A QUALITATIVE EXPLORATION OF PRACTITIONER PERSPECTIVES ON RESILIENCE IN CHILDREN WHO HAVE EXPERIENCED CSA AND THE ROLE OF SPIRITUAL AND RELIGIOUS COPING

by

Lauren S. Hamrick

Liberty University

A Dissertation Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

Liberty University

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ABSTRACT

Traumatic events, such as child sexual abuse (CSA) can negatively impact a child's development across multiple biopsychosocial domains. Yet, many who experience CSA emerge resilient. Resilience involves multiple internal and external strengths that enhance a person's ability to move beyond adversity and thrive. Research has pointed to the protective influence of spiritual and religious coping (R/S coping) among trauma survivors; however, there remains an absence of knowledge regarding the use of R/S coping in children. Therefore, I sought to fill the gap in the literature and capture the experiences of mental health practitioners who treat children who have experienced CSA, with the goal of understanding practitioners' experience with resilience in their child clients, with a special emphasis on the use of R/S coping. Using qualitative phenomenological methodology, I conducted interviews with 15 mental health practitioners who work with sexually abused children. Important components of a child's resilience included external assets such as nurturing and supportive caregivers, and community-based and supportive group activities. Internal child resilience resources included practicing problem-solving coping, leveraging interpersonal resources, emotion-regulation and meaning-making. Spiritual resilience behaviors children use included the connection between the mind and body, attunement outside of self, and engaging in compassionate behaviors. Religious coping practices included spiritual connection with God, family and others; finding support from prayer, religious music and writings, and forgiveness; and meaning-making. Children did experience some spiritual struggle as a result of dismissive or invalidating religious statements, judgement, and CSA connected to the religious community, but many were able to successfully resolve these spiritual

struggles. Practitioners reported being careful to assess, explore, and integrate a child's religious and spiritual beliefs as appropriate. Practitioners incorporated religious coping during relaxation or regulation practice, during cognitive processing of the trauma, and through creative methods with young clients. Insights from this study confirm and add to current understanding about CSA and resilience in children. Themes discovered from the exploration of R/S coping in children reveal aspects of positive and negative religious coping that can enhance or reduce resilience. Additionally, this study exposes important insights regarding practitioners' assessment and incorporation of R/S coping in work with sexually abused children.

Keywords: child sexual abuse, resilience, coping, religious coping, practitioner perspectives, qualitative

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Dedication

I want to dedicate this dissertation first to my husband, James, without you this dream would never have been fully realized. I am so thankful that God put you in my life. Thank you for your encouragement, your love, your strength, and the foundation you have provided for me to succeed. Thank you for your heartfelt celebration at each and every step, which kept me going! You are my gift from God! Second, to my daughter Halle. In the beginning of my doctoral journey, you began a journey of your own. I am in awe of your courage and continue to be impressed by the wisdom you have beyond your years. Your willingness to proofread my writing and the kind uplifting feedback you gave, has been a treasured experience that most parents do not have, I cannot wait to see your own dreams realized!

I also want to recognize and dedicate this dissertation to the countless professionals that dedicate their lives to helping children who have experienced all forms of maltreatment, but especially CSA. You are the heroes that actively seek and cultivate resilience in children. You are the individuals who hear, feel, and know what these children experience. Thank you for your willingness to step into the trenches with children, providing pathways to hope. Matthew 25: 34-40 states, “The King will say to those on his right, ‘Come, you who are blessed by my Father; take your inheritance, the kingdom prepared for you since the creation of the world’… ‘Truly I tell you whatever you did for one of the least of these brothers and sisters of mine, you did for me.’” May God continue to bless the work of your hands.

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CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

According to the World Health Organization (2020), worldwide one in five women and one in thirteen men reported they were sexually abused as children. The adverse short and long-term consequences of child sexual abuse (CSA) have been extensively documented and researched over the past forty years (Domhardt et al, 2015). This has created increasing awareness regarding the prevalence and impact of CSA and has provided a platform for the stories of survival and resilience (Collin-Vezina et al., 2013). Through this research, we have a greater understanding of the complex nature of CSA trauma and its impact on children and families (Collin-Vezina et al., 2013). However, because sexual abuse is a multi-layered problem, practitioners and communities need to continue to explore avenues to help families and sexually abused children emerge resilient.

Spiritual and religious coping have been identified as having a positive influence both on resilience and an individual's ability to cope with a variety of life struggles, including illness, loss, trauma, and specifically CSA (Pargament et al., 2011; Peres et al., 2007; Vilvens et al., 2021; Van Dyke et al., 2009). Positive spiritual and religious coping, CSA, and resilience have primarily been studied using adult samples of CSA survivors responding to their childhood experiences from an adult perspective. Additionally, studies on CSA and resilience may mention spiritual and religious coping, but fewer studies examine these constructs with children. Mental health practitioners who work with CSA survivors have a unique vantage point to elevate understanding regarding factors associated with resilience from CSA. These practitioners have a working

knowledge of child development, CSA, and elements that relate to healing. Thus, this study sought to enhance CSA resiliency research by speaking to clinicians who work with child victims of SA regarding factors associated with resiliency, emphasizing the exploration of spiritual and religious coping.

Background

In Christian literature and the Bible, the word, "resilience" may not be overtly used. However, the Bible is full of accounts of historical figures who experienced suffering that fuels perseverance, faith, and the ability to endure. An encounter with suffering is a guaranteed experience in this earthly life. Jesus, who was both God and man, lived his short life on earth immersed in suffering with a climax of anguish as he was nailed to and died upon a Roman cross. Yet, the story does not end in tragedy; the story ends with the resurrection three days later, and the promise of redemption for those who accept that gift. Those who follow him, such as the Apostle Paul, recognized the paradox of strength amid weakness. In 2 Corinthians 12:10, Paul states, "For when I am weak, then I am strong" (*New International Version Bible*, 2011). The ability to endure through the experience of adversity is the hallmark of resilience.

Resiliency

Resiliency research has gained momentum over the past several decades. The research arose after a group of pioneering researchers who were examining children raised in various challenging circumstances noticed the capacity of some to thrive despite experiencing deprivation (Garmezy et al., 1984, Rutter, 1989; Werner & Smith, 1982). The concept of resiliency appears straightforward; however, it is a challenging construct

to define. Resilience is defined as the ability of a human (or family or community) to maintain a trajectory of positive functioning during stress (Liu et al., 2017; Unger, 2019). This trajectory is a deviation from expected psychopathology or other maladaptive outcomes, which may be a predicted response based on the level of adversity (Liu et al., 2017). The capacity for resilience encompasses biopsychosocial systems or could be a network of systems (internally or externally) that interact to optimize the functioning of a person (Unger, 2019).

Resiliency is currently acknowledged as both an individual trait and a process (O'Dougherty-Wright et al., 2013). However, ultimately it is viewed as a bidirectional process that emphasizes a person-environment interaction, whereby the individual both is an influencer and is influenced by circumstances found within their environment, such as a person's easy temperament and the experience of poverty (Liu et al., 2017; O'Dougherty et al., 2013). The processes that have been identified as "protective" can be separated into three categories that entail individual, environmental, and regulatory influences (Hornor, 2016). These include internal factors such as optimism, self-efficacy, and regulation, as well as external factors of the person such as the presence of supportive adults, a safe neighborhood, and access to care services (Goldstein & Brooks, 2013).

Resiliency and CSA

Resiliency is dependent upon some type of suffering (Richardson, 2002). Research on the maltreatment of children has long recognized the threat that childhood maltreatment has to the subsequent development and well-being of the individual (Masten, 2018). Child abuse in all forms disrupts the functioning of children in a multisystemic way, making it a significant predictor of physical, mental, emotional,

relational, and behavioral challenges in childhood as well as adulthood (Brewer-Smith & Koenig, 2014).

CSA as a form of child maltreatment has repeatedly been shown to have a potentially devastating impact on functioning (Marriott et al., 2014). Psychologically, CSA survivors may experience mood disturbances such as depression as well as anxiety disorders, posttraumatic stress, dissociation, or personality disorders (Collin-Vezina et al., 2013; Gal et al., 2011; Trickett et al., 2011). Those who have experienced CSA are also at risk for physical health concerns, academic failure, substance abuse, sexual risk-taking behavior, and behavioral disturbances, in addition to self-harm or suicide (Banyard et al., 2017; Collin-Vezina et al., 2013; Ferguson et al., 2013; Najaman et al., 2023; Trickett et al., 2011). Yet despite the risk factors associated with CSA, some individuals can maintain or regain healthy functioning and experience post-traumatic growth (Kaye-Tzadok & Arad, 2016; Yoon et al., 2020).

Factors that influence resilience following CSA are numerous. As with other types of traumas and resilience, for those who have experienced CSA, resilience is associated with variables that involve the individual, internal factors, and variables outside the person, or external factors (Domhardt et al., 2015). In a review of thirty-seven adult and child CSA studies, Domhardt et al., (2015) found a “normal level of functioning” in 10-53% of the population. Resilience is related to internal factors connected with the child including having a good temperament, social and cognitive skills, the ability to regulate emotions, a positive outlook, self-esteem, religiosity, and internal control beliefs (Borg et al., 2019; O’Dougherty-Wright et al., 2013). Family characteristics such as high-quality caregiving, a stable home, educated parents, and

positive sibling relationships are also correlated with resilience (Domhardt et al., 2015; O'Dougherty-Wright et al., 2013; Vilvens et al., 2021). Last, community characteristics, for example, affordable housing, access to healthcare, effective schools, prevention programs, and adult mentors all serve to stimulate resilience in CSA survivors (Domhardt et al., 2015; Marriott et al., 2014; O'Dougherty-Wright et al., 2013). Despite the large amount of research on resilience and CSA, these studies regularly use adult populations, requiring the individuals to retrospectively answer questions regarding events in their childhood, rather than utilizing child or adolescent samples (Beaujolais et al., 2021).

CSA, Resiliency, and R/S Coping

Spirituality and religion are sources of strength in many people's lives and are a predominant force across several cultures globally (Ano & Vasconcelles, 2005). The practice of religion or spirituality has permitted those suffering to cope and may serve to elevate recovery and self-growth by providing hope, meaning, and support amidst the traumatic experience (Peres et al., 2007; Schaefer et al., 2018). Religion and spirituality are considered separate constructs in scientific research; however, there are significant areas of overlap and thus they are viewed as correlated constructs (Pargament et al., 2006). Researchers agree that religious coping and spiritual coping have features that distinguish one from another (Oman, 2015). However, these concepts are recognized as interrelated and complementary and thus should be viewed in terms of connectedness (Oman, 2015; Pargament et al., 2006). Within the field of psychology, religiosity is viewed as centering around a set of beliefs and practices that are recognized by a specific organization or institution, and spirituality is related to the pursuit of the "sacred" (Pargament et al., 2011). Spirituality does not have to be connected to an organized or

institutionalized set of practices, but commonly spirituality is experienced within organized religion (Bryant-Davis, 2012; Pargament et al., 2011). Frequently, public and academic institutions link these concepts, citing that individuals can engage with the scared privately within the context of organized religious institutions (Walker et al., 2009).

Using religion and spirituality to recover and grow from adversity is referred to as religious and spiritual coping (R/S coping) (Schaefer et al., 2018). Within the construct of R/S coping, there can be positive forms of R/S coping (PRC) and negative forms of R/S coping (NRC), with PRC being associated with increased resilience (Schaefer et al., 2018). PRC includes concepts such as forgiveness or benevolent religious reappraisals, and NRC, which is negatively related to resilience, includes punitive or demonic reappraisals and views of God as rejecting (Pargament et al., 2013; Schaefer et al., 2018).

In CSA and child maltreatment literature, R/S coping has been related to resiliency in populations with adults and with children. Qualitative studies with adult samples have cited participants' adaptive use of R/S coping to create meaning, gain social support, regulate thoughts and emotions, and have hope for the future (Newsom & Myers-Bowman, 2017; Singh et al., 2012; Singh et al., 2013). R/S coping has been demonstrated to moderate the connection between CSA and depression in samples of adolescents and adults and post-traumatic stress in adults (Doxey et al., 1997; Freeny et al., 2021; Sigurvinsdottir et al., 2021). While researchers have explored R/S coping and resilience from stress or trauma, this concept, as it relates to CSA is limited. Furthermore, understanding this idea with children and adolescents is especially scarce, thus more understanding and research are needed in this area.

Problem Statement

Child maltreatment, and especially CSA, creates a public health problem. The consequences of CSA are vast and impact the child, family, and community at large (Finkelhor & Browne, 1985). An individual experiencing CSA is at an elevated risk of developing cognitive, social, emotional, and behavioral problems in childhood and adolescence that continue into adulthood (Heger, 2022). Yet, despite the trauma connected with CSA, some of these children will exhibit a capacity to function and perform within or above psychological and developmental norms (Beaujolais et al., 2021).

Individuals who have positive outcomes despite experiencing “threats to adaptation” are described as “resilient” (Masten, 2001). Resilience is thought to be both a process and an outcome, which encompasses several aspects of adaptability, including internal and external constructs. Research has demonstrated that spiritual and religious coping is associated with both risk and protective factors that relate to resilience following CSA. However, the specific way spiritual and religious coping influences child (not adult) sexual abuse survivors’ resilience is less clear.

Resilience research involving CSA that captures mental health practitioner perspectives has been largely missing from the literature (Beaujolais et al., 2021; Dillard et al., 2021). The studies that are available do not directly explore practitioner perspectives about resilience and children in general or inquire about the role of spiritual and religious coping on resilience in children. This is a missed opportunity. Practitioner interviews offer a unique chance to obtain knowledge from individuals with expertise in child development and CSA. Mental health practitioners are well-positioned to provide

insight into R/S coping and recognize the mechanisms that are responsible for healthier outcomes (Beaujolais et al., 2021; Yoon et al., 2020).

Phenomenological qualitative inquiry provides a framework that allows the participants, mental health practitioners, to expand on their responses. Therefore, this study sought to qualitatively explore mental health practitioner perspectives regarding the role of resilience in children who have experienced CSA, and the way that spiritual and religious coping can influence resilience. It is my hope this study can encourage dialogue between mental health professionals and members of faith communities regarding ways to support survivors of CSA. Additionally, the perspectives of the professionals can guide researchers regarding future areas of study, and potential positive spiritual and religious coping strategies, that can be used in the treatment of CSA survivors.

Purpose of the Study

The purpose of this qualitative phenomenological study is to gain a substantial and meaningful understanding of practitioners' perspectives on resilience in children who have experienced CSA. Additionally, the specific influence of spiritual and religious coping on resilience, and the ways clinicians may incorporate R/S coping in their treatment of CSA survivors, was explored.

Research Questions

The specific research questions were:

1) How do practitioners describe resilience in child clients who have experienced sexual abuse?

2) What are the practitioner perspectives regarding the role of spirituality in the development of resilience following CSA?
3) What are the practitioner perspectives regarding the role of religious coping in the development of resilience following CSA?
4) What aspect(s) of spiritual and religious coping do practitioners believe made the largest contribution to their resilience?
5) How do practitioners encourage and /or facilitate spiritual or religious coping in their CSA clients?

Assumptions and Limitations of the Study

Assumptions

There were several assumptions made regarding important aspects of this study. First, I assumed the qualitative methodology would be appropriate to address the research problem and that the interview questions would accurately reflect the phenomena, resiliency, being explored. The target sample for the study was mental health practitioners who work with children and adolescents who have experienced CSA. I worked in child advocacy centers and as a mental health practitioner for over twenty years and therefore, assumed I would have the ability to access practitioners who were willing to share their personal experiences with clients regarding resiliency and R/S coping. Additionally, I assumed the participants would have a knowledge and understanding of the concepts and factors connected to children and adolescents, resilience, and R/S coping that are consistent with the knowledge that mental health practitioners with a minimum of a master's degree in some type of mental health counseling would have. I assumed that participants would possess a willingness to share

truthfully and honestly. Last, I assumed the concept of resiliency from CSA would be important to the participants, as restoration and healing are common goals of therapy. I assumed the results of this study would be meaningful for practitioners, researchers, and members of faith communities who work with children and adolescents.

Limitations

There were several limitations relating to this study. The first set of constraints involved the qualitative phenomenological design, which limits generalizability. Thus, the results may not be generalizable to all practitioners who work with children who have experienced CSA or all children who have experienced CSA. Additionally, the method of participant recruitment led to recruiting participants from one region, which could further influence generalizability. Regarding participant responses, with qualitative research that involves face-to-face interaction with another individual, there is potential for bias in responding, such as seeking to provide desirable responses. Last, when discussing resiliency and R/S coping, there may be a gap between what is known and understood in the academic community and what is practiced in a therapeutic setting. Thus, practitioners may not have knowledge of ways they are building these constructs into assessments or interventions.

Theoretical Foundations of the Study

This study focused on understanding spirituality, religious coping, and resilience in children who have experienced CSA through the eyes of their clinical practitioners. The study utilized the following theoretical frameworks to ground understanding of this topic: Attachment Theory, Finkelhor and Browne's (1985) Four-Factor Traumagenics Model, and Resilience Theory, with emphasis on the Resilience Portfolio Model (Bowlby

1969/1982; Grych et al., 2015; Richardson, 2002;). These theoretical foundations and models were utilized in the formation of research questions and interview questions and laid a groundwork for an understanding of the impact of CSA, resilience, and the processes of resilience, including spiritual and religious coping, as understood by the practitioners who treat them therapeutically.

CSA

Attachment Theory

Emerging out of an exploration of psychoanalytic object relations theory and evolutionary theory, Bowlby (1969/1982) explored the understanding of the infant-caregiver bond as a precursor and foundation of connection and love (Grady et al., 2017). The attachment that an infant has with their primary caregiver is deemed necessary for survival and believed to influence an individual throughout the lifespan (Bowlby 1969/1982; Kirkpatrick et al., 1990). Attachment theory posits that as children experience caregiving by their parent or primary caregiver, they create behavior patterns, beliefs, and expectations regarding that relationship (Bretherton, 1992; Kirkpatrick et al., 1990). As the caregiver readily and sensitively meets the needs of the infant, he or she in turn develops a sense of safety and security, which translates into "proximity-seeking" behaviors, especially when experiencing distress (Grady et al., 2017; Kirkpatrick et al., 1990). The infant utilizes this attachment with their primary caregiver as a "secure base" to explore the world around them (Kirkpatrick et al., 1990). Ainsworth et al. (1978), who studied individual differences in attachment styles, noted this style of attachment is known as the "secure attachment" and is the most common form of bond. This secure attachment is cultivated through the sensitivity and responsiveness of the caregiver to the

needs of the infant and represents the optimal form of attachment (Ainsworth et al., 1978; Grady et al., 2017). However, if the pattern of caregiver responsiveness is impaired, or the caregiver is inconsistently responsive, for example in the case of child abuse, an insecure attachment can be formed (Ainsworth et al., 1978; Grady et al., 2017; Kirkpatrick et al., 1990). Ainsworth et al. (1978) noted three styles of poor-quality attachment, anxious/ ambivalent, avoidant, and disorganized (Grady et al., 2017). These patterns of insecure attachments emerge through unresponsive, neglectful, abusive, or inconsistent caregiving (Grady et al., 2017; Kirkpatrick et al., 1990). Bowlby (1969) described the attachment of infants as working models that lead to attachment across a child's development into adulthood (Kirkpatrick et al., 1990). Research has consistently indicated that child maltreatment influences the security of attachment in childhood, as well as in the context of adult relationships (Cassidy & Shaver, 2016; Grady et al., 2017; Kirkpatrick et al., 1990).

Attachment theory was especially useful for this study when conceptualizing both the impact and resilience response in children who have experienced CSA, as well as resilience through spiritual and religious coping. Child abuse has been identified as one source of insecure attachment since the early stages of the development of Attachment theory (Ainsworth et al., 1978; Bowlby, 1969/1982). Research on the resilience of children who have experienced child maltreatment has consistently observed that children who have experienced sensitive and responsive caregiving tend to respond more resiliently in the face of adversity (Cicchetti & Lynch, 1993; Grady et al., 2017; Goldstein & Brooks, 2013). Last, the Attachment Theory was relevant to this study's interest in spiritual and religious coping. Kirkpatrick et al. (1999) and other researchers

have examined attachment and connection to God as a potential secure substitute attachment figure (Beck & McDonald, 2004). Researchers note individuals can utilize their attachment to God to enhance their ability to cope with the experience of trauma (Beck & McDonald, 2004; Kirkpatrick et al., 1999).

