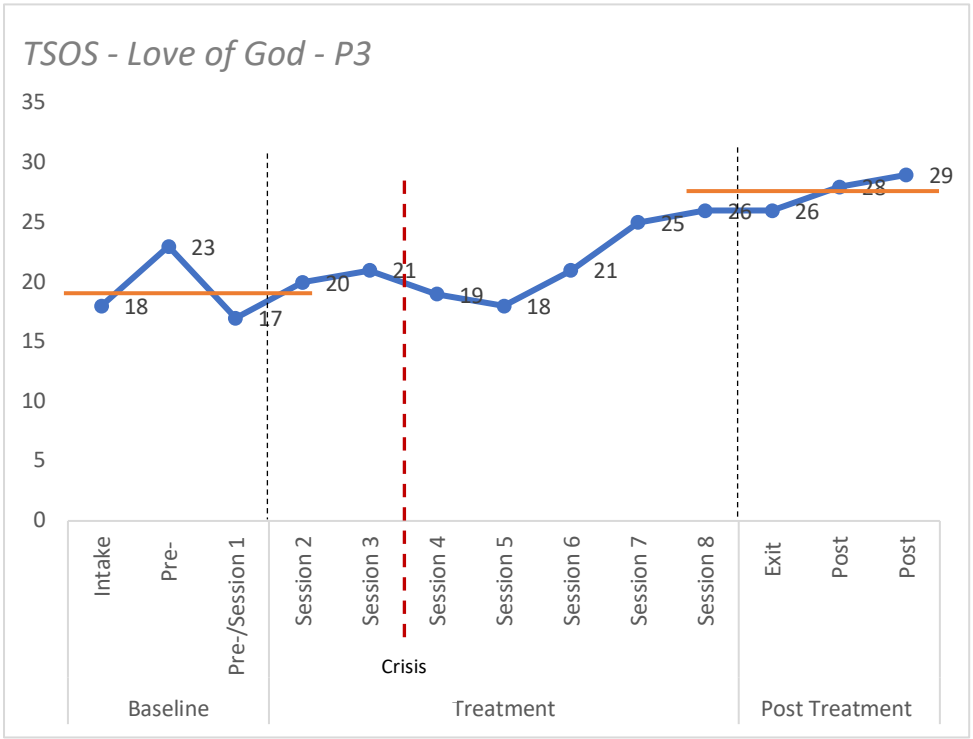
Treatment
Post Treatment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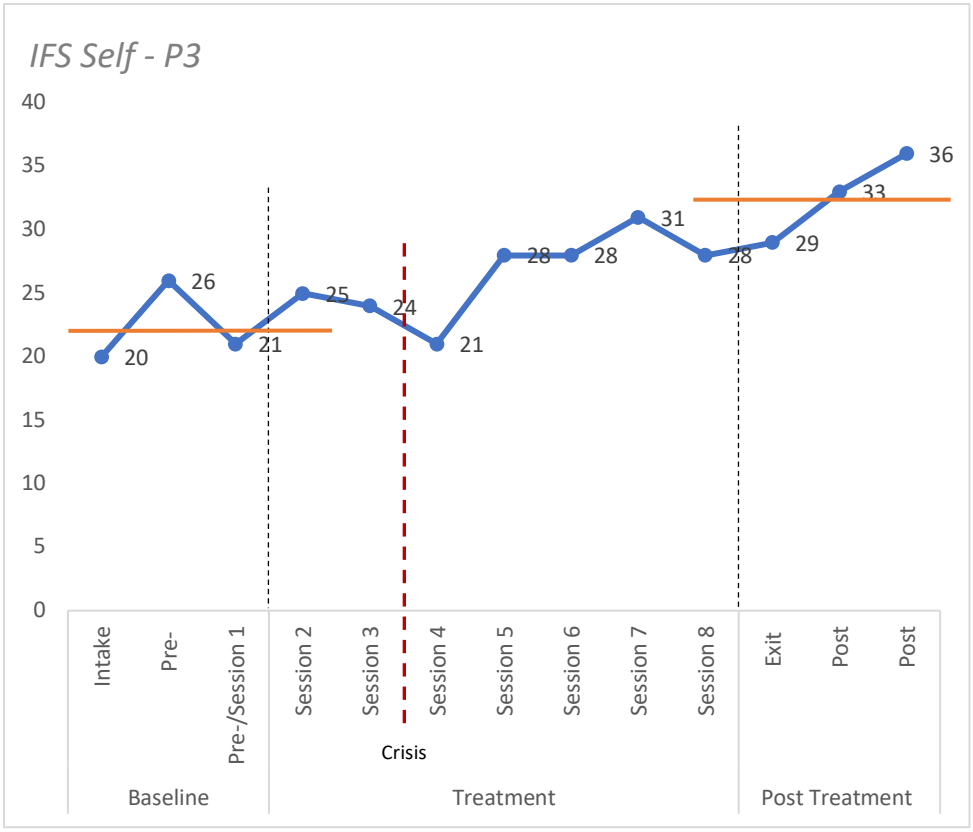
Crisis
Baseline
Treatment
Post Treatment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Crisis
Baseline
Treatment