Four-Factor Traumagenics Model

An understanding of the impact of CSA was anchored in Finkelhor and Browne's (1985) Four-Factor Traumagenics Model. This model, along with Attachment Theory, served to establish an understanding of the impact of sexual abuse on the clients the participants (mental health practitioners) in this study treated. To fully conceptualize resilience and coping following a traumatic event, there first needs to be a foundational understanding of the impact of the trauma; these models served to inform that understanding.

The Traumagenics Model highlights four factors that sexual abuse victims can experience, including traumatic sexualization, betrayal, powerlessness, and stigmatization (Finkelhor & Browne, 1985). Traumatic sexualization is discussed as a "process" that shapes the child's sexual development that can result in a distortion of sexual attitudes and feelings (Finkelhor & Brown, 1985). Betrayal or loss of trust is especially found when a child has a relationship with a perpetrator, or when they perceive adults to be unprotective or unsupportive (Collin-Vezina et al., 2013; Finkelhor & Brown, 1985). Powerlessness is experienced when the child's "will, desires, [and] sense of efficacy" are circumvented and their body is invaded against their will. Powerlessness is exacerbated depending on the level of manipulation or coercion, and when a child's attempts to stop the abuse are thwarted (Finkelhor & Brown, 1985). The last component of the model is

stigmatization, which involves “negative connotations” or feelings such as guilt and shame that shape a child’s identity and can be communicated to the child through the secrecy of the act, as well as by the perpetrator, the community, and through caregiver reactions (p. 533).

Resiliency Theory

Resiliency theory emerged out of a “phenomenological identification of characteristics” of survivors of adverse experiences (Richardson, 2002, p. 307). The pioneers of this theory noted the existence of children who, despite varying adverse childhood experiences, were developing at or exceeding developmental expectations and were socially thriving (O’Leary, 1998; Richardson, 2002). Resiliency theory involves a “disruption and reintegration.” The disruption, in the case of this study, CSA, causes a disturbance to the “biopsychospiritual homeostasis” of the individual” (Richardson, 2002, p. 310). During reintegration, the individual can reorient back to homeostasis, experience a deterioration to functioning, or can experience “resilient reintegration” and cope in a form that elevates growth, not unlike the Calhoun and Tedeschi’s (2006) concept of Post-Traumatic Growth (Richardson, 2002).

The process of resilience first requires a stressor or experience that makes a child vulnerable to the possibility of a negative developmental outcome; in this study that stressor was CSA (Goldstein & Brooks, 2013). Resilience is an extension of coping and involves dynamic processes that are influenced by the individual (the child) and a “constellation of stress and risk factors” as well as the protective influences that characterize the child’s life (Grych et al., 2015, p 344; Goldstein & Brooks, 2013; Grych et al., 2015, p 344; Liu et al., 2017). These processes and factors have a multidirectional

influence on a child's functioning over the lifespan (Goldstein & Brooks, 2013). Thus, there is a "transactional" view of the development following adversity over time (Goldstein & Brooks, 2013). This transaction involves the child as an "active organizer of their experiences," who is both an influencer and is shaped by the caregiver bond, the family, and community, and the culture in which the child is embedded (Goldstein & Brooks, 2013, p. 5; Southwick et al., 2014).

Over the past fifty years, researchers have uncovered several processes and factors connected with resilience from child maltreatment (Southwick et al., 2014). These factors involve resources within the individual such as personality factors and methods of coping, as well as the social resources within the family or the community (O'Leary, 1998). The factors and processes connected to resilience from childhood maltreatment are further explored in the literature review section. A factor frequently connected with resilience, spiritual and religious coping, is also discussed at length in the literature review.

The Resilience Portfolio Model

Emerging from resilience theory is the Resilience Portfolio Model (Grych et al., 2015). This strengths-based model was uniquely applicable to this study because it emerged out of a specific connection to understanding resilience in victims of violence (Grych et al., 2015). This framework expands the understanding found in resilience theory and further integrates insights from positive psychology, post-traumatic growth, and stress and coping, then applies it to how individuals emerge to live "fulfilling lives despite exposure to violence" (Grych et al., 2015, p. 344). Post-traumatic growth, which is included as a form of resilience, has been described as related to, but a separate

construct from resilience, and implies a state of being that involves growth after adversity, not just a return to normal or expected functioning (Calhoun & Tedeschi, 2006; Grych et al., 2015). The inclusion of positive psychology elevates understanding of resilience through the study of character strengths such as gratitude, perseverance, and grit. These strengths may contribute to a state of well-being and represent a factor that can promote functioning in general as well as after a traumatic incident (Grych et al., 2018). Last, the authors recognize contributions from Lazarus and Folkman's (1987) model of stress and coping to help understand certain strengths and protective factors that "foster resilience by shaping appraisals and coping behavior" (Grych et al., 2015, p. 345).

In the model, each person is believed to have a "portfolio" that includes diverse characteristics that encourage healthy functioning (Gonzalez-Mendez et al., 2021). Grych et al. (2015) have created three "functional domains" that are organized around strengths. These domains include self-regulation, interpersonal strengths, and meaning-making, p.346. The regulatory strengths connected to resilience encourage and facilitate the ability to control impulses and regulate emotions, and when experiencing setbacks can persevere (Gonzalez-Mendez et al., 2021). Interpersonal strengths focus on the strengths of the individual to develop and keep strong social ties, and the degree of strength of their outside social network. Last, meaning-making strengths emphasize the ability to cultivate meaning in general as well as make sense of the traumatic experience. In the Resilience Portfolio Model ways of coping such as spiritual and religious coping are emphasized as pathways toward growth in each of the three domains, which was a particular focus for this study.

Theoretical Foundations Conclusion

The above theories and frameworks provided structure for this study. Attachment Theory and the Four-Factor Traumagenics Model ground understanding regarding the traumatic impact of child abuse, as well as the processes that underpin the complexity of the trauma (Bowlby, 1969/1982; Finkelhor & Browne, 1985). To understand the construct of resilience, Resilience Theory and the Resilience Portfolio Model were used to support inquiry. Spiritual and religious coping and resilience were explored with practitioners to elevate understanding of a child's ability to utilize spiritual and religious coping to emerge from an abuse experience resilient.

Lastly, this study is anchored with a Christian worldview. It is my understanding, through God's ordained Word, the Bible, that He both designed and governs the world (*New International Version Bible*, 1978, Genesis 1). Further, God desires a relationship with his creation; however, through sin, the world is subjected to a curse, yet through the sacrifice of Jesus Christ, we can be redeemed and can one day be in union with our Creator (*New International Version Bible*, 1978, Genesis 2 & 3, John 3). Further, God promises that there can be healing and renewal in life on this side of Heaven because God helps to bind up the brokenhearted, to proclaim liberty to captives and freedom to prisoners (*New International Version Bible*, 2011, Isaiah 61:1). God's promised freedom applies to mental prisons involving beliefs that one is unworthy of healthy, safe, loving relationships that adverse events such as CSA can create. It is through this worldview that the concept of resilience is grounded.

Definition of Terms

The following is a list of terms that are central to the focus of this study. Definitions are provided below to provide clarity and align understanding.

1. **Child Sexual Abuse (CSA) -** Enticing or forcing a young person to take part in sexual activities of any kind (Borg et al., 2019). The activities may involve exploitation and can be contact or non-contact behaviors. Last, the child may not have an awareness of what is happening, and /or the activity may appear consensual (Borg et al., 2019).
2. **Negative Religious Coping -** A form of coping that is associated with a struggle with God, self, and /or others around "scared matters" (Pargament et al., 2013).
3. **Positive Religious Coping -** A form of coping that involves a secure relationship with God and a sense of connectedness with others (Pargament et al., 2013).
4. **Religious and Spiritual Coping (R/S Coping) -** A form of coping that utilizes religion and spirituality in the process of healing (Schaefer et al., 2018; Pargament et al., 2013). The coping methods can encompass a variety of strategies that help the individual to make meaning, establish mastery and control, receive comfort and connection, and transform behaviors (Pargament et al., 2013).
5. **Religiosity -** Commitment to beliefs and practices associated with an organized institution that is supported by rituals, worship, or communication with the "sacred or divine, God, or Ultimate Truth" (Oman, 2013 p. 27; Pargament et al., 2013).

6. **Resiliency -** Resilience is defined broadly as an individual who has first experienced a form of adversity and second, displayed some evidence of healthy functioning following the adversity (Hamby et al., 2018; Schaefer et al., 2018).
7. **Spirituality -** The way a person searches for and expresses meaning and purpose, and experiences connectedness to the scared, which may or not take place within an institution (Oman et al., 2013; Shafranske, 2023).

Significance of the Study

Resiliency and CSA in Children and Adolescents

To date, there exists a need to understand more about resiliency from the trauma of CSA in child and adolescent populations. CSA research has primarily focused on utilizing adult populations with participants reflecting on their experiences in youth (Yoon et al., 2020). Although this research is enlightening, further inquiry is needed on understanding child and adolescent CSA survivors' experiences with resilience. Those studies that do exist with children and adolescents are largely quantitative and seem to connect and explore all forms of child maltreatment, rather than CSA individually. These reports help to identify and isolate factors associated with resilience development; however, these studies may miss "how" resilience is cultivated in childhood following abuse (Beaujolais et al., 2021). In this study, by approaching this gap qualitatively and using mental health practitioner perspectives, the individuals working with children and adolescents who have survived CSA could share their experiences working directly with these clients in a more open forum than answering a survey. This broadened the data-gathering process, allowing for a more comprehensive grasp of resilience in youth.

Practitioner Perspectives

Examining resilience and R/S coping in childhood and adolescence is important, as this is a period of profound developmental change. Mental health practitioners as participants provide a valuable source of information and are largely understudied (Yoon et al., 2020). Practitioners possess education on child development, trauma, and CSA, and have witnessed first-hand challenges and healing associated with these constructs (Yoon et al., 2020). Practitioners partner with the families of the victims and frequently collaborate with community partners such as law enforcement, the Department of Child and Family Services, schools, and faith communities, which enhances the insight into a child's experience with resilience. The studies that have investigated resilience using practitioners' perspectives have focused on child maltreatment in general, not CSA, and explore different constructs associated with resilience such as caregiver influences, developmental differences, or vicarious resilience (Beaujolais et al., 2021; Silveira & Boyer, 2015; Yoon et al., 2020;). Thus, this study provided a unique and comprehensive insight into the experience of resilience in youth after CSA by allowing practitioners to share their expertise through an unrestricted method.

Resiliency, CSA, S/R Coping in Children & Adolescents

As previously suggested, R/S coping has been demonstrated as a method of helping recover from various forms of trauma in adult and adolescent populations (Bryant-Davis, 2012). However, few studies explore CSA and R/S coping, and even fewer use child and adolescent populations (Bryan-Davis, 2012). Pargament et al. (2013) categorized R/S coping research with children and adolescent samples in general as a "neglected" population. Given that R/S coping research is sparse with children and

adolescents, this study contributes by providing attention to the distinct way R/S coping may impact resilience in victims of CSA.

Impact of the Study

By providing an account of experts in the field of CSA, this qualitative study contributes to the understanding of resilience and the role of R/S coping in children and adolescents who have experienced CSA. The results can be valuable in several ways. First, mental health practitioners and agencies that work predominantly with CSA, such as child advocacy centers, can benefit from this research, as these individuals are frequently the primary agencies and individuals treating children and families therapeutically and forensically. Frequently these individuals, especially in child advocacy centers, collaborate with and educate local agencies regarding the impact of CSA and how to help the survivors and their families. Thus, knowledge from this study on resilience and R/S coping can enhance community education and therapeutic interventions designed for caregivers and victims. Additionally, mental health practitioners who work with CSA survivors may partner with faith communities to educate these communities on the impact of CSA and how to support the children and families in a way that promotes positive R/S coping and cultivates resiliency.

Summary

CSA is a problem that impacts millions of individuals and creates a host of negative consequences at the individual and societal levels (Houshyar et al., 2013). Given the injurious and long-term effects of CSA, there is a sustained demand for research in this area, especially surrounding the way individuals can emerge resilient (Houshyar et al., 2013). Although pioneering and contemporary researchers have laid a solid

foundation of empirical research, gaps persist, especially when understanding children's and adolescents' experiences of resilience (Yoon et al., 2020). The present phenomenological qualitative study was designed to increase understanding regarding the experience of resilience in children and adolescents who have experienced CSA, through the eyes of their mental health practitioners. An emphasis was placed on R/S coping, and the way child survivors and their practitioners incorporate these elements into their experience of resilience.

The concept of resilience was conceptualized through the lens of Resilience Theory and the Resilience Portfolio Model. Through these frameworks, it is hoped that this study captured the "essence" of resilience and R/S coping in youth through the perspective of mental health practitioners. The knowledge gained from the voices of the participants helped to guide the discussion of themes and contributed to the understanding of CSA survivors, resiliency, and the way they utilize R/S coping. The subsequent chapter will provide a review of the literature on what is known regarding the concepts discussed in this study.

CHAPTER 2: LITERATURE REVIEW

Overview

A systematic review of the literature was conducted to explore the topic of resilience from CSA with an emphasis on R/S coping. The initial section focuses on the problem of CSA and includes a discussion on the definition, prevalence, characteristics, pattern, and impact that CSA has on mental and physical functioning, as well as the impact on the family, community, and society at large. The subsequent section provides a review of resilience research. The discussion opens by defining and conceptualizing resilience and providing an overview of early and contemporary resilience research. Last, this section discusses factors that are associated with resilience from child maltreatment, including internal and external characteristics. Following the topic of resilience is an enhanced focus on an area connected to resilience, R/S coping. The review opens with an examination of positive and negative R/S coping, then an explanation of R/S coping in the context of child development. Next, the review narrows the focus to R/S coping as a protective element for children and teens. Last, this section discusses using R/S coping to heal from child maltreatment, citing research with adults and child samples. The last section of this chapter provides a biblical foundation for this topic of inquiry. The topics of CSA, resilience, and R/S coping are discussed from a biblical lens, citing references to Scripture, biblical commentary, and examples of accounts from individuals from the Bible.

Description of Search Strategy

The literature search for this study was conducted utilizing articles and books accessed primarily through Liberty University's library. The articles and books were

retrieved from databases and search engines including ProQuest, PsycARTICLES, PsycBOOKS, PsycExtra, EBSCO, PsycINFO, Ebook Central, ERIC, and SAGE Journals. Google Scholar was utilized to locate open-access articles. The articles selected were from peer-reviewed journals in behavioral health sciences or related sciences. The following terms were used as keywords to locate articles specific to this study: resiliency, coping, post-traumatic growth, healing, recovery, trauma, child abuse, child sexual abuse, children, adolescents, protective factors, risk factors, mental health outcomes, religious coping, religiosity, spirituality, and spiritual and religious coping. These terms were used in multiple ways and in various combinations to ensure that the literature search was exhaustive. Additionally, articles were found using references cited in peer-reviewed scholarly articles and dissertations. Articles that were published within the last five years were given preference for non-seminal research. Last, the Bible, Wolters's (2005) "Creation Regained", and Grudem's (1994), "Systematic Theology" were primarily used for the Biblical Foundations section and to anchor the research from a Christian worldview.

Review of Literature

Understanding CSA

Child maltreatment is a prevalent problem in the United States as well as globally. Types of maltreatment can include physical, emotional, and sexual abuse as well as neglect (Vilvens et al., 2021). All forms of maltreatment can negatively impact the process of healthy child development, resulting in a host of negative outcomes over a child's lifetime (Freeny et al., 2021). These negative outcomes involve a cost to the

individual, as well as the family, the community, and society at large. Child sexual abuse (CSA), a unique form of child maltreatment, has been increasingly researched over the past forty years (Vilvens et al., 2021). This intensified understanding provides knowledge regarding the prevalence, patterns, and impact CSA has on those who have experienced it.

Defining CSA

In the past, CSA was defined only through contact abuse, for example, fondling or penetration (Collin-Vezina et al., 2013). More recently non-contact forms such as exhibitionism or exposure of genitals have been included in the definition to define the experience of CSA more broadly (Borg et al., 2019; Collin-Vezina et al., 2013). CSA is currently described as any sexual activity between a child and an adult or another child who is in a "relationship of responsibility, trust, or power" with the activity intended to "gratify" or "satisfy the needs of another" (Collin-Vezina et al., 2013, p. 2). This is the case even if the child is not aware of what is happening (Borg et al., 2019). The recent definition maintains the inclusion of contact activities such as touching, oral sex, and rape (Borg et al., 2019). In addition, non-contact forms are added, such as having children view sexual behaviors online or in person or enticing a child to behave in an inappropriate way sexually (Borg et al., 2019). Last, child exploitation involves an individual or a group that "takes advantage of an imbalance of power" and pressures or manipulates a child into sexual activity (Borg et al., 2019, p. 6). Exploitation is applicable even if the behavior appears to be consensual and may be applied even in the case of non-contact situations, as in the case with the use of technology (Borg et al., 2019).

Prevalence of CSA

It is estimated that each year 60,000 children will be sexually abused in the United States (Schaefer et al., 2018). Estimates regarding the frequency of CSA vary greatly depending on the way the abuse is measured. In the United States, an effort was made by Finklehor et al. (2014) to create a more accurate estimate of the incidence of CSA in a pooled cohort of 2,293 males and females ages 15-17 years of age. The sample reflected a lifetime experience of sexual abuse or assault in 26.6% of females and 5.1% of males. Estimates in developed countries have indicated that 5-10% of females and 1-5% of males will experience penetrative acts. These numbers raise when any type of sexual abuse is assessed, ranging from 15-30% of females and 5-15% of boys (Borg et al., 2019). Worldwide estimates can be especially problematic to assess due to variations in definitions of sexual abuse, reporting natures, age of consent, and support during the disclosure process (Collin-Vezina et al., 2013; Barth et al., 2012). The result is a range of 8-31% of females and 3-17% of males worldwide (Collin-Vezina et al., 2013).

Individuals who are female are twice as likely to be sexually abused as males, however, underreporting in males is commonly discussed as a roadblock to obtaining accurate numbers of sexual abuse in males (Borg et al., 2019; Collin-Vezina et al., 2013). Individuals with disabilities and learning difficulties have an elevated risk of CSA, as well as all other forms of maltreatment (Borg et al., 2019; Collin-Vezina et al., 2013). Other risks connected to an increase in CSA are living in poverty, family conflict and substance abuse, and being isolated (Barth et al., 2013; Collin-Vezina et al., 2013). Individuals who are members of ethnic minorities are at amplified risk for adverse childhood experiences (ACEs), in which sexual abuse is included (Freeny et al., 2021). In one study, African American adolescents were more likely than non-African Americans

to experience six or more adverse childhood experiences (Freeny et al., 2021). Additionally, children who represent undocumented and/or unaccompanied groups, as well as those who are experiencing humanitarian crises, are at increased risk of sexual violence (Wekerle & Kerig, 2017).

Characteristics and Patterns of CSA

The experience of CSA varies greatly from child to child. The variations may be across dimensions such as frequency, duration, degree of severity, amount of violence, and the relationship to the perpetrator. The occurrence of sexual abuse may begin with "grooming," which is an attempt by the perpetrator to gradually manipulate a child for sexual gratification (Borg et al., 2019). This behavior can include inappropriate touching through play or wrestling and move into additional types of abuse, such as viewing pornography, exposing genitals, and digital penetration. Grooming may also include alcohol or sedation as well as bribes and threats to lure a child into compliance (Borg et al., 2019). Technology has raised access to children and provided offenders with platforms to rapidly abuse a child with little detection (Borg et al., 2019). In some cases, perpetrators entice children into sending sexually explicit pictures and then use them as extortion to force a child into engaging in sexual contact (Borg et al., 2019).