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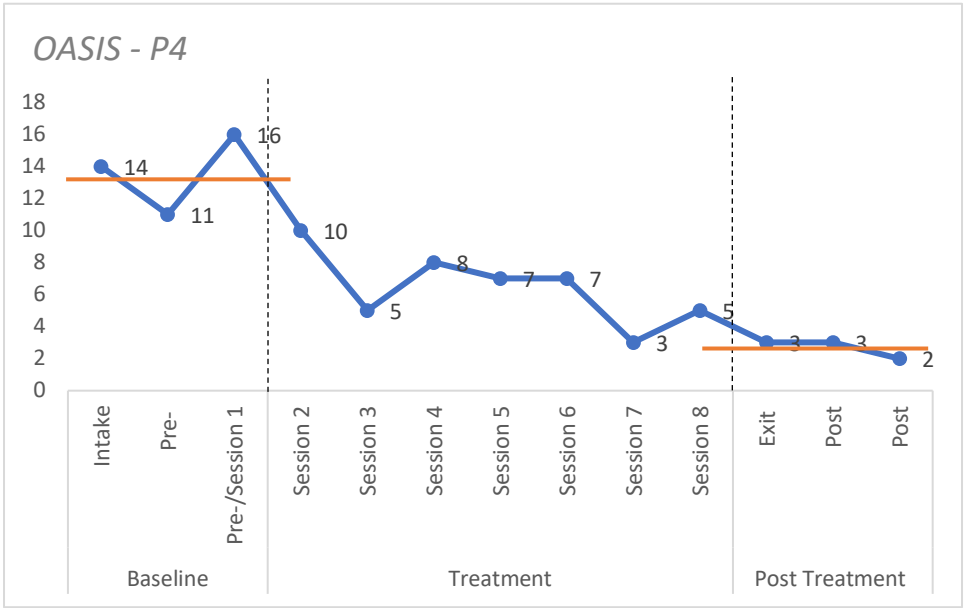
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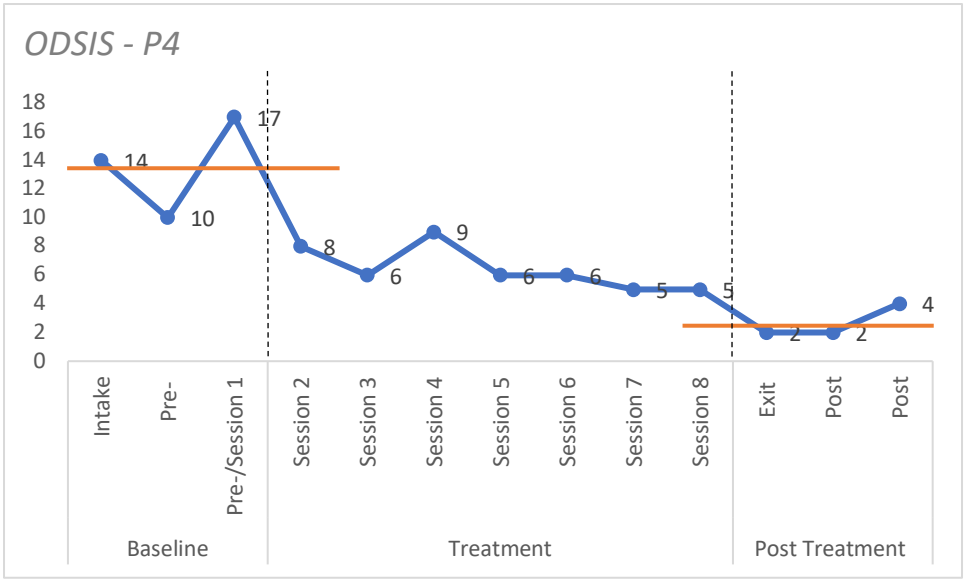
Treatment
Post Treatment


ODSIS - P4
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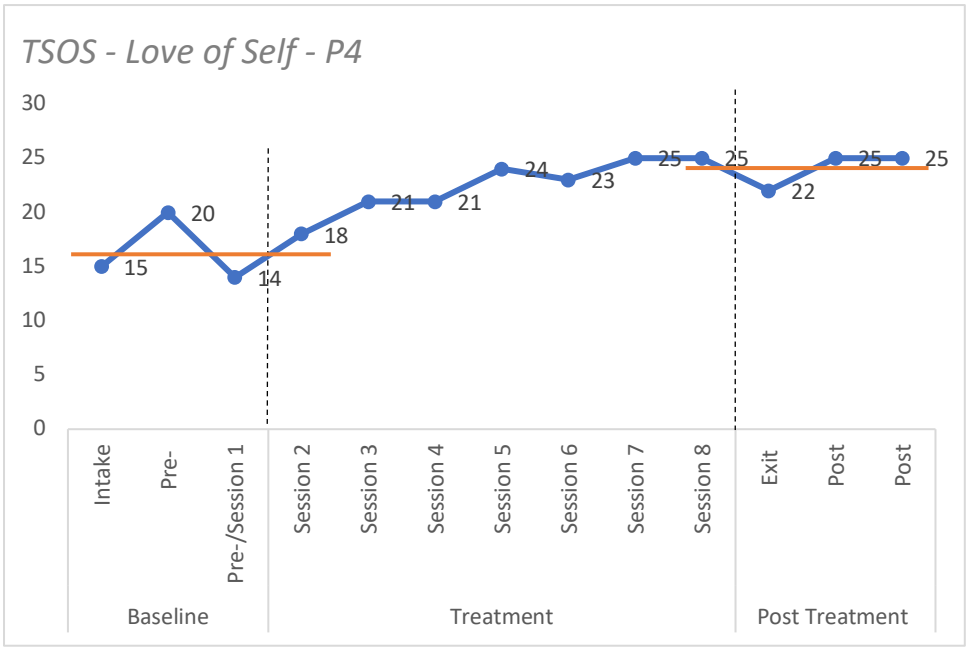
Baseline
Treatment
Post Treatment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Intake
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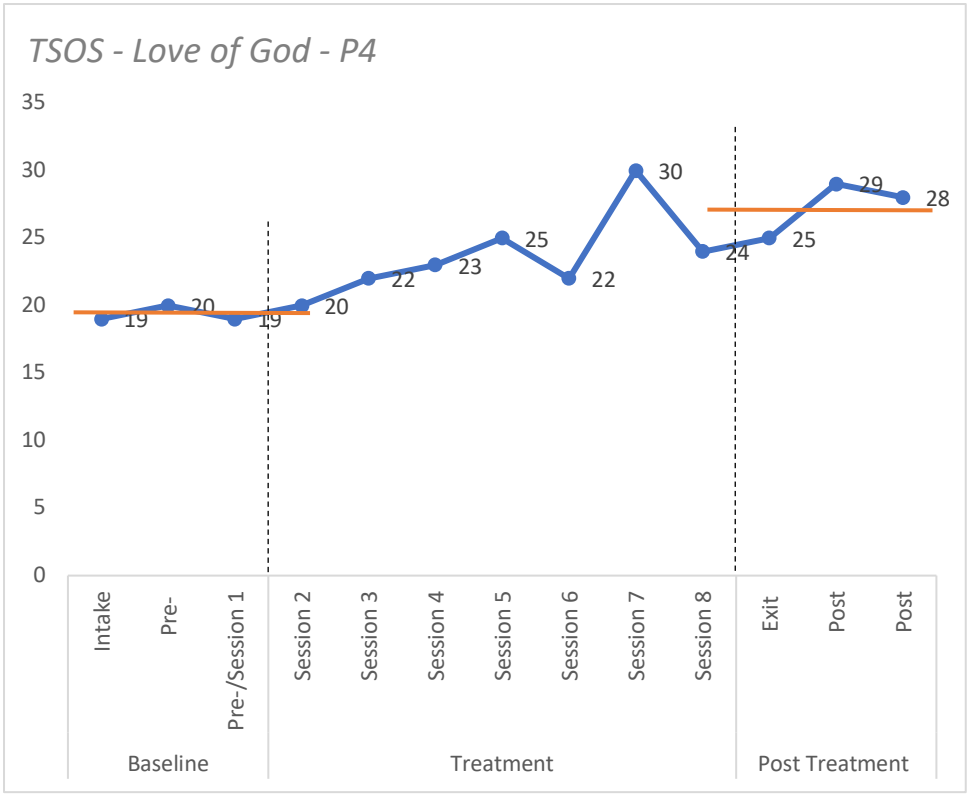
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Intake