It is estimated that 90% of the cases of CSA involve someone the child knows, which confirms the "rarity of stranger danger" (Borg et al., 2019, p. 7; Collin-Vezina et al., 2013; Heger, 2022). When questioning a child regarding sexual abuse it is important to remember perpetrators are commonly family members, which can serve as a barrier to reporting (Borg et al., 2019; Heger, 2022). Juvenile offending has been a subject that has become increasingly studied, with the recognition that child-on-child sexual victimization

also has a significant impact on functioning (Borg et al., 2019; Collin-Vezina et al., 2013).

Impact of CSA

Children who have faced sexual abuse are at risk for experiencing negative mental, physical, and behavioral outcomes, which have individual, familial, and societal implications (Vilvens et al., 2021). Finklehor and Brown's (1985) Traumagenics Model, as discussed in Chapter One, provides a way of organizing an understanding of the impact of sexual abuse on a child's development. The model suggests that CSA changes a child's orientation to the world cognitively and emotionally. This change alters their self-concept and their emotional capabilities, which can influence a child's development mentally, physically, and behaviorally (Finklehor & Brown, 1985). The overarching picture of those who have experienced CSA is one that has a potential for alternation of functioning across multiple biopsychosocial domains. Thus, pointing to the importance of understanding how to enhance functioning and growth in these individuals.

Mental Health

Mood Disorders. It is estimated that in the United States that by age 18 twenty percent of adolescents will have at least one depressive episode (Freeny et al., 2021). Children who have exposure to child maltreatment and CSA are at an increased risk of developing mood disorders such as depression (Freeny et al., 2021; Gal et al., 2011; Sigurvinsdottir et al., 2021; Trickett et al., 2011). In CSA victims, depression may have an earlier onset and continue into adulthood (Gal et al., 2011; Sigurvinsdottir et al., 2021; Trickett et al., 2011). Anxiety disorders are also documented in maltreated children (Tabachnick et al., 2022).

Post-Traumatic Stress and Anxiety Disorders. Anxiety disorders and post-traumatic stress are well-documented in those who have experienced child maltreatment (Fergusson et al., 2013; Tabachnick et al., 2022). Elevated amygdala volume has been discovered in maltreated children, as well as heightened amygdala sensitivity and differential processing of stimuli that is emotional, all of which are connected to anxiety and post-traumatic stress disorders (Houshyar et al., 2013). In some research, rates of anxiety disorders are higher and are more likely to extend over a lifetime in CSA victims than in victims of physical abuse (Collin-Vezina et al., 2013; Gal et al., 2011). In longitudinal studies, post-traumatic stress and anxiety disorder rates in CSA victims have been shown to continue into adulthood (Fergusson et al., 2013; Trickett et al., 2011). In a matched study of female school-aged youth (those who had experienced CSA and those who had not), those in the CSA group had a risk of PTSD four times the control group (Collin-Vezina & Hebert, 2005). Of significance, the participants in both CSA groups (less severe and severe) showed this risk of PTSD development, indicating that regardless of the severity of the sexual abuse, there was a higher risk of PTSD (Collin-Vezina & Hebert, 2005). Although studies of CSA with male participants have been less frequent than with female participants, based on research the risk of developing PTSD and anxiety disorders is similar for males as females (Collin-Vezina et al., 2013; Ressel et al., 2018).

Dissociation. Dissociation is conceptualized as a "separation of psychological processes such as thoughts, emotions, memory, and identity" and has a range from normal dissociation, such as daydreaming, to more serious interference with functioning, as in the case of splitting and incoherent sense of self (Collin-Vezina & Hebert, 2005). High levels of dissociation have been documented in preschool children who have

experienced physical and sexual abuse (Collin-Vezina et al., 2013; Macfie et al., 2001). Childhood is a sensitive period where people begin to integrate memories and develop a coherent sense of self. Maltreatment may serve to interrupt this integration, which in turn leads to a vulnerability to dissociation (Macfie et al., 2001). Dissociative symptoms have been documented in CSA victims over time and extend into adulthood (Trickett et al., 2011).

Physical Health

The impact of childhood adversity and trauma, in general, has been regularly related to a lower quality of physical health (Banyard et al., 2017). Recently, the connection between CSA and physical health has garnered increased attention. Having experienced CSA has predicted an increase in doctors and hospital visits in a 30-year longitudinal study and is a predictor of a host of major illnesses and chronic pain (Collin-Vezina et al., 2013; Fergusson et al., 2013; Trickett et al., 2011). In a multigenerational twenty-three-year longitudinal study by Trickett et al. (2011), CSA related to an earlier onset of puberty, a higher rate of obesity, an increased risk of having a child who is premature, and more healthcare utilization. Additionally, individuals who have experienced child maltreatment, such as CSA, may have key alterations to their neurobiological systems such as their hypothalamic-pituitary-adrenal axis or the stress response system (Tabachnick et al., 2022). The impact on this system can be experienced mentally and emotionally but is also heavily tied to abnormality of immune, hormone, and bodily processes leading to a deterioration in physical health (Collin-Vezina et al., 2013; Tabachnick et al., 2022; Trickett et al., 2011).

Behavioral Consequences

Aggression and Sexual Behavior. Aside from mental and physical consequences, CSA is linked to a substantial number of behavioral disturbances. CSA is connected to a higher number of acting-out behaviors such as aggression, conduct problems, and delinquency (Collin-Vezina et al., 2013; Sigurvinsdottir et al., 2021). In addition to aggression, young children may present with sexualized behaviors such as chronic masturbation, wanting to touch others' genitalia, and wanting to engage in oral sex during play (Borg et al., 2019). In a review of articles on CSA and adult sexual risk behavior by Menard and MacIntosh (2021), CSA was related to numerous risky behaviors. The review found that in males and females, CSA was related to a higher number of sexual partners, more unprotected sex, sex while using substances, and increased risk for sexually transmitted infections (Menard & MacIntosh, 2021). The age of sexual debut was significantly earlier in males, however, in females, there were mixed findings in research. In samples of female survivors, some research showed an earlier sexual debut, and in other studies with females, there was no difference in sexual debut when compared to non-abused controls (Menard & MacIntosh, 2021). In females, the review revealed a pattern of results showing significantly greater involvement in transactional sex, teen motherhood, and unwanted pregnancies (Fergusson et al., 2013; Menard & MacIntosh, 2021;). These risky sexual behaviors may lead to further victimization, as it has been well documented that those who have experienced CSA are at substantial risk for re-victimization relationally and sexually (Borg et al., 2019; Fergusson et al., 2013; Menard & MacIntosh, 2021; Trickett et al., 2011;).

Substance Use & Self Harm. The experience of sexual abuse is associated with a well-documented risk of substance use and abuse, as well as self-harming thoughts and

behaviors (Carliner et al., 2016; Fergusson et al., 2013; Trickett et al., 2011). The abuse of substances can enhance other risky behaviors, as discussed in the previous paragraph, leading to engaging in more sexual behaviors while intoxicated (Carliner et al., 2016; Menard & MacIntosh, 2021). Longitudinal studies have indicated that individuals who have experienced CSA over time are at higher risk for alcohol and drug dependence and experience higher levels of suicidal ideation, self-harm, and suicide attempts than their counterparts (Fergusson et al., 2013; Trickett et al., 2011). Further, having a younger age of onset of CSA appears to increase vulnerability to the use of all types of substance use as well as to engagement in self-harming behaviors (Carliner et al., 2016; Trickett et al., 2011).

Impact on Family, Community & Society

The impact of child maltreatment is not solely an individual problem. Child maltreatment and specifically CSA is a problem with multigenerational costs that echo throughout society, with an estimated economic cost of hundreds of billions of dollars (Peterson et al., 2018; Schaefer et al., 2018; Trickett et al., 2011). Those victimized as well as their children are more likely to experience both academic and economic disadvantages (Najman et al., 2023; Trickett et al., 2011). Parents of those who have been sexually abused are more likely to have been a victim of some type of child maltreatment and may have been a victim of CSA themselves (Fergusson et al., 2013; Najman et al., 2023; Trickett et al., 2011). The parents struggle with intense emotions from guilt to despair and may struggle with a variety of outcomes because of the disclosure of sexual abuse (Vilvens et al., 2021). Non-offending parents may discover their child’s abuse, lose a partner, and have to grapple with the legal system, leading to a cascading amount of

stress impacting their ability to support their victimized child properly (Trickett et al., 2011; Vilvens et al., 2021).

CSA is a global problem, with repercussions for those who have survived as well as their families and the communities they are embedded in. Further, CSA places these individuals and their offspring at risk for a lifetime of challenges (Krugman & Korbin, 2022). Although over the past forty years, CSA has been heavily researched, it is critical to continue to understand pathways of healing for this group. Much of the research on CSA has stemmed from adult samples, yet research has indicated that a younger age of onset of CSA is connected to lower levels of functioning across domains (Borg et al., 2019; Carliner et al., 2016; Fergusson et al., 2013). Thus, it is important to elevate understanding specifically regarding the way children can positively cope and become resilient in the face of their sexual abuse experience.

Defining and Conceptualizing Resilience

One CSA survivor was quoted as saying, "You become resilient when you are able to have strength and support…when you make the decision it's not going to define you" (Newsome & Myers-Brown, 2017, p. 935). According to the Oxford English Dictionary, resilience is defined as "the capacity to recover quickly from difficulties; toughness." In humans, resiliency has been associated with a host of adjectives such as flexibility, strength, coping, and character, and is used to describe a person "bouncing back" after loss, natural disaster, cultural change, death, illness, and trauma (Agaibi & Wilson, 2005). Resiliency at the surface appears simple, yet defining and researching resiliency has proven to be a complex process (Agaibi & Wilson, 2005; Marriott et al., 2014; Richardson, 2002; Southwick & Chaney, 2018).

Calhoun and Tedeschi (2006) created a visual of resilience as a tree bending when the strong wind blows but resuming its original state following the storm. At the heart of resilience, there needs to be a stressor. The stressor must create an alteration in normative functioning. An individual cannot be resilient if he or she does not have something to be resilient from; thus, stress or trauma is always a requirement for resiliency. The response to that stressor may be recovery, but it may also be resistance, as a tree stands impervious to the winds (Calhoun & Tedeschi, 2006). A third response to a stressor is "reconfiguration" where the tree may accommodate the storm and transform aspects of the self to withstand the stressor (Calhoun & Tedeschi, 2006). This is related to post-traumatic growth. However, the authors note that transformation may have a positive or negative direction of change, with post-traumatic growth signaling a positive directionality of change. Thus, post-traumatic growth has been identified as a form of resilience, and currently is identified as a separate, but related construct.

In some literature, resiliency has been defined as a trait, a "proven competence," whereas in others it is conceptualized as the "absence of a negative" outcome, such as psychopathology (Marriott et al., 2014). The American Psychological Association defines resilience as "the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands" (APA Dictionary, 2023). The common thread to all definitions of resilience is some form of adaptation in the face of adversity (Southwick & Charney, 2018). The APA definition, as well as the current thinking in research, recognizes the multiple factors that contribute to adaptation, which are multidimensional and multisystemic involving transactional processes between an

individual and the environment (APA Dictionary, 2007; Southwick & Charney, 2018). Importantly, resilience is viewed as something that can be cultivated.

Understanding Resilience Research

Early Resilience Research

Conceptualizing and researching resilience emerged out of longitudinally investigating high-risk children. Studies such as Werner and Smith's (1992) Kauai children study, Rutter's (1979; 1985) study of inner-city children, and the Isle of Wright study, as well as Garmezy et al.'s (1991) study on children of schizophrenic parents, revealed subgroups of children that exhibited "positive adaptation" despite their high risk for poor developmental trajectories (Masten, 2001; Richardson, 2002). The early innovative researchers represented a shift in psychological thinking from a deficit model to exploring how individuals recover and cope following adversity (O'Dougherty-Wright et al., 2013). It was believed that these resilient children were extraordinary and possessed an "invulnerability" that allowed them to be impervious to stress (Masten, 2001; O'Dougherty-Wright et al., 2013).

The first wave of resilience research began to recognize the commonness or "ordinary magic" of resilience (Masten, 2001, p. 227). The early generation of resilience research advanced thinking by defining terms, clarifying compensatory, promotive, and protective factors, and developing a "short list of resilience correlates" for children (O'Dougherty-Wright et al., 2013; Richardson, 2002). These correlates, which will be discussed in the next section, represented promotive and protective factors such as a child's temperament or a stable and supportive family environment that relate to positive outcomes. Last, primary researchers noticed the impact that the stage of child

development had on both protective factors and vulnerabilities (O'Dougherty-Wright et al., 2013). For example, during infancy and adolescent years a child may be more vulnerable, whereas school-aged children may receive more protective factors, such as a school environment away from an abusive home (O'Dougherty-Wright et al., 2013).

During the second wave of resilience research, researchers began to shift from "what" questions to "how" questions and grew curious about the "processes" that were involved in building resilience (O'Dougherty-Wright et al., 2013; Sapienza & Masten, 2011). A model of resilience was established, which directed researchers toward a more transactional systems approach to understanding the way a child responds to adversity (O'Dougherty-Wright et al., 2013; Richardson, 2002). As a child interacts with their environment it influences the development of their adaptive systems such as their attachment, emotion regulation, and mastery systems (O'Dougherty et al., 2013). These systems interact with the community and culture that the child is embedded in such as school, community, and other social networks such as religious organizations (Richardson, 2002).

The second wave of research helped to uncover ways that children respond differentially to protective factors. For example, positive expectations of the future served only to be protective when it was paired with realistic expectations; when expectations were unrealistic it was not connected with enhanced resilience (Wyman et al., 2003). As research continued to emerge, the understanding of how at-risk children were resilient became more nuanced (O'Dougherty-Wright et al., 2013). The development of a child, for example, reflects a continuing capacity for change, which is reflected in a child's pattern of resilient functioning. Longitudinal studies revealed patterns where a child may

be resilient during one period of development, and experience challenges in the next, only to experience reintegration in adulthood (Richardson, 2002). This pattern may emerge when a child experiences sexual abuse, which causes behavioral and emotion-regulation struggles in childhood, but with maturation, the child is able to resiliently reintegrate using more advanced coping skills (Richardson, 2002).

Contemporary Resilience Research

The third wave of researchers utilized the knowledge gained during the initial stages to promote resilience, with the motivation to prevent problems in high-risk populations (O'Dougherty-Wright et al., 2013). Researchers examined preventative factors and models to create and measure interventions to reduce childhood emotional and behavioral problems. An example of this type of project is the Chicago longitudinal study, where interventions were provided with high-risk preschool students that resulted in fewer of the treatment group being placed in special education classrooms (Reynolds et al., 2018). Interventions included multiple areas of support such as lowering class size, family support services, nutritional support, and social-emotional education (Reynolds et al., 2018). The influence of resilience research and resilience theory is also credited with having an impact on the increase of strength-based interventions and programs designed to multiply a child's positive resources and relationships as early as possible (O'Dougherty-Wright et al., 2013). During this phase of research, there arose an understanding that the timing of intervention can have a lasting impact on the effects of behavior across domains, thought of as "cumulative consequences" (Patterson et al., 2010; Sapienza & Masten, 2011, p. 268). An example of this is found in the Patterson et al. (2010) study. Parents were provided with parent-management training that was

designed to elevate positive interactions between parents and children. The group was measured over a period of nine years with results demonstrating a "cascading" positive impact on healthier social interactions and a higher standard of living (Patterson et al., 2010).

The last wave of research appeared with the development of more sophisticated ways to measure neurobiological processes (O'Dougherty-Wright et al., 2013). A translational approach in the social and behavioral sciences integrated the study of the brain and behavior (Houshyar et al., 2013). This involved merging disciplines and using techniques such as neuroimaging, genetics, and animal studies to examine how stress impacts behavior and neural reactivity as well as gene expression (Houshyar et al., 2013). This research has revealed that stressful early life experiences are linked with profound effects on brain functioning (Houshyar et al., 2013). The study of genetics has produced a recognition of a gene and environmental risk factor connection, which Brody et al. (2009) used to study at-risk youth. In this study, groups known to have a genetic risk and who were exposed to trauma were provided with an intervention, known as Strong African American Families. The intervention consisted of several meetings with parents, families, and individual youth. The meetings included skill building around parenting, handing racism, handling and following rules and communication. The treatment group was less likely to develop both internalizing behaviors, such as self-blame, and externalizing behaviors, such as acting out, compared with the control group which also received information, but in handout form only (Brody et al., 2009).

The last wave of research points to an exciting shift in learning, where individuals across disciplines can creatively contribute to enhancing resilience in children

(Southwick et al., 2014). The concept of resilience is now believed to apply to all areas of human functioning with a cascade effect, where "positive behavior spreads and competence begets competence" (Sapienza & Masten, 2011, p. 68). This signals not only the importance of timing and targeting interventions in youth but also recognizing how disciplines may connect with other disciplines to elevate interventions. In the case of the current study, understanding the ways children utilize spiritual and religious coping to respond resiliently to CSA may lead to advances in connecting psychotherapeutic interventions with spiritual and religious practices to use when treating children.

Factors Associated with Resilience in Child Maltreatment

The body of literature that focuses on protective and promotive factors connected to resilience is vast. Furthermore, as discussed in the section above, resilience is now viewed as a multifaceted process with systems that connect and influence one another, which influences the way a person responds to a stressor (Schaefer et al., 2018). As Southwick and Charney (2018) discuss in their book, "Resilience," it is valuable not to view resilience as binary and merely consider if it is present or absent. Researchers and mental health professionals should consider different domains of functioning when evaluating if a person is viewed as resilient. An individual may be successful in one domain, for example interpersonal relationships, but not in another domain such as academics (Goldstein & Brooks, 2013; Southwick & Charney, 2018).

The resilience research pioneers formulated a list of processes, moderators, and mechanisms that encourage positive adaptation, which serves as a guide for targeted intervention practices with maltreated youth (Houshyar et al., 2013). Masten (2001) categorizes these systems as a "common phenomenon that results in most cases from the

operation of basic human adaptational systems" (p 227). These systems involve a variety of biopsychosocial processes that facilitate adaptive outcomes within the individual and involve the child, family, social environment, community, and society or the culture of the child (Masten, 2001; O'Dougherty et al., 2013). As Hamby et al. (2018) highlight in the Resilience Portfolio Model, it is important to recognize the concept of "poly-strengths" in a child's "portfolio," or the number of protective factors in general and across different domains of functioning. The poly-strengths concept relates to the concept of poly-victimization, which considers the cumulation of victimizing stressors in a person's life, and the effect that has on the amount of distress that person experiences (Finkelhor et al., 2011). Thus, the more strengths or protective factors in a person's portfolio, the more adaptive and resilient the response (Hamby et al., 2018). Additionally, as an individual develops, strengths can "cascade" resulting in "cumulative consequences" that influence development across systems (Sapienza & Masten, 2011).

The subsequent section will focus on the factors connected with resilience in human functioning in general; however, because the focus of this study is on child sexual abuse, research will be primarily centered around resilience relating to child sexual abuse and/or child maltreatment, which includes child sexual abuse. Factors will be subdivided into those relating to the internal characteristics of the child and those related to the external characteristics of the family or supportive relationships as well as the community. Regarding the experience of CSA, it is important to recollect risk factors and elements discussed in the "Understanding Child Sexual Abuse" section of this document and how those risk factors may influence the resiliency of the child victim. Risk factors frequently associated with negative outcomes due to CSA involve the relationship to the

perpetrator, the level of violence and penetration involved in the abuse, the age of onset of victimization, as well as the duration of abuse (Finkelhor & Brown, 1985; Schaefer et al., 2018; Tabachnick et al., 2022).

Internal Characteristics

The initial phases of resilience research provided a "short list" of characteristics that are most frequently associated with healthy adaptation or resilience (O'Dougherty-Wright et al., 2013). This shortlist has often been broken down into various "buckets" of protective factors that are recognized to interact and play off of one another to enhance protection. Four "buckets" of factors will be discussed below relating to several constructs including self-esteem, self-efficacy, control, emotional intelligence, coping skills, optimism, hope, positive belief systems, and social competence. Spiritual and religious coping has been identified as a protective factor in both child and adult CSA literature; however, as this construct is of importance to this proposal, it will be separated out and discussed in greater detail in the later part of chapter two.