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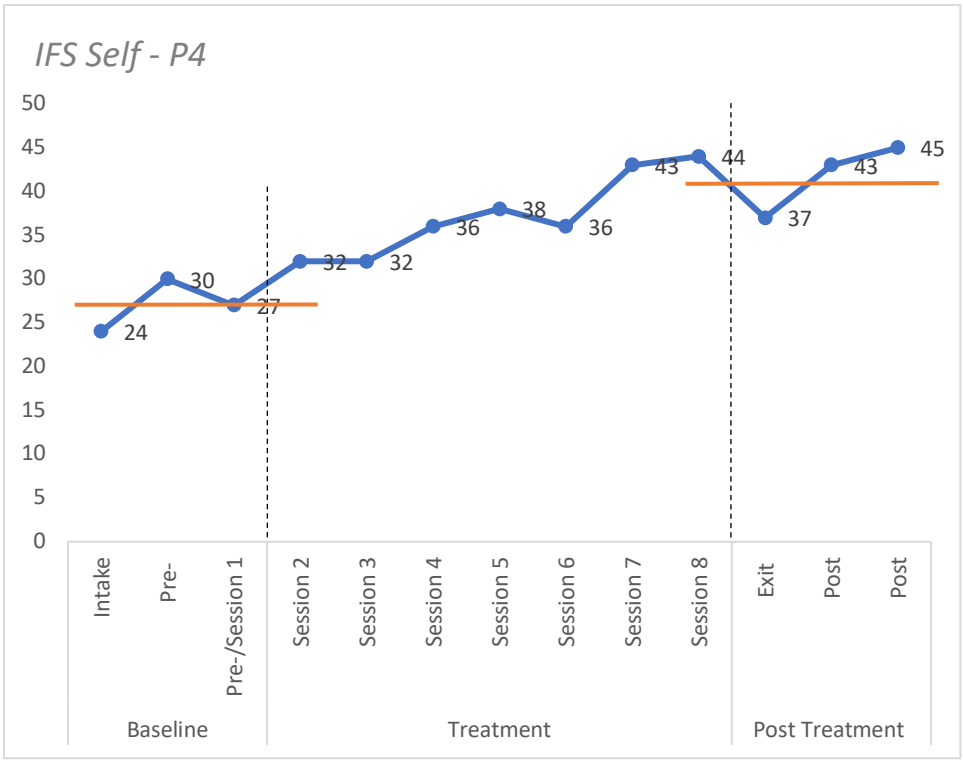
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Intake
Pre-
Pre-/Session 1
Session 2
Session 3
Session 4
Session 5
Session 6
Session 7
Session 8
Exit
Post
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Baseline
Treatment
Post Treatment