Self-Esteem, Self-Efficacy, and Control Beliefs. In resilience literature, self-esteem and self-efficacy are commonly connected to a child's ability to cope and emerge from maltreatment adaptively (Borg et al., 2019). Self-esteem, self-efficacy, and control beliefs serve as buffers that appear to protect children from traumatic experiences such as CSA. Mastery and degree of control have been demonstrated to be predictive of a lower risk of mental health struggles following CSA (Agaibi & Wilson, 2005; Domhardt et al., 2015). In a study of sexually abused girls aged 16-19, the factor of self-esteem was the strongest negative predictor of depressed mood and anger (Asgeirsdottier et al., 2010). The level of depression and anger was further decreased when attitudes towards school

and sports participation were factored in. In a longitudinal study of female adolescents, Daigneault et al. (2007) noted that degree of empowerment was associated with resiliency, as measured by scores on a resiliency survey. Further, the degree of empowerment experienced by the adolescents was connected to less conflict with mothers in the same study.

In adult standard and longitudinal research, self-efficacy serves a protective function against problems relating to sexual risk-taking behavior, interpersonal relationship problems, and drug use (Dufour & Nadeau, 2001; Lameoureux et al., 2012). In qualitative research with adult CSA victims, survivors frequently discuss the importance of “reclaiming” their control through their identity, personal power, sexuality, and self-acceptance (Crete & Singh, 2015; Newsome & Myers-Bowman, 2017; Singh et al., 2012). Finally, studies showing individuals who have experienced CSA and have an internal locus of control rather than an external locus of control tend to exhibit less PTSD and psychopathology (Agaibi & Wilson, 2005). Self-esteem, self-efficacy, and control beliefs may be specifically important elements when measuring resilience in the context of CSA. As explained by Finklehor and Browne’s (1985) Four-Factor Traumagenics Model, child sexual abuse contains patterns of traumatic sexualization that involve powerlessness, secrecy, and stigmatization that may deteriorate a child’s feelings of control and mastery over their lives.

Emotional Intelligence, Emotion-Regulation, and Coping. The ability of a person to self-regulate their cognitive, emotional, and behavioral responses involves a process of interrelated components that enhance positive functioning (Grych et al., 2015). Emotional intelligence is a construct that is defined as a group of social, emotional, and

personal factors that link to an individual's ability to adapt to their environment (Mamani-Benito et al., 2018). Emotional intelligence involves a person's ability to identify, understand, and regulate their various emotional states and use strategies to cope with their environment. The concept of emotional intelligence is separate but related to Folkman and Lazarus' (1985) theory on stress and coping, where individuals use different forms of coping (problem-focused or emotion-focused coping) to manage various aspects of a stressor. The emotions tied to a stressor are a result of how the person views their "transaction" with the environment, and the coping is tied to a person's cognitive and behavioral efforts to control that emotional response (Folkman & Lazarus, 1985). Thus, a person with high emotional intelligence would be able to implement appropriate methods of managing their emotions using varied techniques at the appropriate time (Mamani-Benito et al., 2018).

In CSA literature, emotional intelligence has been identified as a protective factor in children, adolescents, and adult studies (Cha et al., 2009; Southwick & Chaney et al., 2018; Yoon, 2018). In a longitudinal study of maltreated children, emotional intelligence, as defined by regulation and prosocial skills, was identified as decreasing children's externalizing behaviors over time (Yoon, 2018). The results were especially significant when CSA was singled out from child maltreatment in general. Emotional intelligence was identified as a moderator between CSA and suicidal ideation and attempts in adolescents (Cha et al., 2009). Additionally, interventions designed to help teach emotional intelligence have been connected with lower suicidal ideation, higher stress management skills, and elevated "general mood" (Mamani-Benito et al., 2018). Last, in research on coping skills and trauma, problem-centered versus emotion-focused coping

had been associated with the management of stress related to trauma in children and adults (Compas et al., 1991; Folkman and Moskowitz, 2000).

Optimism, Hope, and Positive Belief Systems. Optimism has been identified as a factor that "ignites resilience" in a way that provides the "energy to power other resilience factors" (Southwick & Chaney, 2018, p. 35). Optimism is connected to an expectancy or a hope in the future, and contrary to belief, it does not involve avoidance of a problem, as in blind optimism (Southwick & Chaney, 2018). Optimism has been linked with problem-focused coping, goal-directed and approach behavior as well as enhanced social relationships (Kaye-Tzadok & Davidson-Arad, 2016; Lapore & Revenson, 2006). In child studies of CSA survivors as well as studies of maltreated children, optimism or "hope and expectancy" beliefs about the future were positively associated with resilience, as measured by the degree of psychopathology (Edmond et al., 2006; Williams & Nelson-Gardell, 2012). The connection between positive beliefs around health and education has been cited in adolescent CSA research as creating positive pathways toward resilience (Chandy et al., 1996; Marriott et al., 2014; Williams & Nelson-Gardell, 2012). In a study of 99 adolescent females who had been sexually abused and were in foster care, girls who had positive expectations regarding their future as well as "certain expectations" regarding their educational future (meaning they felt more certain about the positive direction of their future), were significantly less likely to experience mental health symptoms and negative behavioral symptoms such as skipping school and substance use (Edmond et al., 2006). In review studies of CSA survivors, academic achievement and positive beliefs about school are associated with better outcomes when reviewing over 75 studies (Domhardt et al., 2015; Marriott et al., 2014).

In adult research, optimism, positive belief systems, and hope have been well-documented as protective influences from stress and trauma (Southwick & Chaney, 2018). In a study of adult CSA survivors, Schaefer et al. (2018) found that both higher resilience and posttraumatic growth were associated with higher optimism, which highlights the importance of optimism in both resilience and posttraumatic growth. Having hope was tied to resilience in another group of 100 adult CSA survivors, where hope was identified as a coping strategy that focuses the individual's attention away from the trauma and towards problem-solving (Kay-Tzadok & Davidson-Arad, 2016). Optimism and hope have additionally been related to higher resilience and less sexual risk-taking behavior in a group of HIV-infected adults who had been sexually abused as children (Tarakeshwar et al., 2006). In qualitative research with CSA survivors, investigators regularly document participant reports that hope, positive beliefs, and optimism are a part of their resilience stories (Crete & Singh, 2013; Bryant-Davis, 2005; Newsom & Myers-Bowman, 2017; Singh et al., 2012). Last, mental health practitioners who work with victims of CSA identify clients' hope and optimism as a pathway toward "vicarious resilience" that protects the practitioners from secondary trauma (Silveria & Boyer, 2015).

Social Competence. The concept of social competence or interpersonal strengths recognizes the important characteristics of an individual to develop and maintain close relationships (Grych et al., 2015). Social support is recognized as one of the most important components of resilience from trauma and will be discussed in the next section; however, research has identified strengths of the individual that enhance social bonds and strengthen the connections between self and others (Grych et al., 2015). These social

strengths are conceptualized as a component of the individual that positively interacts with the social environment; thus, the individual is an active participant in engaging in social support (Southwick & Chaney, 2018).

In a study with 449 young child survivors of CSA, prosocial skills and social competence, as measured by a child's ability to cooperate, positively assert, take responsibly, and have self-control, were associated with significantly fewer behavioral problems (Yoon, 2018). These results echo a previous longitudinal study by Lansford et al. (2006) on young physically abused children. Children were followed from kindergarten through eighth grade and rated on social skills by teacher ratings on the child's understanding of others' emotions, accurately understanding what peers are doing, social awareness, generating positive responses to interpersonal problems, and being aware of how their behavior impacts others. Early high levels of social competence (that interacted with caregiver competence) were significantly associated with less internalizing and externalizing behaviors in the children over the time from kindergarten to eighth grade (Lansford et al., 2006). In a sample of adolescent CSA survivors at risk for offending, social and emotional competence related to less sexual rumination (Leon et al., 2008). The ability to trust others is a documented strength connected to the building of social bonds. Daigneault et al. (2007) demonstrated that adolescents who have higher degrees of interpersonal trust were less likely to experience psychopathology following CSA. In adult CSA studies, the ability to trust others, work well with others, and have interpersonal competence were all predictive of resilience (Aspelmeier et al., 2007; Banyard et al., 2002; Simpson, 2010;).

External Characteristics

In addition to traits within an individual, external characteristics also contribute greatly to resilience. Resources within the family and within the caregiver especially contribute to resilience in children following an experience of CSA, as childhood is an experience that is embedded in a system (Lepore & Revenson, 2006). Returning to the tree metaphor, when a tree that is vulnerable is among other trees, those trees may provide protection from wind, rain, and other elements that could harm that vulnerable tree. This is the case with external supports (Lepore & Revenson, 2006). Researchers often recognize that focusing on external factors that influence risk and resilience can serve to remove the temptation to "blame the victim" for not having "traits" that are resilient (Lepore & Revenson, 2006; Southwick et al., 2014). The following section focuses on external factors that contribute to resilience including social support, characteristics of the family, and characteristics of the community.

Social Support. Human beings are a social species that continuously interact and are influenced by other humans. Childhood is colored by the social systems that the child is entrenched in, beginning with the caregiver bond and the attachment related to that bond (Masten, 2001; Southwick et al., 2014). Early childhood attachment, as discussed in the theoretical framework section, may influence a child's ability to form secure relationships outside of the family, leading to a continuation of positive social relationships (Southwick et al., 2014). In the case of childhood maltreatment, early social relationships may be damaged due to an abusive experience, especially if the perpetrator is a parent or family member (Sapienza & Masten, 2011). However, resilience research demonstrates that social support within and outside the family for children is a key

protective factor that helps a child adapt following an experience of abuse (O'Leary, 1998).

Caregiver Support. The relationship a child has with their caregiver sets the stage for future relationships (Southwick et al., 2014). CSA review research cites the support of a caregiver as one of the most crucial factors connected to resilience (Domhardt et al., 2015; Marriott et al., 2014). In a longitudinal study by Kim and Cicchetti (2004) on the mother-child relationship and maladjustment following child maltreatment, children who had more secure mother-child relationships had fewer internalizing and externalizing behavior problems. These results were echoed in Yoon (2018), where caregiver support and a child's social skills predicted a decrease in externalizing behavior problems in young children who had experienced CSA. In adolescent research, caregiver support provides a positive influence on mental health symptomology and relationship quality, as evidenced by fewer conflicts with mothers (Asgeirsdottier et al., 2010; Chandy et al., 1996; Daigneault et al., 2007; Gower et al., 2020;). When participants viewed support as higher, it predicted lower depressed mood and anger and higher rates of psychological functioning (Asgeirsdottir et al., 2010; Gower et al., 2020). Even when removed from the family, positive caregiving in foster care is associated with resilience in adolescent victims of CSA (Leon et al., 2008). This signals the importance of enhancing caregiver support at any stage of child development (Marriott et al., 2014).

In adult studies, greater family or caregiver support has been cited as "central" to the development of resilience (Banyard et al., 2002; Schaefer et al., 2018). Support from caregivers has been acknowledged as a protective factor relating to fewer post-traumatic stress symptoms and elevated post-traumatic growth (Hetzel-Riggin et al., 2021).

However, a challenge to receiving caregiver support can be "negotiating" with family and setting boundaries when child maltreatment has occurred (Bryant-Davis, 2005; Newsome and Myers-Bowman, 2017; Singh et al., 2012). Despite these challenges, agencies that attempt to work with victims of CSA recognize the importance of including caregivers in the treatment process to facilitate positive family support for the victim (McGillivray et al., 2017). The amount of social support the caregiver perceives has been demonstrated to influence the amount of support they are able to give to their child victim. Therefore, in child advocacy agencies, the non-offending caregiver may additionally receive support services (Beaujolais et al., 2021; McGillivray et al., 2017).

Supportive Adults and Peer Support. As discussed above, for some children, receiving support from a caregiver may not be possible due to traits within the environment or within the caregiver (Southwick et al., 2014). Nevertheless, the presence of a significant adult such as a teacher or mentor has also been related to resilience (Howell & Miller-Graff, 2014). Having support from professionals in the child's world such as a school nurse or child protective service caseworker is correlated with higher resilience in adolescent samples (Chandy et al., 1996; Leon et al., 2008). This highlights the importance of periphery relationships on resilience where adults not regularly interacting with the child may still have a positive influence (Leon et al., 2008). Teachers frequently are mentioned in qualitative and quantitative literature on buffering the lack of support from caregivers at home (Dillard et al., 2021; Eisenberg et al., 2007; Singh et al., 2012). For school-aged children, caring teachers may provide an escape from a negative or abusive home environment, leading to a decrease in vulnerability for children as they enter school (Dillard et al., 2021; Eisenberg et al., 2007).

As children move into adolescence, the influence of peers becomes greater (Hebert et al., 2014). Peers may be the first people to whom a child discloses his or her experience of abuse, and thus the peer may serve as the first person to provide support (Hebert et al., 2014). In research on individuals who experienced sibling abuse, participants cited "seeking refuge" in the homes of friends and experiencing stability in their friend's homes and support from friends' parents as protective factors that contributed to their resilience (Meyers, 2016). In a sample of 694 adolescents, peer support predicted lower post-traumatic stress symptoms to a greater degree than maternal support (Hebert et al., 2014). Peers additionally have an impact on the behaviors of CSA victims. In research by Chandy et al. (1996) on adolescents who experienced CSA, resilient adolescents had peers that scored higher on the "positive peer behavior scale" and had peers that had less substance use than the non-resilient participants. Last, in research with college students who were sexually abused as children, support from friends, but not family was correlated with greater resilience (Howell & Miller-Graff, 2014). Furthermore, social support during mid-life in a group of adults who experienced child maltreatment predicted a lower risk of mortality, even when controlling for confounding risk factors (Chiang et al., 2018).

Characteristics of the Family

Factors such as parent well-being, stable parenting, higher parent education, SES, and positive parenting practices are linked to positive influences on child behavior in general (Lepore & Revenson, Chandy et al., 1996; Yoon, 2018; Dillard et al., 2021). However, these components relating to the family are especially important in child resilience from victimization, as these factors repeatedly interact with the amount of

support a caregiver can provide (Yoon, 2018). Even living with both biological parents is connected with resilience in CSA survivors, pointing to stability in care as a protective factor (Chandy et al., 1996). Caregiver well-being in general has been related to a decrease in behavior problems in young child victims of CSA over time (Yoon, 2018). Substance use in parents as measured by the amount of beer or wine consumed by a parent was linked to resilience in adolescents, with lower levels of parental substance use negatively correlated with resilience (Chandy et al., 1996). Last, factors such as the amount of education of the parent and socioeconomic status have additionally been identified as protective characteristics relating to resilience in CSA victims (Chandy et al., 1996; Williams & Nelson-Gardell, 2012).

Characteristics of the Community

The community, as defined by contexts outside the home, such as school, extended social networks, extra-curricular activities, and proximity to community supports such as medical and mental health services are important in facilitating resilience in maltreated children (Dillard et al., 2021). The characteristics of a supportive and safe community have been shown to be protective in adult studies of CSA victims (Banyard et al., 2002). In the examination of a large group of individuals in a rural setting, where adversity and child maltreatment were high, resilient individuals cited several "poly-strengths" relating to the community they were inserted in such as community support, services, and participation in religious activities (Hamby et al., 2018). Schools that provide safe and less stressful school environments are identified as having a protective influence on sexually abused children (Chandy et al., 1996; Eisenberg et al., 2007). The ability to connect with activities outside of school may have a positive

impact on negative coping. In one study, belonging to clubs outside of school was related to less rumination in an adolescent sample (Leon et al., 2008). Last, access to treatment is cited by professionals as a hurdle that many clients must navigate. Some clients lack transportation to treatment centers or funds to pay for services. Further, when these systems are in place, mental health practitioners may have long waiting lists (Dillard et al., 2021). When children have support and access to treatment, the ability to emerge from their CSA resilient is elevated (Damhardt et al., 2015; Dillard et al., 2021).

Religious and Spiritual Coping

Spiritual and religious beliefs are a significant part of most cultures and can help individuals find support, experience community, gain direction, and develop a sense of purpose (Gower et al., 2020; Peres et al., 2007). Practicing religion and spirituality has been important in guiding how individuals manage and cope with trauma and loss and is identified as an approach that elevates resilience and self-growth (Peres et al., 2007; Starnino, 2016). Regarding resilience, spiritual and religious coping have been connected to resilience and post-traumatic growth in ways that are positive and negative (Schafer et al., 2018). In spiritual and religious coping (R/S) coping literature with children, there remains a dearth of inquiry, as adult perspectives are more easily captured (Gower et al., 2020). The following section presents a discussion on defining R/S coping and an explanation of what is currently understood regarding these constructs with an emphasis on children and adolescents who have experienced childhood maltreatment and/or specifically CSA.

Positive and Negative R/S Coping

On occasion, research on R/S coping has led to conflicting or mixed results, which brought about advances in the way investigators measured R/S coping, such as isolating specific religious coping strategies and measuring the strategy used with the outcome (Pargament et al., 2015). R/S coping is now viewed as positive or negative depending on the strategies utilized by the individual (Pargament et al., 2015). Meta-analyses have revealed resilience and post-traumatic growth are positively associated with positive religious coping (PRC), while negative religious coping (NRC) has a negative relationship with well-being, adjustment, and stress symptomology (Schaefer et al., 2018; Ano & Vasconcellos, 2005).

PRC reflects a “secure relationship with God and a sense of spiritual connectedness with others” (Pargament et al., 2015, p. 563). This secure relationship is reflected in a person’s ability to forgive, view God as “benevolent”, and utilize R/S coping to shift goals and priorities that enhance “meaning” and purpose (Schaefer et al., 2018). PRC has been tied to resilience in a variety of contexts such as those experiencing major health crises, veterans with PTSD, adults with severe mental illness, individuals coping with the death of a loved one, and people recovering from natural disasters (Ano & Vasconcellos, 2005; Sharma et al., 2017; Starnino, 2016; Pargament et al., 2015; Southwick & Charney, 2018; Davis et al., 2018).

NRC involves struggle and insecure emotions towards God or with others “around scared matters” (Pargament et al., 2015). NRC often centers around three buckets of spiritual struggle: interpersonal, intrapersonal, and divine (Pargament et al., 2006). Types of coping in these buckets may involve R/S conflicts with family or friends, questions about religious belief and practice, religious “punitive reappraisals” where God

is viewed as vengeful or punishing, and demonic reappraisals of suffering (Schaefer et al., 2018; Ano & Vasconcellos, 2005). NRC is correlated with negative physical functioning and an increase in mortality (Pargament et al., 2001). Additionally, NRC is related to a host of negative mental health outcomes including depression, anxiety, distress, and PTSD (Ano & Vasconcellos, 2005; Pargament et al., 2015).

Child Development and R/S Coping

Emerging R/S coping in children involves crucial components of social-cognitive development (Richert & Granqvist, 2015). Symbolic and mentalizing capacities have been identified as "prerequisites for children's developing understanding of religious and spiritual concepts" (p.165). These concepts and the subsequent connection with the theory of mind lay a developmental foundation for an understanding of God that emerges around 3-5 years of age (Richert & Granqvist, 2015). The cognitive abilities interact or "capitalize" on a child's attachment system; thus, when a child is more able to become satisfied with visual or imagined "symbolic" contact with an object of security (around preschool), the child is more able to view God as an "attachment surrogate" (Richert & Granqvist, 2015). Attachment and cognitive abilities additionally interact with the social and environmental sphere, all of which play a fundamental role in shaping the structure and content of a child's religious and spiritual development and a child's use of R/S coping when managing stressors (Richert & Granqvist, 2015; Bryant-Davis et al., 2012).

As children mature, shared cognitions relating to religion and spirituality move into internalized working models that may be activated and incorporated into the functioning of the child (Richert & Granqvist, 2015). In adolescence, children move from parental guidance in religious and spiritual beliefs to a more peer-dominated influence

(Richert & Granqvist, 2015; Arnett, 2008). R/S coping in adolescents is impacted by rapid growth physically, mentally, and psychologically (Bryant-Davis et al., 2012). Additionally, the development associated with adolescence can lead to more independent spiritual or religious beliefs or rejection of beliefs connected with childhood (Arnett, 2008). Additionally, at this period of development, adolescents are more able to understand and engage with abstract thought and coping mechanisms, enhancing the use of R/S coping (Levenson et al., 2013).

R/S Coping as Protective Factors in Children and Adolescents

Spirituality and religiosity in children and adolescents have been categorized as protective factors that are associated with positive development in several aspects of functioning. Religious involvement in adolescents has been correlated with positive psychosocial adjustment and a greater sense of self-worth (Good et al., 2011; Holder et al., 2010). In studies with children, specifically 8-12-year-olds, spirituality was linked to greater happiness (Holder et al., 2010). These results remained significant even when controlling for temperament. Additionally, religiosity has been tied to several factors attached to happiness such as life satisfaction, well-being, self-esteem, and empathy in international samples of adolescents (Russell & Alderman, 2022; Huuskes et al., 2016).

While spirituality and religiosity are linked to well-being, they are also recognized as protective factors against risky behaviors (Bryant-Davis et al., 2012). For example, in a longitudinal study of adolescents, Good and Willoughby (2011) found that more frequent religious attendance in one grade of high school predicted lower substance use in the next grade, even after controlling for individual, peer, and family traits. Regarding sexual risk-taking behaviors, several studies identify religiosity and spirituality as

protective against early and risky sexual activity (Kogan et al., 2008; Langer et al., 2001; Bryant-Davis et al., 2015). Last, spirituality and religiosity have been demonstrated to positively influence academic achievement and motivation and are negatively correlated with misbehavior in school (Milot et al., 2009).

S/R Coping and Resilience from Childhood Maltreatment

Child maltreatment such as abuse or witnessing and experiencing violence in childhood can impact a person's religious and spiritual development (Walker et al., 2009). Samples of individuals who have experienced child maltreatment have reported their religiosity and spirituality were enhanced or declined because of their maltreatment (Walker et al., 2009). Victims have positively used R/S coping to make sense of their experiences and derive meaning, hope, and healing (Bryan-Davis et al., 2012). Conversely, many survivors question their trust in God. Survivors may believe they are being punished by God, wonder how God could have allowed the abuse to occur, or feel abandoned by unsupportive members of religious organizations (Pargament et al., 2006; Walker et al., 2009). What is consistent is that positive R/S coping provides critical ingredients that serve as a "trigger" that enhances a person's ability to cope (Tedeschi et al., 2018). The positive forms of R/S coping help individuals who have experienced child maltreatment find support, empowerment, meaning, and transformation following their experience (Tedeschi et al., 2018).

Research with Adults

Qualitative research with adult CSA survivors provides a rich opportunity to hear the voices of the survivors' lived experiences. In these studies, participants regularly cite the power of R/S coping on resilience and post-traumatic growth (Singh et al., 2012;

Bryant-Davis, 2005; Singh et al., 2013). In a 2017 study, Newsom and Myers-Bowman noted that several female participants in their study emphasized the positive impact of their religious beliefs on healing. One participant reported, "now I see sex as a gift from God…faith defines it for me" (Newsome & Myers-Bowman, 2017, p. 938). Other studies speak about the participants' spiritual or religious strategies chosen such as prayer, church attendance, and pastoral counseling, which were utilized to heal faulty beliefs about self, sexuality, and God or a higher power (Singh et al., 2012; Bryant-Davis, 2005). In a 2021 qualitative study of CSA practitioners, participants cited "religious involvement" as "key" when discussing resiliency from CSA (Dillard et al., 2021).

Research with Children and Adolescents

The majority of the resiliency research examining religion, spirituality, and CSA or child maltreatment utilizes samples of adult survivors (Bryant-Davis, 2012; Gower et al., 2020). However, when examining the research that has been conducted with samples of youth who have experienced child maltreatment, R/S coping appears to positively influence resiliency (Bryant-Davis, 2012; Gower et al., 2020; Sigurvinsdottir et al., 2021). A study with CSA adolescent survivors and their non-offending caregivers showed that "divine support" and caregiver support were positively correlated both together and separately with resiliency (Gower et al., 2020). This was consistent with an earlier study of adolescent females who had experienced CSA, with R/S coping increasing the likelihood of self-reported resilience compared to those survivors who did not utilize R/S coping (Chandy et al., 1996). Spirituality has been identified as a protective factor against depression and anger in adolescent survivors of CSA and child maltreatment (Freeny et al., 2021; Sigurvinsdottir et al., 2021). Given the link between

R/S coping and resiliency indicated by these studies, it is important to continue to research the impact R/S coping has on resiliency in children and adolescents.

Biblical Foundations of the Study

Christianity, and specifically the Bible reverberates with the sound of resilience. The words of Isaiah 61:3 speak of God's strength, "For you have been my refuge, a strong tower against the foe" and hope is communicated in Jeremiah 29:11, "'For I know the plans I have for you,' declares the Lord, 'plans to prosper you and not to harm you, plans to give you hope and a future'" *(New International Version Bible*, 2011). Thus, when we think about the concepts presented in this paper, CSA, resilience, and R/S coping, it is necessary to conceptualize these constructs through a biblical lens. In the beginning, the Creator God spoke the world and man into existence and continues His active role to this day (*New International Version Bible*, 2011, John 1:1-3). The history of human beings, as written in the Scriptures, is a history of mankind's initial connection to God in the Garden of Eden and man's subsequent rebellion against God's plan, leading to a separation from God and the unified life God originally designed (Grudem, 1994). As a result of man's rebellion, sin entered the world. Sin is defined as "any failure to conform to the moral law of God in act, attitude, or nature" (Grudem, 1994, p. 490). All the world has been touched by the sin of man. In Genesis 3:17, God says to Adam, "Cursed is the ground because of you," and in Romans 3:10, Paul states that no man is "righteous not even one" (*New International Version Bible*, 2011; Wolters, 2005). Therefore, the world was in need of redemption. As sin entered the world through one man, redemption is

found through one man, Jesus, who "while we were still sinners," He "died for us" (*New International Version Bible*, 2011, Romans 5:8 & 5:12).

Salvation or redemption is restoration, and it brings one into a state of regeneration (Grudem, 1994). Scripture speaks of a "new birth" representing that restored person (Grudem, 1994; *New International Version Bible*, 2011, Romans 8:10). It is not just a restoration, but a transformation in the person. This healing transformation is echoed throughout the Bible in biblical persons such as Paul, who prior to experiencing Jesus on the road to Damascus was Saul, a Pharisee who persecuted early Christians (*New International Version Bible*, 2011, Acts 9). In the psychological scientific community, this transformation is evident when we listen to the words of survivors of CSA and their family members such as, "We make sure we lean on God now more than ever," and "I know that counseling and therapy does work, but God is the actual answer" (Bryant-Davis, 2005, p. 411; Vilvens et al., 2021, p. 2695). Jesus says, "I have told you these things, so that in me you may have peace. In this world, you will have trouble but take heart! I have overcome the world!" (*New International Version Bible*, 2011; John 16:33). Thus, when we think about resilience, there is no greater image than Jesus' empty tomb.

With a concept as challenging as CSA, it is easy to attach it to sin. Galatians 5:19-21 speaks about "acts of the flesh" such as sexual immorality, impurity, and debauchery (*New International Version Bible*, 2011). Paul states that those who practice these acts "will not inherit the kingdom of God" (*New International Version Bible,* 2011, Galatians 5:21). Jesus says in Mark 10:14, "Let the little children come to me, and do not hinder them, for the kingdom of God belongs to such as these" (*New International Version*

Bible, 2011). The act of child sexual abuse must be especially devastating to God, as those who belong to the kingdom of God are violated in “acts of the flesh” (Galatians 5:19). In fact, in Matthew 18:6, Jesus says “If anyone causes one of these little ones – those who believe in me – to stumble, it would be better for them to have a large millstone hung around their neck and to be drowned in the depths of the sea” (*New International Version Bible,* 2011).

Understanding those who experience child maltreatment, specifically child sexual abuse, and believe themselves to be resilient is an important topic to explore and gain understanding. The Bible is filled with accounts of resilience from maltreatment and adversity. The Psalms provide the words of King David and others who utilize R/S coping to remind them of the ways that God will eventually lead them to victory despite the current challenge they are in. For example, in Psalm 61:2 David cries, “as my heart grows faint lead me to the rock that is higher than I” (*New International Version Bible*, 2011). David then adds in 61:3, that God is and has been his “refuge” and “strong tower against the foe”. The biblical story of Joseph is also an important account that reminds us of the healing and redemption that can come following a violation, and a vision of the use of R/S coping (*New International Version Bible*, 2011, Genesis 37-47). Joseph, after being sold into slavery by his brothers and subsequently experiencing further hardships, emerges “resilient.” He is eventually able to restore his brothers and father, as a high-ranking official in Egypt. The story of the Bible is a story of resilience and of healing. Experiencing child sexual abuse is a violation and a dramatic challenge for a child to overcome, and research tells us that there are individuals, like Joseph, who despite the trauma can thrive (Marriott et al., 2014). This study contributes to knowledge, from a

biblical perspective, by studying how children experience resilience, and specifically how resilience is impacted by spirituality and religious coping. This understanding can serve to inform faith communities and practitioners about how to elevate the support provided to these children and their families.

Summary

Until the last thirty-five years, research with individuals who had experienced CSA primarily focused on the damaging impact resulting from the abuse (Marriott et al., 2014). This valuable work allowed an understanding of the way CSA is especially destructive across several domains of functioning placing an individual at greater risk for psychopathology, health problems, aggression, risk-taking behaviors, substance use, self-harm, and suicide (Banyard et al., 2017; Carliner et al., 2016; Collin-Vezina et al., 2013; Freeny et al., 2021; Menard & MacIntosh, 2021; Tabachnick et al., 2022; Trickett et al., 2011). However, this pattern of maladaptation is not the only possible outcome connected with CSA.

Researchers conducting longitudinal studies with at-risk children, such as Werner and Smith (1979), noted they felt “deeply impressed” with the capacity of these children to positively acclimate despite their circumstances. This represented the beginning of a paradigm shift from the “deficit model” to a model of “thriving” that emphasized adaptation from adversity or resiliency (O’Leary, 1998, p. 427). Subsequent research provided a list of internal factors associated with resilience, for example, self-efficacy, optimism, hope, and social competence, as well as external factors such as social support, and characteristics of the home and community (Banyard & Williams, 2007; Chandy et

al., 1996; Daigneault et al., 2007; Domhardt et al., 2015; Marriott et al., 2014; Williams & Nelson-Gardell, 2012). Resilient children were initially viewed as super-human; however, as research became more prevalent, it was understood that resilience is a phenomenon that arises from “ordinary human adaptive processes” (Masten, 2001). In the Bible, the “ordinary magic” of resilience is communicated in the stories of human suffering, loss, restoration, and redemption (Masten, 2001). Despite the momentum of resilience research, there is a continued need to explore resilience in children and adolescents who have experienced CSA, as much of the research conducted utilizes adult populations discussing their abuse from childhood.

Across the globe, individuals regularly engage in religious and spiritual practices. These practices can help individuals function positively in several ways but can be especially helpful when experiencing adversity. R/S coping is a well-recognized form of coping, that is tied to resilience and can help individuals make meaning, practice forgiveness, receive support, and develop a sense of purpose (Good & Willoughby, 2006; Hamby et al., 2018; Pargament et al., 2001). R/S coping is linked to overcoming childhood maltreatment and CSA by decreasing anger, depression, and PTSD (Bryant-Davis, 2012; Freeny et al., 2021; Sigurvinsdottir et al., 2021). Yet, there remains an insufficient amount of research that examines R/S coping in children and adolescents who have experienced CSA.

This study sought to approach the gap in resilience and R/S coping research by exploring these concepts with mental health practitioners who work with children and adolescents who have experienced CSA. The next chapter will provide a description of the methodology, procedures, and design of the study.

CHAPTER 3: RESEARCH METHOD

Overview

This study used a qualitative phenomenological method to research resilience and R/S coping from the experiences of mental health practitioners who treat children and adolescents who have experienced CSA. In this chapter, I will discuss the research methods, design, and procedures.

Research Questions

1) How do practitioners describe resilience in child clients who have experienced sexual abuse?
2) What are the practitioner perspectives regarding the role of spirituality in the development of resilience following CSA?
3) What are the practitioner perspectives regarding the role of religious coping in the development of resilience following CSA?
4) What aspect(s) of spiritual and religious coping do practitioners believe made the largest contribution to their resilience?
5) How do practitioners encourage and /or facilitate spiritual or religious coping in their CSA clients?

Research Design

My study utilized qualitative research design. Qualitative research entails methods that seek to explore, illustrate, and illuminate a problem, rather than quantify, predict, or determine a causal relationship regarding the problem, as in quantitative methodology (Creswell & Poth, 2018). In qualitative methods, the analysis provides a way to describe

a problem that includes details from interacting with individuals with experience with the problem in question. Using qualitative methodology is advantageous because it allows flexibility in the flow of questions and enhances the researcher's ability to probe for deeper meanings (Rasmussen & Goodman, 2018). My study aspired to describe the experiences of mental health practitioners who have worked with children and adolescents who have experienced CSA to gain an understanding of the ways these practitioners describe their clients' experience of resilience with an emphasis on R/S coping. As such, a qualitative method was the most appropriate method.

Transcendental Phenomenology

The qualitative design selected for this study was the transcendental phenomenological approach, also referred to as the psychological phenomenological approach (Creswell & Poth, 2018). Phenomenology is "knowledge as it appears to consciousness" and involves the science of communicating what a person perceives and knows in their own experience (Moustakas, 1994, p. 26). The word phenomenon comes from the Greek words that mean "bring to light" and "to show itself in itself" (Moustakas, 1994, p. 26). Phenomena are conceptualized as "the building blocks of human science" and represent a starting point for inquiry (Moustakas, 1994, p. 26). It is the goal of phenomenological research to document, analyze and interpret the "essence" of a human experience, in this case, resilience from CSA (Creswell & Poth, 2018). The term "transcendental" is used because it "moves beyond the everyday" beliefs that surround the phenomenon (Moustakas, 1994, p. 34). A key idea of phenomenological research is "intentionality," which refers to consciousness or setting the mind to the object. An essential component of this method is "epoche," the Greek word that means to "refrain

from judgment" and pause from viewing something in an "ordinary" way, to view the material "as if for the first time" (Creswell & Poth, 2018; Moustakas, 1994, p. 33).

Using the transcendental phenomenological approach allows the investigator to gather information from participants from the vantage point of the participants. Collecting information using this approach involves interviews, self-reflection, and descriptions of the meaning of the lived experiences of participants (Creswell & Poth, 2018). In this study, interviews were conducted with participants with questions designed to capture their experience in terms of the phenomenon, which is resilience in children and adolescent CSA survivors (Creswell & Poth, 2018). Phenomenological inquiry utilized this information and identified themes to determine an "essence" with the goal to contribute to the gap in the literature on resilience from CSA and R/S coping in children and adolescents (Creswell & Poth, 2018).

Bracketing

As discussed in the previous paragraphs, an essential component of transcendental phenomenological research is epoche (Creswell & Poth, 2018; Moustakas, 1994). To view the phenomena through a new lens, non-judgmentally, the researcher's first step is to "bracket" or set aside preconceived assumptions, past experiences, personal beliefs, biases, and perceptions (Creswell & Poth, 2018). For this study, I first acknowledge seven years of previous work at child advocacy centers as a therapist intern, therapist, and forensic interviewer and evaluator. I am also a mental health counselor, currently in private practice, and have worked with children and adolescents for a total of 20 years. During the study, I needed to bracket these past experiences and assumptions of resilience based on those previous experiences. Additionally, as a practicing Christian, I

will need to bracket any assumptions connected to my Christian beliefs, practices, and personal experience of using positive R/S coping during periods of stress.

Participants

Following the acquisition of institutional review board (IRB) approval, I recruited mental health practitioner participants. Initially, I circulated information about the study to local mental health practitioners and local Child Advocacy Centers (CACs). For the identification of participants, I utilized a convenience sample along with a snowball sample of mental health providers that work with children and adolescents and CSA (Creswell & Poth, 2018). The criterion for participants were: a) individuals must be mental health providers with a minimum of a master's degree in counseling b) participants must have worked with child clients under the age of 18 as a mental health practitioner c) participants must have or have had employment as a mental health practitioner at a CAC or have worked regularly with children who have experienced CSA for a minimum of one year.

In phenomenological inquiry, the number of participants can vary from small samples of 4-5 to larger samples of 10-15 individuals (Creswell & Poth, 2018). Recruitment for the study continued until no new themes emerged from the data, yielding a total of fifteen participants.

Study Procedures

Qualitative research employs a systematic method of obtaining data that allows for the flexibility of the qualitative format while maintaining an organized, structured approach to information gathering (Creswell & Poth, 2018; Moustakas, 1994). The procedures for my study consisted of recruiting participants, obtaining consent from the

participants, interviewing participants, coding data, and identifying themes relating to the data.

Participants

I began the recruitment of participants by contacting gatekeepers and potential participants through local contacts. Gatekeepers were executive directors of Georgia CACs, child forensic interview trainers, independent therapists, and executive directors at mental health agencies that work with children and adolescent clients. The gatekeepers and potential participants were sent information to send to their mental health practitioners and other practitioners. As an incentive to participate, at the conclusion of the interview, each participant received a $10 Amazon gift card and a raffle ticket for a $50 gift card.

I will sent the gatekeepers and possible participants a recruitment email (Appendix A) with an attached consent form (Appendix B). During the consent process, the individuals were informed, in accordance with Creswell and Poth's (2018) suggestions, of the following information: a) the right to withdraw at any time during the study, b) the purpose of the study and data collection procedures, c) procedures surrounding confidentiality, and d) the risks and benefits of the study. Participants were emailed the consent form and upon receipt of the consent form, I emailed them to confirm eligibility, collected demographic data through a brief emailed survey (Appendix C) and scheduled the individual interview. I collected the following demographic information: age, race, gender, years of practice working with children and adolescents, and religious affiliation (Appendix C).

Interview Procedures

In phenomenological research, intentionality involves focusing consciousness on the concept of exploring a phenomenon through the lens of those who have experienced it, in this case, the practitioner (Creswell & Poth, 2018). The interview in qualitative research is designed to elicit a "vivid picture of the participant's perspective" and is an effective method to gather data on a person's opinions, experiences, feelings, and beliefs about a phenomenon (Mack et al., 2005, p. 29). Thus, the interview format was an ideal method of data collection for my study because an interview allows the participant an opportunity to express a description of their thoughts and beliefs about their experience(s) with child and adolescent victims of CSA and their resilience, as well as R/S coping (Mack et al., 2005; Moustakas, 1994). The interview format was semi-structured, which is an interview method that involves structured questions with an allowance of flexibility, moderation, and expansion of questions to enhance the gathering of data (Creswell & Poth, 2018; Mack et al., 2005). Open-ended questions were utilized to elicit responses beyond "yes" and "no" answers, see Appendix D for a list of interview questions (Creswell & Poth, 2018).

At the beginning of the interview, I reminded the participants of the purpose of the study and reminded them of the signed consent, confidentiality, and recording procedures. I additionally informed the participants that they are viewed as the expert on the subject, that I was there to learn, that there are no right or wrong answers, and that they may choose to not answer a question and may end the interview at any time (Mack et al., 2005). Additionally, I told the participants that I will be taking notes during the meeting. My initial contact with the participants was rapport-building / background questions, followed by questions about resilience from CSA, and lastly, R/S coping.

Interviews were performed primarily via the Zoom platform, and two interviews were in person interviews. Thirteen interviews were sound recorded with permission, and two interviews were unable to be recorded due to malfunctioning equipment; however detailed notes were taken. I additionally took field notes during the interviews, as is recommended in the event that the audio recording malfunctions (Mack et al., 2005). Interviews lasted from 40-150 minutes. No participant withdrew from participating or concluded an interview prematurely. At the conclusion of the interviews, I will provided each participant with a $10 Amazon gift card and a raffle ticket for a $50 Amazon gift card.

During the interview procedure, I took steps to suspend judgment and bracket assumptions as described previously in all stages of the study (Moustakas, 1994; Mack et al., 2005). In the interview, I viewed the participant as the expert and myself as the student (Mack et al., 2005). I asked key interview questions regarding their perspective on resilience and strategies that promote resilience from CSA, as well as questions regarding their perspective on positive R/S coping and resilience.

At the completion of the interview, I thanked the participants for their participation and gave them their raffle ticket and gift card. All identifiers were removed from the data, and the data is stored in password-protected files that will be maintained for a minimum of three years (Creswell & Poth, 2018).

Instrumentation

The questions were designed to explore the meaning of the phenomenon (in this study resilience and R/S coping in CSA survivors). The interview questions were self-generated and based on examining studies exploring practitioners' perspectives in

previous studies such as Dillard et al. (2021) and Beaujolais et al. (2021). The questions were grouped according to categories. The first questions centered around building rapport and gathered basic background information about their work experience as a mental health practitioner who works with children and adolescents. The second group of questions was structured to elicit examples of how practitioners understand resilience and the factors that they believed contributed to resilience development. The next group of questions focused on the practitioners' definition of R/S coping and understanding of how R/S coping enhanced resilience from CSA. The last questions were regarding the ways practitioners incorporate R/S coping into practice. For a list of interview questions, see Appendix D.

Trustworthiness

Trustworthiness is a way that researchers can ensure the results of the study are worthy of notice (Lincoln & Guba, 1985). Trustworthiness is believed to be the qualitative equivalent of validity and reliability in quantitative research and is accomplished through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985; Nowell et al., 2017). Credibility is thought to occur when readers recognize the relationship between the participants' voices and the researcher's interpretation of them (Creswell & Poth, 2018; Lincoln & Guba, 1985). In this study, I worked to ensure that credibility was accomplished in two ways. First, through contact with participants for clarification, and second, through member checking (Creswell & Poth, 2018). Transferability, which is related to the generalizability of the study, is achieved by providing descriptions that are complete enough for a reader to determine if the results relate to a different population (Creswell & Poth, 2018; Lincoln & Guba,

1985). Dependability primarily involves an auditor and having an audit trail, which documents the methodological decisions the researcher makes, by keeping detailed records and reflexive journals (Creswell & Poth, 2018; Nowell et al., 2017). In this study, an external auditor was utilized, and records consisting of raw data, field notes, transcripts, and reflexive journals were retained to ensure a clear audit trail (Nowell et al., 2017). Through these outlined processes, confirmability, which establishes that the researcher's findings are the result of the data, is reached (Creswell & Poth, 2018; Nowell et al., 2017).

Data Analysis

Data analysis was conducted in phases. During all phases of data collection and analysis, I employed epoche by maintaining a stance as a novice while setting aside preconceived notions of the phenomenon (Moustakas, 1994). I accomplished this through reflexive journaling and bracketing assumptions and experiences. The initial phase involved transcription and familiarization with the data. Transcriptions were verified with the sample through member checking, and participants were open to being contacted for clarification (Creswell & Poth, 2018; Newell et al., 2017). I transcribed audio recordings verbatim, and participant and interviewer voices will be tagged as A and B with identifiers removed. My field journals served as reminders of situational and contextual factors (Creswell & Poth, 2018).

In the next phase, I examined the data and evaluated each statement while viewing them as having equal worth, which is known as "horizonalization" (Creswell & Poth, 2018; Moustakas, 1994). The subsequent phase involved generating a list of "non-repetitive, non-overlapping statements," which developed into larger units, referred to as

"meaning units," and clustered into similar meaning units (Creswell & Poth, 2018, p. 201). From the clusters, I began coding preliminary themes that I enhanced through "textual descriptions," which provided an illustration utilizing direct quotations from participants (Creswell & Poth, 2018, p. 201). Codes had "boundaries" so that they are not redundant and represent clear specific ideas or topics revealed through the practitioner narratives (Newell et al., 2017; Sutton & Austin, 2015). I moved to the next phase when all data was initially coded and relevant data were grouped into themes (Creswell & Poth, 2018). Themes were dependent on the relationship to the overall research questions and were generated inductively or deductively (Newell et al., 2017). Themes were refined and renamed with a goal of a "structural description" (Creswell & Poth, 2018). The final phase began when there were firmly established themes, which provided an "essence" of the participant experiences.

My chair, Natalie Hamrick, aided in the coding of meaning units associated with the interview data. Any discrepancies were resolved and applied to other participants' data if needed.

Delimitations, Assumptions, and Limitations

In this study, I maintained the assumption that the participants are interested in participating in the study and that their answers to the interview questions are truthful. Additionally, I assumed the sample, as mental health practitioners, valued the concept of resilience from CSA. The study's scope is meant to capture the experience of mental health practitioners who work with children and adolescents who have experienced CSA. The study boundaries surround an understanding of resilience from CSA with an emphasis on how R/S coping enhances resilience from CSA and how practitioners

incorporate R/S coping into their clinical practice. Last, this study is bound by qualitative methodology; thus, this research was not intended to test a hypothesis or draw causal or correlational conclusions.

My study has some limitations. First, my research was intended to contribute to generalized knowledge through understanding experiences, thus possibly serving to improve research and services provided to youth who have experienced CSA; however, because of the nature of a qualitative study and a small sample size, the results may not be generalizable to the perspectives of all practitioners who work with CSA survivors. Second, response bias, meaning that participants may have sought to provide a desirable response to questions, is always a factor when conducting interviews.

Summary

The design of this study was a transcendental phenomenological qualitative design. This design was chosen to enhance understanding regarding practitioners' lived experiences as mental health clinicians working with child clients who have experienced CSA, and their understanding of resilience and the role of R/S coping. Following IRB approval for the study, participants were recruited and informed consent was obtained. The method of obtaining data was audio-recorded interviews. The data was transcribed, and methods were employed to code and assess for themes consistent with phenomenological qualitative research. During the data collection and analysis process, all data was kept securely stored in password-protected digital files with personally identifiable markers removed. All data will be securely stored for no less than three years (Creswell & Poth, 2018). In the next chapter, the results of the interviews will be discussed and the themes that emerged will be examined.

CHAPTER 4: RESULTS

Overview

The purpose of this qualitative phenomenological study was to gain a substantial and meaningful understanding of practitioners' perspectives on resilience in children who have experienced CSA. Additionally, I explored the specific influence of spiritual and religious coping on resilience, and the ways clinicians may incorporate R/S coping in their treatment of CSA survivors. In this chapter, I will provide the results of data analysis and will include the study research questions, an overview of the data collection, demographic information, and a description of participants. Additionally, I will discuss an overview of the analysis of data and the findings, including themes, their meanings, and quotations from the participants, concluding with a summary of the results.

I used a transcendental phenomenological design involving semi-structured interviews and demographic surveys to collect data. I analyzed the data from the 15 interviews in several phases that resulted in generating and narrowing themes. During the data collection and analyzing phase, I practiced bracketing and member checking, with the goal of reducing research bias and preconceived ideas (Creswell & Poth, 2018; Moustakas, 1994). Five research questions served to guide this study:

RQ1: How do practitioners describe resilience in child clients who have experienced sexual abuse?

RQ2: What are the practitioner perspectives regarding the role of spirituality in the development of resilience following CSA?

RQ3: What are the practitioner perspectives regarding the role of religious coping in the development of resilience following CSA?

RQ4: What aspect(s) of spiritual and religious coping do practitioners believe made the largest contribution to their resilience?

RQ5: How do practitioners encourage and /or facilitate spiritual or religious coping in their CSA clients?

Descriptive Results

Participants included 15 mental health practitioners with a minimum of a master's degree in counseling who had regular experience at some point in their career working with children who had experienced CSA. Participants were recruited using convenience sampling by contacting child advocacy centers and child mental health practitioners in the state of Georgia. From that convenience sample, a snowball sample emerged, yielding 15 participants. Thirteen participants were located throughout the state of Georgia. Additionally, one participant resided in Alabama and one in North Carolina.

Participant Demographics

Table 1 displays a breakdown of demographics by participant. The sample consisted primarily of white females identifying as Christian. The majority of participants had 11-20+ years of experience, and over half were 41+ years old. See table 1 for details.

Table 1

Participant Demographics

Participant	Work Setting	Yrs Experience	Age Range	Religious Affiliation	Race	Gender	Degree
P1	CAC	21 +	51+	Christian	White	F	MS/ EdS
P2	Private Practice	16-20	41-50	Christian	White	F	MS
P3	Private Practice	0-5	31-40	Christian	White	M	MS
P4	Private Practice	21+	51+	Christian	White	F	MS
P5	CAC	21+	51+	Christian	White	F	MS
P6	CAC	21+	51+	Christian	White	F	MS
P7	CAC / Private Practice	11-15	31-40	Jewish	White	F	MS
P8	Private Practice	0-5	21-30	Christian	White	F	MS
P9	CAC/ Private Practice	16-20	41-50	Christian	White	F	MS
P10	CAC/ Private Practice	16-20	51+	Christian	White	F	MS
P11	CAC	0-5	21-30	Christian	White	F	MS
P12	CAC	16-20	41-50	Christian	White	F	MS
P13	CAC	6-10	31-40	Christian	White	F	MS
P14	CAC	16-20	41-50	Chistian	Black	M	PhD
P15	CAC / Private Practice	6-10	31-40	Christian	White	F	MS/ EdS

Data Analysis

I conducted data analysis in phases as outlined and described in Chapter 3. Consistent with transcendental phenomenological studies, I employed epoche, setting aside preconceived notions (Moustakas, 1994). The initial phase of analysis involved transcription of the audio interviews and familiarization with the data (Creswell & Poth, 2018). I read interviews several times in conjunction with audio recordings to ensure accuracy. I then examined statements made by participants for significant phrases. Responses, using quotations, were grouped into meaning units. The meaning units provided initial codes that represented clear specific ideas and topics (Creswell & Poth, 2018). Last, the codes I created were examined for connections and grouped into preliminary themes. The initial themes related to each research question were narrowed resulting in primary themes and sub-themes. The themes and sub-themes provide an essence of participant experiences with their child clients regarding resilience from child sexual abuse and the role of R/S coping.

Study Findings

The findings of the study are organized into sections pertaining to interview and research questions. The initial paragraph contains a discussion of the protocols and theories used by the practitioners. In the subsequent sections, the five research questions were separated, each containing individual themes, sub-themes, quotations, and tables. When explaining findings, the following words were used to describe the number of participants who responded to a theme or subtheme: 11-15 = Most/ Majority, 6-10 = Some/ Several, 2-5 = Few. Table 2 provides a visual of themes and subthemes connected with research questions.

Table 2

Themes and Subthemes for Each Research Question

Research Question	Themes & Subthemes	Participants Responding
RQ1: **How do practitioners describe resilience in child clients who have experienced CSA?**	**1) Influence of Caregiver Relationships** a. Safe / Stable Environments b. Nurturing / Supportive Caregivers	*n* = 15
	2) Significance of External Social Networks a. Community-Based Networks b. Supportive Individual Relationships	*n* = 15
	3) Use of Active Coping a. Practice Problem-Focused Coping b. Leveraging Interpersonal Resources c. Use of Emotion-Regulation Strategies to Manage Trauma d. Engage in Meaning Making	*n* = 15
RQ2: **What are practitioner perspectives regarding the role of spirituality in the development of resilience following CSA?**	**1) Connection Between Mind & Body**	*n* = 11
	2) Attunement Outside of Self	*n* = 10
	3) Use of Non-Religious Spiritual Practices	*n* = 6
	4) Engaging in Compassionate Behavior	*n* = 5

RQ3: **What are practitioner perspectives regarding the role of religious coping in the development of resilience following CSA?**	**1) Spiritual Connectedness within the Religious Community** a. Connection with Family b. Connection with Others **c.** Connection with God	*n* = 13
	2) Negative Religious Coping a. Experienced Dismissive or Invalidating Religious Statements b. Received Judgment **c.** CSA Connected to Religious Community	*n* = 12
	3) Support from Religious Practices a. Prayer b. Religious Music c. Reading Religious Texts or Writings d. Forgiveness	*n* = 11
	4) **Resolution of Spiritual Struggles**	*n* = 7
	5) Meaning Making	*n* = 9
RQ4: What aspect(s) of spiritual and religious coping do practitioners believe made the largest contribution to their resilience?	**1) Connection to Spiritual Community**	*n = 8*
	2) Receive Comfort & Stress Regulation	*n = 5*
	3) Reframe the CSA Experience & Meaning Making	*n= 9*
RQ5: **How do Practitioners encourage and /or facilitate spiritual or religious coping in their CSA clients?**	**1) R/S Coping Incorporated During Relaxation & Regulation Practice**	*n = 7*

	2) Incorporating R/S Coping During Cognitive Processing of Trauma	*n* = 9
	3) Incorporating R/S Coping Through Creative Methods with Young Clients	*n* = 9

Protocols and Theories

The introductory interview questions were designed to gather background information on the mental health practitioners and inquire about the protocols or theories used frequently when treating children who have experienced CSA. Most of the participants (n = 12) reported receiving specialized training and/ or certifications that inform their practice when working with children who have experienced CSA. Every one of the therapists listed a combination of approaches when treating CSA, while stressing the importance of anchoring treatment to align with a trauma-informed approach. Twelve participants reported using Trauma-Focused Cognitive Behavioral Therapy when working with CSA victims and all twelve referenced incorporating elements of play therapy, especially when working with young children. Eight practitioners reported they incorporated Eye Movement Desensitization and Reprocessing with CSA survivors if possible. Other methods listed by individual therapists that were used in conjunction with other methods of treatment were Internal Family Systems (IFS), person-centered therapy, narrative therapy, and dialectical behavioral therapy (DBT). Theories most cited were attachment theory and systems theory.

RQ1: How do practitioners describe resilience in child clients who have experienced CSA?

All the participants reported experiencing resilience in their clients. Participant 9 stated, “It’s really actually hard for me to think of a kid that was sexually abused that I didn’t find resilient.” The practitioners additionally conceptualized children who have experienced CSA through a resilience lens. Participant 14 described using this lens at the outset of treatment:

> We look for it, we name it, we identify it…a trauma assessment is helpful but rather than only identifying pathology, looking at those strengths and those things that kids are bringing to the table, because kids are a mix of it all. They’re not just their pathologies…they are fuller than a traumatized kid.

Participant 6 discussed viewing this resilience as remarkable:

> I would think, ‘Oh my God! This kid’s incredible! How can they even be alive?’ I would be dead as a door nail! I wouldn’t have survived that! Where would I be? I’d be dead, I would be so dead! And I would see them as resilient, and I did see them as just remarkable.

I identified three themes that relate to RQ1. These include 1) influence of caregiver relationships/ environment, 2) significance of external social networks, and 3) use of active coping skills. In addition to the three primary themes, I identified eight subthemes. These themes and subthemes will be described and defined, along with illustrative quotes to convey the language of the practitioners.

RQ1 Theme 1: Influence of Caregiver Relationships/ Environment

The theme of influence of caregiver relationships/ environment was the first, most obvious, and most frequent theme that emerged from the analysis of individual questions regarding resilience. This theme is defined as caregiver environments and relationships

that are physically and emotionally safe, especially regarding safety from CSA. These relationships and environments may provide affection, positive modeling, predictability, and an active engagement of parenting practices as well as support when there are challenges, especially regarding the CSA experience. All the participants cited this theme during their interview, and most of the practitioners highlighted this theme as the most significant influence on resilience from CSA. Participant 13 shares:

> The factor that is consistent across the board is supportive caregivers. That is something that I've noticed being a huge factor. In both kids being able to bounce back, but also how quickly kids are able to get there.

Theme 1 was further divided into two subthemes 1A) safe / stable environments and 1B) nurturing/ supportive caregivers.

RQ1 Subtheme 1A: Safe/ Stable Environments

Often emphasized at the beginning of the resilience discussion was a mention of safety and stability in the environment. Practitioners defined a safe and stable environment as one that provided a more predictable routine, basic needs were met, fewer chronic stressors, and less chronic sexual abuse. For example, Participant 5 noticed that more resilient children have in place a "predictable routine, having a calm, not chaotic family, and a predictable routine so there's food and a sleep pattern." Participant 15 discussed the impact of the environment, especially when there are less resources available, saying:

> Even if they have some support, those who I saw who were less resilient had maybe less resources in general. Less predictable lives, less nurturing, could also be less educated parents, or parents that had their own trauma history, less money,

> and all those things that can go hand in hand with having less advantages in general.

Participant 11 also discussed the influence of environment and how it may impact resilience from a CSA experience:

> If a child comes from chronic or constant trauma, often it's gonna be harder for them to be resilient, because all they know is trauma. Whereas if we have a child who comes in and they've had a pretty safe, emotionally healthy upbringing, and then they have trauma, it might be a little easier for them to lean back on their safe family and upbringing and can heal from that.

In this example, Participant 11 indicated that less chronic stress in the environment provided a platform that allowed the child the ability to lean back on that positive environment for healing. Participant 14 reiterates this experience:

> I think a lot of it depends on the functioning in that child's life even before the trauma took place. I know we focus a lot on the incident, but I find so many times the things that we've embedded in a kid, or a kid has learned prior to the incident really can determine how they respond.

Every participant referenced the importance of having either a foundation of stability prior to the CSA, or in the absence of this foundation, the importance of establishing safety and stability in their current environment. For example, Participant 8 posits, "If the family environment isn't safe, then is the kid ever feeling that sense of safety? I just don't know how it's going to happen. And so then, what resilience can there really be?" Participant 6 enthusiastically echoed the sentiment:

> They have to be safe! They have to be safe! And in an attached safe environment! Where we can say, "Hey we can live differently now!" If a child has got that good enough caregiver, and they're out of danger, man, we got a yellow brick road! So, let's dance!

RQ1 Subtheme 1B: Nurturing / Supportive Caregivers

The second subtheme under influence of caregiver relationships / environment considered the supportive and nurturing behavior of those in care of the child, usually a parent. This subtheme emphasized the impact of the caregiver's behavior directly towards the child and the influence on healing. As with the previous subtheme, all participants referenced the power in having nurturing and/ or supportive caregivers, and the effect on resilience from CSA. Practitioners described nurturing/ supportive behavior in a variety of ways that included believing the child's allegations of CSA, engagement with therapeutic resources, displaying affection, modeling emotional stability, effective communication skills and engaging in positive parenting practices that enhance a child's secure attachment.

Twelve participants specifically stressed caregiver support leading to resilience by emphasizing the role of believing the child's allegations of CSA. For example, Participant 11 stated, "Having a parent or any family member who will listen to them and believes them and is supportive, that's one of the best indicators that a kid is gonna be resilient." Participant 9 likewise emphasized the importance of caregiver belief, but highlighted caregiver support in the reporting of the abuse:

> If they were believed and the response when they told, not just if they were believed, but if people were glad that they told…. whether they were protected, or

> whether they got in trouble. What repercussions was this kid paying for telling? I feel like that was the biggest factor in their resilience, and then there was less to have to overcome.

Nine of the practitioners listed other supportive practices such as support for the child attending therapy, as well as the non-offending caregiver participating in therapy. For example, Participant 9 reported that she brings parents in and involves them in the instruction of coping skills, stating, “I think the child’s ability to connect, and coping with their primary source of connection [caregiver], fosters the most resilience and healing.” Participant 2 also described the impact of having parents as a part of the therapeutic process:

> I think having parents…participate, even if that’s just bringing them, and the children, seeing that their parents are gonna take time out of their life for their session, and when an abuse event becomes a family issue, and they know they’re not alone in that struggle, I think healing happens leaps and bounds.

Participant 3 reflected that a “big predictor” of child resilience “is if parents do their own therapy work to be able to hold their own emotions.”

Eleven practitioners also described supportive behavior as containing nurturing components. Participant 10 noticed, “If the family has a good healthy communication style, emotionally healthy, I think that emotional stability is so important.” Participant 3 emphasized the influence of parental modeling on resilience, saying “In my experience, it’s been the modeling from the parents, their vulnerability.” Participant 3 added that modeling vulnerability provides the child with the ability to “resolve conflict within themselves.” Several practitioners discussed caregiving behaviors that influence a child’s

secure attachment, described by Participant 5 as “loving relationships.” Other practitioners, such as Participant 3, discussed lack of nurturing and the negative impact on resilience, saying caregivers may ignore the trauma of the sexual abuse and focus more on negative external behaviors the child exhibits, for example, “yeah this sucks that they were sexually abused, but they’re still a bad kid.” Participant 12 explained her experience with nurturing caregivers, attachment, and the disclosure and resilience process.

> When you look at a kid who is securely attached, they have caregivers who are attuned. The caregivers themselves have healthy coping skills. This child might have been sexually abused, but the kid who's more securely attached is more confident…they’re gonna disclose clearer. They're going to call more attention to what's going on because they trust their caregiver.

Several practitioners discussed the consequences of not having a supportive caregiver. For example, Participant 5 observed that with lack of support a child “just won’t even pull forward. They’re hesitant, so that resiliency might be in there, but to pull that out is difficult.”

RQ1 Theme 2: Significance of External Social Networks

Caregiver support and environment were overwhelmingly the most reported influence in resilience from CSA; however, all fifteen of the participants additionally described the positive influence of external social supports on resilience. These external social networks are individuals and communities that are outside the immediate family circle. These networks can serve as a place where children can feel they belong and can connect with others. Importantly these external networks provide a place where children

can receive encouragement, empathy, support, and guidance. Participant 13 was one practitioner who identified the importance of external social networks saying, "I definitely see that a lot, kids who were able to be resilient without the support of a caregiver, it doesn't have to be mom or dad necessarily, but just having one person there for them." Theme 2 is divided into two subthemes, 2A) community-based networks and 2B) supportive individual relationships.

RQ1 Subtheme 2A: Community-Based Networks

Most practitioners mentioned community or activity-based support during their interview. Practitioners frequently described the positive influence that support groups, sports, clubs, religious groups, and other group activities had on resilience from CSA. Nine practitioners cited engagement with sports as having a positive impact on resilience, and seven practitioners discussed the importance of other group activities such as a club or choir. Further, as is shown later for RQ3 specifically assessing R/S coping, all the participants reported religious group activities as resilience enhancers. Participant 10 discussed the specific importance of connection during group activities:

> I think if a child is involved in a sport, it's not just the sport. Do they feel the team they are on really supports them? Is it a good connection? So having some sort of support group, whether it's through friends or the team that they're playing on, or maybe the church they're involved in... I've had clients that were involved in things, but they weren't really connected, so are they connected?

Participant 3 echoed the importance of a sense of belonging, "community where they're around people their own age. To help them normalize…there's that sense of belonging that's felt, that's huge for them."

Some of the participants referenced group counseling and support groups as contributors to resilience. Participant 2 enthusiastically stated:

> Group settings are awesome! They observe in others their experiences and that helps them. They're like, 'I couldn't say it but then Johnny in my group said it,' and that validates themm what they've been feeling, so that is HUGE!

Participant 14 also reported witnessing the positive influence of online support groups, saying:

> It can be a source of positive connection. A lot of kids who in years past, they would not have support in an in-person setup, especially for some LGBTQ-identifying youth, have been able to find community online, so when people come to the table with that, it's amazing how much more they're able to navigate some of the negatives.

Participants 6, 10 and 15 discussed the reduction of available group therapy, and the importance that the role of group therapy can have on resilience. Participant 6 stated in CACs they would do individual and then group therapy as well, "and they did things that I couldn't give these children." She further described the excitement of a client being able to see positive things in herself when she met other sexually abused children and viewed them in positive ways, saying, "She couldn't believe me until she saw it face to face in [this other child in group]…In other words, [this child in group] she's not despicable, she's not dirty, she's not nasty, she's not…and it happened to her! It happened to her!"

RQ1 Subtheme 2B: Supportive Individual Relationships

The subtheme of supportive individual relationships emerged from 80% of the group and represents an idea that outside the caregiver relationship, other individuals

supporting a child who has experienced CSA can enhance resiliency. Supportive relationships listed included friends, romantic partners, neighbors, and coaches. The 80% that identified the importance of these supportive relationships also listed the role of the therapist as a supportive individual relationship. Participant 6 told the story of a little girl, "not at the good house, but her next-door neighbor was the good house." She then proceeded to tell how regularly the girl went to this house adding, "Where was she every moment she could get over there? She was on the front porch with this grandmother figure, who would say 'you are so smart, you are such a smart cookie!'" She then discussed the ways this little girl exhibited resilience from both her CSA and her challenging home life.

Most therapists listed supportive relationship examples that buffered the impact of not having positive caregiver relationships or support. Participant 12, discussed this challenge:

> We're gonna tell ourselves the truth about this, I think maybe the parents do not believe the child. And I just refuse, I just refuse, Lauren, to believe that that kid can't make progress and be resilient anyway! But, we just have to factor it in. It has to become a part of the treatment!

Participant 12, then moved on to discuss how she factors that in, one of the ways being recognizing other supportive relationships. Participant 1 echoed this sentiment, "A lot of parents who didn't believe, even though they believed they didn't care. I've seen that, but kids will find their own support…whether it's a boyfriend, best friend, and hopefully a therapist too!" Participant 8 directly stated, "I'm trying to use myself to be that safe person and create that feeling, that sense of safety." She then discussed a situation with a

client who experienced abuse who did not have family support, but had positive friendship support, saying, “Her social support was good, and her plan was to go teach English…and she did it!”

RQ1 Theme 3: Use of Active Coping

Research question 1 themes shift from more external influences towards internal factors. These factors relate to the behaviors, practices, or strategies of the individual child that could guide their likelihood of displaying resilience. Practitioners were all able to identify individuals who possessed a deficit of external protective elements, such as supportive caregivers, yet were displaying resilience. Participant 1 stated, “There’s a part to play with who we are as individuals too, I think, and our personality and how we view life.”

The fifteen participants were able to recognize several ways that children cope with the adversity of CSA, recognizing that some coping methods, such as active coping, were more resilience-building than other methods. Practitioners often added disclaimers prior to answering questions about effective coping skills and resilience. For example, ten participants expressed thoughts regarding the individuality of effective coping strategies, as demonstrated by Participant 1, “It depends on who THEY are because there’s not one thing that works for us all.” Practitioners were also quick to comment that they did not view a child who was not coping well as “not resilient.” For example, Participant 8 stated, “It feels limiting to say, ‘oh, this kid has resilience, this kid doesn't have resilience.’” All fifteen readily connected the use of active coping styles with resilience, following the disclaimers.

Active coping is a broad theme that represents a range of thoughts, behaviors, and strategies the child uses to manage the traumatic impact of CSA in a proactive and direct way Active coping includes taking steps to change a situation or alter a reaction towards the situation. (Lazarus & Folkman, 1984; Walsh et al., 2010). This theme contains four subthemes 3A) practice problem-focused coping / grit, 3B) leveraging interpersonal resources 3C) use of emotion regulation strategies to manage trauma symptoms and 4D) engage in meaning-making.

RQ 1 Subtheme 3A: Mastery Mindset / Grit

Individuals who have a mastery mindset demonstrate a method of active coping that is aligned with grit, which involves perseverance, diligence, and overcoming setbacks (Duckworth, 2016). Mastery mindsets are supported by concepts such as positive belief systems, optimism, and self-determination as these enhance motivation to persevere in the face of stress (Grych et al. 2015). Ten therapists identified these characteristics of children in their experience who displayed resilience from their CSA experience.

Participant 9 described these clients: “Some clients are just little warriors. They just don’t give up. They’re gonna keep moving forward; they know they can do it.” She further described this as “hope” and added, “They have a hope they can get through it, that grit. They’re saying, ‘I need to get through this, I want to get through this, I want to be a happy kid.’” Participant 6 also described this perseverance:

> I’ve seen kids who, it’s just amazing, they go after it! Whereas another child internally gives up, there are some of those kids who just seek it out! They know, ‘I’ve got to get the good, I gotta get to the good people, I gotta get to the good.’

> They beat the bushes till they find somebody. These kids seem to be able to have the antennas up and seek it out.

Practitioners repeatedly used the words “showing up” or “moving forward.” For example, Participant 8 was asked what resilience looked like in clients and stated emphatically, “It looks like is the ability to show up. To show up, meaning they still go to volleyball practice, or school, or they go on the family vacation.” Participant 14 also viewed resilience in this way saying, “From the outset, you’re starting to see factors of resiliency. You’re starting to see this ability to smile and proceed in the face of adversity.”

Practitioners repeatedly reported the benefit of exhibiting an ability to have agency and mastery for sexually abused children. Participant 14 described this self-determination in a simple way when he felt amazed when he saw a child leave a challenging forensic interview and became excited about going to McDonalds. He said, “It just kind of broke the energy because of all the things that happened, and this kid is like, ‘I just want McDonalds! I just want my burger, fries, and my toy!’” He explained, although we may not initially view this as resilience, the “ability to be in the moment, really attending to his own needs…that’s part of the resilience picture.”

Other therapists described recognizing growth when their clients shift towards self-mastery behavior or “power.” Participant 1 explained this idea:

> I think the most resilient kids I’ve seen have been so full of themselves…in terms of this power! They’ve just had to get in touch with that power within them…it can be a very gentle power, but they get in touch with that power and it’s the most beautiful thing in the world to see.

Mastery was also depicted by some as healthy “defiance” or “rebellion.” Participant 9 discussed one resilient client who had suffered sexual abuse from a very young age until she was a teenager. She described her as having an “F-you quality” and “that little dose of defiance…she’s not a hundred percent compliant. She’s the one that ended up telling…she felt like she had to say something.” Participant 14 explained that while defiance may be viewed as a negative initially, it “actually helps them and aids them getting through the bad stuff, the gunk that they’ve had to deal with.”

This form of coping was labeled by seven therapists as “optimism” or “positive beliefs” and even humor / playfulness. Participant 15, separated this cognitive processing from denial saying, “It’s that realistic, not denying the bad, because that’s not good, but positive outlook they can use to overcome.” Participant 11 directly stated having “an optimistic personality and optimistic outlook on life has something to do with it [resiliency].” Participant 14 and others emphasized the ability to be positive and playful: “There are kids who in spite of what they’ve been through, they don’t lose their sense of laughter, and their sense of humanity.”

RQ1 Subtheme 3B: Leveraging Interpersonal Resources

Leveraging interpersonal resources is an active coping method defined as an individual’s ability to foster and maintain close relationships, and engage support when adversity occurs, in this case CSA (Grych, Hamby & Banyard, 2015). The ability to foster and maintain interpersonal connections is supported by active behaviors to engage socially, for example, openness, communication, and being vulnerable. Behaviors that foster social reciprocation such as expressing gratitude, displaying empathy, and compassion towards others additionally support this method of coping (Grych, Hamby &

Banyard, 2015). Twelve therapists referenced these characteristics of children they viewed as resilient.

Participants widely agreed that the ability to engage with others, and especially with the therapist, was an important component in fostering resilience. For example, Participant 11 stated in her experience, “I think that’s one of the biggest things, if a child is more open and willing to talk about what happened, they’re gonna be more resilient.” Participant 11 additionally relayed that she noticed initial resilience when children are more willing to engage in counseling: “It’s not something that their parent has to force them to do, and they’re really wanting it.” Participant 3 labeled this openness as “vulnerability” saying, “Sharing, the biggest thing is not keeping it inside.” Some practitioners, such as Participant 8, emphasized that sharing their story does not have to be exclusively verbal saying, “whether that’s written, verbally or through some sort of art. I think being able to externalize and say their story in some sort of medium is empowering if done safely.” Many practitioners referenced witnessing growth when a child became more open. For example, Participant 10 stated resilience occurs when clients are “able to engage in writing their trauma story and going through those steps” and added that clients who are “less resilient would be more resistant in doing that.” Participant 1 described the special risk for children when they “brood,” “not take outside help,” “deal with things all internally,” and “not share.” She further explains that children, versus adults, who internalize their experience are especially vulnerable, saying because of “their lack of experience and lack of perspective, really then they don’t have anything to fight this [CSA].”

Some of the therapists acknowledged leveraging social support was not limited to the therapy setting and discussed additional ways children can be actively engaged with others. Participant 9 experienced resilient children as sharing with loved ones or friends, not just sharing about their sexual abuse, but "talking about everything…talk about stuff that happened at school that bothered them. They're not holding secrets, they're not trying to sit with their feelings by themselves…they are willing to connect. Connection is a huge piece of coping." Participant 15 described leveraging social support in younger children: "With our little people, are they playing and playing well with others? When they're at school, can they play with peers, take turns, cooperate like their peers? Are they able to play in the playroom with the therapist? That ability to play and play with others in positive ways is such a sign of health."

Openness was separated from the personality traits of extroversion and introversion through further questioning. A few therapists initially reported positives that are accompanied by extroversion, such as comfort with social engagement and communication; however, most were quick to note examples when extroverted clients may appear open but not share thoughts and feelings about their CSA experience. Participant 11explained:

> I don't think it's an introvert / extrovert thing. Because I will have kids who are introverted, shy and not super outgoing, but they're willing to dig into what they're feeling and thinking. Whereas I'll have kids who are extroverts, and they talk. They talk all the time, but they're not gonna dig into what they're thinking. They may divert the conversation. They may cope with humor and make a joke or something like that, and those trauma symptoms are still gonna be there.

Participant 1 aligned, “I don’t know if it’s really introversion…it’s, you’re more of a brooder…you stay stuck, they’re not sharing anything.” Participant 15 supporting the previous comments, adding an “introverted person may be more vulnerable to internalizing, which could lead to not talking about it, but if they do open up, gosh they can be better at facing their trauma.”

RQ1 Subtheme 3C: Use of Emotion Regulation Strategies to Manage Trauma Symptoms

Fifteen participants identified the application of coping strategies that relieve emotional distress as valuable. This style of coping is defined as emotion-focused coping, which consists of regulative efforts to reduce the emotional impact of a stressor (Lazarus and Folkman, 1984; Schoenmakers et al., 2015). The participants heavily conceptualized this theme through a therapeutic practice lens, with most of the examples of emotion regulation strategies being taught in the therapeutic setting. Participant 1 justified the purpose of these strategies saying, “Kids have to have the ability to cope before they can process any of those traumatic experiences.”

Practitioners highlighted the advantage for clients who initially possessed methods of emotion focused coping at the outset or were able to actively apply skills learned in session externally. Participant 13 reflected on children who possess these skills coming into therapy or practicing outside therapy, saying when a child is “able to deal with their emotions, you could say that they would be more resilient.” Participant 1 recounted her experience with teaching coping skills: “Honestly, I find that some kids you can teach and teach and teach those coping skills, and they're not gonna use them.” She then described other children, even very young, that will heavily engage. One

example she provided was of a 5-year-old boy identified as exhibiting resilience teaching his anxious older brother “bubble breathing” outside of session.

All practitioners discussed the significance of following a child’s areas of interest when teaching regulatory strategies. “Sometimes they tell you but have to be tuned into and then use it therapeutically, but lots of times they are showing you” (Participant 6). The therapists also stressed giving a child a sense of agency regarding the various methods of emotion-focused coping. For example, Participant 13 said, “If a kid tells me that they've tried meditation for example, and they didn't like it, I'm not gonna force them.”

The most frequent examples of emotion-focused coping were the use of grounding techniques or other methods of calming the physiological stress response. Ten of the practitioners listed these methods as the most beneficial forms of emotion-focused coping. Practitioners explained that this occurs initially in early phases of treatment and continues throughout the trauma-focused therapy. Participant 8 discussed the special need for this type of work in those who have experienced CSA: “Learning to be present in your body, there’s a lot of fear with that because the body is unsafe, so it’s creating that safety.” She explained that because “with sexual abuse survivors, the trauma was happening in their bodies, they become detached from their bodies.” She added that a goal in practicing grounding or calming techniques that incorporate the connection of mind and body is “to be able to show up with your mind, body and soul connected and to be present in the environment.” Practitioners reported several consistent methods such as tapping, mindfulness, meditation, guided imagery, progressive muscle relaxation, breath

work, movement, and grounding. Participant 13 described what this style of coping looked like in action with a client who preferred movement:

> So, she would often get dysregulated when we talk about stuff and has a lot of energy, so then we either go outside or throw a ball or something to calm down her big emotions. And then after that, we need to do a little bit of calming, whether that is painting or her doing things versus meditation.

RQ1 Subtheme 3D: Engage in Meaning-Making

Participants identified the capacity for child clients to find meaning or purpose in their pain as promoting resilience. This theme is defined as a person's desire to make sense of and comprehend one's experiences, and to link these events to broader or future contexts (Lazarus & Folkman, 1984; Grych, Hamby & Banyard, 2015). Meaning making may be secular or accompany a spiritual / religious framework. Nine practitioners identified this subtheme, and repeatedly described it as a positive shift in perspective, a focus on helping others, or integration of their CSA experience towards future goals or higher purpose.

Some of the sample described meaning-making through a spiritual or religious lens, for example, Participant 2 stated, "to have the belief in something outside of themselves plays a huge piece." Other practitioners defined this experience as their clients finding a "purpose" or using it "for good."

> I think those that are able to manage their experience seem to find, like not a reason they were abused, but find a meaning or find their purpose. I've had several say they want to become a therapist later on or help those who've been

> abused in some way, so they're able to maybe use their experience in a positive, and that helps (Participant 15).

Participant 3 spoke about this experience as "integration" of their experience more fully, and clients "start living out that purpose in confidence." Additionally, therapists identified clients who found meaning through "internalized" empathy, as explained by Participant 6:

> There is this incredible compassion for others because they know the journey of true pain and suffering and trauma, but they did NOT become mean-spirited. It can hurt you so terribly, and you could be so crippled by it, and be so angry and hurtful, OR you can choose the other path.

RQ 2: What are Practitioner Perspectives Regarding the Role of Spirituality in the Development of Resilience Following CSA?

Most participants conceptualized R/S coping strategies through the lens of religious coping. Therefore, I asked follow-up interview questions regarding practitioners' experience with clients using non-religious spiritual methods of coping. Follow-up questions were necessary in most interviews. The results of analysis created four themes that relate to RQ2. These include 1) connection between the mind and body, 2) attunement outside of self, 3) use of non-religious spiritual practices, and 4) engaging in compassionate behavior. These themes will be explained and accompanied by descriptive quotes to express the theme in the style of the participants.

RQ 2 Theme 1: Connection Between the Mind and Body

Eleven participants described spiritual coping outside of a religious context, as regulation between mind and body. For example, Participant 8 stated, "there's usually a

big connection between self-care and spiritual. I can't imagine a 14-year-old client that's experienced sexual abuse being like, 'these are my spiritual practices,' so it usually sounds like self-regulation." Self-regulation involves many processes that include managing emotions, thoughts, and the physiological aspects of stress (Grych et al., 2015). Participants cited several examples, for instance, meditation, mindfulness, movement, using mantras or yoga. Participant 2 communicated her experience with clients practicing yoga and the benefit for sexual abuse survivors:

> Breathing, I think, is a big piece of it. That's where yoga comes in as such a gift, and obviously, there's a lot of research that supports yoga as a huge treatment in sexual abuse victims, because I think they learned how to breathe and connect their breaths to their body. And you learn your body. You learn your body in a positive way and what your body can do and conquer, and so I'm a big fan, big fan.

These methods of coping were initially taught in a therapy session and picked up by the client and practiced outside session. Some participants reported that other methods were used by clients after watching on social media. For example, Participant 15 stated, "I've had some, especially with all the streaming videos, really embrace mantras to help calm them or help them feel almost a spiritual strength saying things over and over like, 'I am strong' or 'I am brave.'"

RQ 2 Theme 2: Attunement Outside of Self

Ten participants described examples of non-religious spiritual coping in their sexually abused clients as a connection outside of the self. Connection was explained primarily as attunement between the child and nature but was also described as

attunement within the therapeutic relationship and healing process. Participant 1 referred to therapy with children saying, “I think that it’s all spiritual.” Participant 15 echoed this belief saying, “I guess therapy, or the healing process can feel spiritual, whenever you join with a person in their pain and help them navigate that and see them begin to grow and heal, it feels spiritual even if the child doesn’t say that.” Attunement with nature, without a direct worship of nature, was described as where children who have experienced sexual abuse “feel safe.” Participant 5, for example, stated, “I have a young kid, eight or nine years old and she would use nature. That was her safe space, that was where she calmed and felt safe.” Participant 9 also explained, “I feel like nature is that spiritual connection; it’s just something bigger.”

RQ 2 Theme 3: Use of Non-Religious Spiritual Practices

Most of the participants’ examples of R/S coping were anchored in organized religions; however, six participants additionally identified experiences of clients who experienced CSA using spiritual but non-religious practices. Practitioners verbalized a willingness to understand spiritual practices of their clients, for example Participant 14 discussed incorporating “wisdom of ancestors” into practice and Participant 15 reported learning about Native American spiritualism with a client. The spiritual practices identified by practitioners involved slightly organized practices such as Native American spiritualism, numerology, astrology, or forms of paganism. Participant 14 reported experience with a child connecting with numerology:

> Numerology was really a part of understanding the world around them. So, we were able to bring that into our session, and talk about how it really supported them moving through this traumatic situation, and it became a tremendous asset.

> Just like a tool of coping and a tool of unpacking some of the icky feelings and answering some of those bigger questions.

Practitioners also described other practices that were less organized forms of worship or belief, such as the power of spirits or ancestors, and objects such as the moon or crystals. Participant 8 describes her willingness to explore the use of crystals with her client:

> They got into rocks and crystals and stuff. And they found significant comfort in that…I know it brought them a sense of comfort, and I know it wasn't harming them. And so, I was very grateful for that… I think it was grounding for them. There was something to touch. And again, this is my limited knowledge from what I know, what they literally told me, I think each crystal usually has a different meaning, or a different source or power to it. And so, each crystal would have a different meaning that would provide that sense of comfort.

RQ 2 Theme 4: Engaging in Compassionate Behavior

The *Merrium-Webster's Dictionary* defines compassion as, "sympathetic consciousness of others' distress together with a desire to alleviate it." Five participants labeled spiritual coping as their clients engaging in purposeful compassionate behaviors outside religious contexts. Participants supported this idea through examples of children helping others, practicing compassion, or "putting good" in the world. Participant 6 discussed this belief:

> Some of those clients go on to really be very spiritual, in fact. They can develop good spiritual practices, and an awareness that there is goodness in the world. They may not necessarily be in any organized religion or anything like that. I've

> seen them still go on to have really powerful compassion, and love, and being able to love others.

Participant 6 and others reported experiencing "shock" at the levels of compassion they have experienced in child clients. They perceived that ability to be "spiritual" and emphasized, "when they make the choice that they will love rather than hate, when they will heal rather than continue to rip into themselves…they become giants in the world of spirituality" (Participant 6).

RQ 3: What are Practitioner Perspectives Regarding the Role of Religious Coping in the Development of Resilience Following CSA?

Practitioners responded with consistent reactions to interview questions regarding R/S coping. The participant reactions included conceptualization of R/S coping primarily through the lens of religious coping, and reporting they experienced the use of R/S coping more frequently in adolescent clients.

Practitioners' Conceptualization of R/S Coping

Most participants initially responded to questions regarding R/S coping, through the lens of religious coping. As evidenced by therapists providing responses that centered on clients practicing R/S coping through an organized religion. Twelve of the practitioners discussed their experiences with examples of negative religious coping; however, the majority, fourteen, reported beliefs that clients' use of religious coping was overall positive and/ or resilience building. For example, Participant 13 stated, "I don't think I've ever seen it [R/S coping] being hurtful other than just kids struggling to get through that bargaining…and then that might be more of a working through the bad thought process and that maladaptive belief." Participant 14 added:

> I generally have associated it [R/S coping] with resilience, and I think kids have anecdotally backed that up in terms of seeing it as a strength, seeing it as a positive, seeing it as a way of coping. I think even more so than coping, it's integral to identity for kids as well, in terms of understanding who they are.

Child Development and Use of R/S Coping

Fourteen of the participants verbalized witnessing R/S coping primarily from teenagers, around middle school age and above. For example, Participant 5 stated directly, "young children just aren't as likely to call upon that as the older kids." Some participants discussed developmental factors relating to witnessing the use in older children, such as Participant 12:

> Even the children that are very religious oriented, when we really get into the nitty gritty of trauma therapy, this is not the first direction that they go to in their mind…I think adults, developmentally are more able to translate, 'This is a suffering that I'm going through, and this is the way that I'm choosing to project that suffering into the world, and I'm gonna accept this more abstract level of comfort'

Participants 12 then added a reflection that with development also comes "experience in the world" as well as the "ability to tolerate more complex concepts." She provided an example of a middle-aged adult who practiced a system of belief since childhood resulting in "a more highly ingrained, habitual way of thinking, feeling, and tuning into the world." Nine of the participants were able to cite examples of R/S use in children younger than 10, despite the sample reporting R/S coping primarily from teens. Participant 6 discussed R/S use in very young children saying, "I think for some it [R/S

coping] really does serve them. They'll say, 'Ohhhhh Jesus wouldn't like that' [referring to CSA], and that's important for them."

All practitioners were able to discuss examples of the use of R/S coping in their child clients who experienced CSA. The responses mainly centered around clients identifying as Christian; however, there were also examples of Jewish and Muslim children practicing R/S coping.

My examination of interview responses yielded five themes. Practitioners believed some of their clients who engaged in R/S coping experienced 1) spiritual connectedness within religious community, 2) negative religious coping, 3) support from religious practices, 4) resolution of spiritual struggles, and 5) R/S meaning-making. Several subthemes were distinguished within some themes to enhance description. All themes and subthemes, except theme 2, "negative religious coping" (NRC), were described in language consistent with positive religious coping (PRC). Additionally, practitioners primarily provided examples that involved active and collaborative religious coping methods rather than passive religious coping. Pargament et al. (1988) describe a collaborative style of coping as an individual "partnering" with God to problem solve and a more action-based "self-directed" approach as when an individual perceives that God or their religion equips them to solve or cope with a problem. The following paragraphs will explore the five themes and subthemes along with supportive quotations from participants.

RQ3 Theme 1: Spiritual Connectedness within Religious Community

Thirteen practitioners reported experiencing clients receiving benefit from communal religious experiences; this answer was the most frequent and the most

immediate. Participants described a variety of contexts where children who experienced CSA sought and received a sense of spiritual connectedness. This category was thus divided into three subthemes 1A) connection with family, 1B) connection with others, and 1C) connection with God.

RQ 3 Subtheme 1A: Connection with Family

Eleven participants described the role of parents in both influencing and supporting their child's religious coping. Practitioners mentioned the role of parental PRC in helping to regulate the parent during the CSA crisis. Participant 12 explained, "I think there are lots of strengths for the families that have a strong faith…the spiritually grounded adults…faith grounds the parents and the parents ground the children." Several emphasized positive modeling of religious coping and parental "God image." Participant 3 said, "It comes down to parents instilling into them, 'God loves you, and you're okay, and you're okay with me.'" Participant 10 stated she noticed a difference in resilience from CSA in children from families that have an "internal" religious belief system, where parents are "teaching their children HOW to pray" versus families that are relying on outside spiritual or religious influences. Participant 15 separated out helpful familial R/S coping practices versus unhelpful practices, while discussing the common occurrence of acting out behaviors following CSA. She elaborated the less helpful practices occur when "parents are harsh, I guess focus more on behavior than of God's view of the child." She added when parents focus on "the grace and unconditional love aspect over behavior," she then witnessed more positive influence of R/S coping on the child in healing.

RQ 3 Subtheme 1B: Connection with Others

Thirteen participants reported clients experiencing spiritual connection with individuals outside the family. The contexts varied; however, all were described within a religious community. Examples included youth groups, small groups, prayer groups, church support groups, church attendance, and connection with religious leaders. The most repeatedly cited form of spiritual connection was youth or small group settings and youth/ small group leaders. Participant 11 described a teen who "had a lot going against her" but would regularly report "the best part of the week was always youth group, and she was always looking forward to youth group." She stated her belief that "it really helped her to be resilient." The practitioners repeatedly attributed the healing aspects of group religious support in the positive messages their clients received. For example, Participant 15 said, "When organized religion or a victim's religious community says, 'We love and support you, you're strong and you're brave,' that's incredibly healing." She added that at times religious communities get a "bad rep" because of "some of the ways people have felt hurt" but said she had witnessed the positive messages "a lot" and when given by that community, those messages "are a powerful force." Participant 2 described the way religious "group settings" such as prayer or small groups enhance resilience. She reported these groups allow children to "pray together about some of their experiences" and that having a designated place where "they can go share their concerns with peers and they are coming beside each other and loving on one another" was especially helpful.

RQ 3 Subtheme 1C: Connection with God

Ten participants reported witnessing clients connect with God or the attributes of God. Practitioners described clients' relationship with God as a source of enhancing their

view of self, as well as providing comfort and healing. Participant 9 reported the "connection" with God helps because "they're not alone…the feeling that there is a higher power that wants the best for them, and loves them, that can be very, very healing." Multiple participants cited God's love and God's constant presence as helpful for their sexually abused child clients. Participant 11 conveyed how this helped a client stating, "I think learning about God and learning about unconditional love and someone who's always here to listen if you were to pray was helpful for her." Participant 15 explained how connection with God is healing for sexual abuse survivors saying:

> It helps lead you down a direction where you see your worth, and sexual abuse seems to really hurt feelings of worth, so when God says, "You are lovely and precious," that's, gosh! That is so helpful!

A few participants added that their clients' connection with God led to making more positive behavioral choices. For example, Participant 1 stated, "I've had kids tell me they didn't commit suicide because of God, and they couldn't do it, and I'm like, 'Oh thank you, Jesus!'"

Participant 6 added that when a child's connection to God "becomes very important and moves them towards making good choices that bring about really good things in their lives and in the world," they appear resilient from their CSA experience.

RQ 3 Theme 2: Negative Religious Coping

Negative religious coping is a category within religious coping, that reflects conflict within self, others, and God around "scared matters" (Pargament et al., 2015). The methods associated with NRC tend to be "maladaptive" resulting in a variety of negative mental, physical, and emotional outcomes (Pargament et al., 2015). Twelve of

the fifteen participants referenced situations where they observed their clients experiencing forms of negative religious coping. The examples represented in this theme largely begin externally. It involved negative behaviors or verbalizations stemming from individuals within one's religion and ignited a negative coping response from the child. For example, Participant 14 compares PRC with NRC saying:

> The times where I've seen it go the opposite direction have been those times where the abuse was connected to the church or synagogue or the folks, the people in the community of faith. It was associated with them beginning to question whether or not what they believe is real because of the negative reactions of the people that are involved.

The forms of NRC were divided into three subthemes: 2A) experienced dismissive or invalidating religious statements, 2B) received judgment, and 2C) CSA connected to religious community.

RQ3 Subtheme 2A: Experienced Dismissive or Invalidating Religious Statements

Eight participants discussed their clients experiencing statements, religious in nature, that were received as premature, minimizing, or dismissing of their CSA experience. The statements related to NRC because they led to clients needing to work through some of these statements within counseling. Four practitioners specifically discussed clients experiencing pressure to forgive their perpetrator. Participant 1 reflected on this experience:

> A lot of kids get a lot of pressure to forgive. I think it comes when it's been intrafamilial abuse, and usually the parents are wanting to put the family back together again. I've also seen it when it's been about the parents' religious beliefs,

> and they [the child] haven't even dealt with the abuse, and they're a child, and you're trying to get them to forgive?! That never made any sense to me.

Participant 6 described this pressure to forgive prematurely as "very damaging, very damaging," and further discussed the process of therapy and the client needing to reach a point where they say, "I'm not caught up in the rage and the world of destruction anymore" but emphasized, "THEY can step away and THEY aren't caught up in that anymore, and that does need to happen." She separated that internal experience from external pressure to forgive, possibly prematurely.

Other participants discussed dismissive statements or actions directed at children when they are struggling with traumatic responses from the CSA. For example, "You just have to pray a little bit more" (Participant 3), "All you need is Jesus" (Participant 4), or "God will get you through this" (Participant 10). Participant 10 discussed a child's need for instruction around religious coping saying, "We gotta really teach that concept" versus giving vague statements. She emphasized the process of healing saying, "We've got to give that child time. They're allowed to be angry; they're allowed to be upset. There's a time and a place." Participant 15 compared comments made to children versus adults saying, "We seem to invalidate kids," reporting that dismissive comments are made to adults, but added, "We really say that to kids because we think they are resilient, and they are, but we have to acknowledge that space for hurt in the same way we acknowledge it for adults." Participant 15 then expressed concern for possible consequences of religious invalidating statements, stating, "my fear is that they then go the other way and find people who will validate that pain, and those aren't always the healthy groups or people, but they validate. They validate first so the kid gets hooked."

RQ 3 Subtheme 2B: Received Judgment

Receiving judgment or rejection by individuals connected with their faith or faith community was reported by nine participants as negatively impacting their child clients' ability to be resilient. Participant 14 reported some clients experienced judgment for being "too fast" and defined that as meaning "that this is the kid's fault that this happened." Participant 12 labeled this experience as "religious trauma" saying:

> Nobody needs to even try and increase feelings of shame and guilt for sexual abuse survivors, but sometimes there's a little bit of moralism that comes along with faith communities that can make kids feel like…this is somehow my fault, or I caused this, or this is 'on me' in some way.

Five practitioners reported judgment around children who had same-sex child sexual abuse experiences, or who may have felt conflict around their sexuality relating to their experiences. Participant 9 discussed speaking with parents about the abuse experience when it was a same-sex situation, stating, "You have to be really careful that they are not gonna be punished because they engaged in an act where their religious teaching was telling them that was a sin." Participant 11 mentioned a very young client that struggled after a same-sex abuse experience:

> He really struggled with thoughts of things being sinful…talked a lot about hell and people going to hell. I think that the idea of religion was scary, because of going through something that to his religion would be viewed as a sin, or at least that's how he experienced it from their parents, so he had a really hard time grasping that.

Some practitioners experienced children creating distance from caregivers because of perceived religious judgment. Participant 12 described the impact of fear of judgment on

children, saying they are less open with caregivers and "there's these big barriers that actually ultimately result in damage to the connection." She added there is subsequently "less grounding, and there's less connected flow of energy" in that relationship.

RQ 3 Subtheme 2C: CSA Connected to Religious Community

Six practitioners discussed the complexity of treating a child when their CSA experience has been within a religious community, either perpetrated by a leader or someone in the community, and/ or the community chose to side with the perpetrator over the child. Several practitioners used the word "devastating" to describe this experience for a child. Participant 14 explained the challenge for children managing the impact of CSA within a religious community:

> Especially when the abuse was maybe a minister or pastor, we do have those cases, it can really devastate a kid and devastate a family and lead them to lose a sense of community or state of connection…or if parents might side with the institution and then it becomes even more hurtful for the kid not to be believed.

Participant 8 provided insight regarding child clients experiencing God as "unsafe" following abuse within the church, stating, "Sometimes God wasn't safe, because if God is a person and people aren't safe, sometimes God would be one of those people as well. Especially if the sexual abuse was within a church setting." Participant 8 described the treatment process as "extremely delicate," needing to learn the "triggers" of children sexually abused within a religious setting, and slowing down to understand, "Is God a trigger? Is Jesus a trigger?"

Practitioners also mentioned challenges when working with clients whose religious community did not get involved, did not believe them, or sided with the offender. For instance, Participant 15 said:

> I've also seen where a church will side with the perpetrator over the victim or say that they can't do anything, and then child and family can no longer go to that church and get the support they need so badly, but guess who still gets to go to that church? The offender! I literally had this little girl ask me once, 'Do people really make this up?' She had such a hard time understanding why anyone would make it up, because people sided with her mom's boyfriend who was heavily involved in the church, but she just struggled with that, and it was really so sad.

Participant 15 additionally discussed situations with "bad victims" or misbehaving teenagers who are CSA victims, saying religious communities "for sure doubt them over doubting the perp," and described the result as "devastating." Participant 9 conveyed a similar experience saying, "I've seen where the community supports the perpetrator, and because he asked forgiveness… where does that leave the child?" She suggested, "If they can get on board and be supportive and not say, 'Oh I'm not going to take a stand.' No take a stand! Support the child! And then that can be tremendously healing."

RQ3 Theme 3: Support from Religious Practices

Practitioners observed child clients gain support from engaging in religious practices. Religious practices and rituals entail a variety of behaviors and are designed to strengthen belief (Ladd & Spilka, 2015). Eleven therapists mentioned various practices that children used to positively cope with their CSA. These practices were separated into the following subthemes 3A) prayer, 3B) religious music, 3C) reading religious texts or

writings, and 3D) forgiveness. The therapists also described various benefits from these practices. For example, reading religious texts could be used to regulate emotions, gain a sense of control, or as a reappraisal strategy. Last, practitioners primarily provided examples of religious practices within a Christian belief context.

RQ 3 Subtheme 3A: Prayer

Nine participants described children informing them of the helpfulness of prayer. For instance, Participant 11 shared, "I've definitely had clients talk about praying when they're triggered, knowing that God will get them through what they're going through." Participant 1 verbalized the benefit of clients bringing in their prayers saying, "They actually brought that to the sessions and brought their beliefs and prayers into the session, and it was really good!" Prayer, compared to the other subtheme practices, was often cited as occurring outside the therapy setting where children reported to their therapists that they had prayed about something or reported the positive impact of their prayers. Prayer was listed commonly in conjunction with other practices. For example, Participant 14 reflected, "Internally when it comes to managing the emotional elements of the trauma, I've seen prayer and I've seen relying on religious texts like the Bible or Koran."

RQ 3 Subtheme 3B: Religious Music

Five participants cited clients using spiritual or religious music to cope. Participant 15 shared experiences of clients bringing in music to session and the impact the music had on the client:

> I've seen where kids can cling to religious…songs, where they'll play a song for me or send me a song. They'll write the words down and it seems to penetrate

> those negative voices or thoughts in a powerful way even more than just reading them.

Participant 2 also explained how clients share religious music in session:

> So many clients bring to me the artist that they love that they've identified with or that have had similar experiences, or they obviously are seeing the language of what the client is feeling, hurting, experiencing…when I think about teenagers that I've seen, music has been really, I just can't underestimate the power of that honestly.

For some, such as Participant 8, the use of a "worship" experience at church provided a platform to explore in session: "I would have kids say, 'I went to a worship night and I just cried, and I felt the presence of God,' and I'd be like, 'What did that mean for you?' Essentially, I'd be just riding the coattails of that, which was just the best!"

RQ 3 Subtheme 3C: Reading Religious Texts or Writings

Eleven practitioners mentioned clients using religious texts or writings. Practitioners reported survivors used Christian religious texts such as the Bible as well as Christian sayings, words from leaders, and poems. Two participants also referenced clients using the Koran to positively cope with their experience. Religious writings were the most cited religious practice used within the therapy session. Religious writings were described as beneficial towards a child's emotional regulation, ability to manage negative thoughts, connection to God, and feelings of self-worth.

Participant 2 suggested the use of "Scripture memory" was a "kind of rewiring the brain." She reflected that for a child who has experienced CSA a "huge part of resilience is being able to reframe" but emphasized only if "they believe this, and it's not pushed on

them." Participant 10 also shared, "Oftentimes Scripture that is spoke out, or in memes, leaning into a powerful Scripture verse that means a lot to them that they might stand by, that's what I've experienced."

Participant 15 agreed, reporting, "Bible verses, whatever can be helpful…anything that speaks back to all the negative voices from the abuse is helpful." Participant 15 also shared:

> Kids really need to be told they are loved or maybe that they aren't dirty…I think religion, specifically images of God as a father, not a bad one cause some of them have that, can really help to speak back to those harmful messages that abused kids keep inside them. That's really where I think spirituality can lead to resilience.

Participant 14 shared an experience with a child using the Koran to cope:

> One kid who talked about Allah and the Koran, and he would identify ways in which there was anger he felt, but I remember him saying, "Justice belongs to Allah," and it was his way of saying, "As angry as I feel, I don't need to do anything to him because my faith is going to be first in this situation."

RQ 3 Subtheme 3D: Forgiveness

The concept of forgiveness was discussed primarily in a negative context, regarding outside pressure on a child to forgive an offender prematurely; however, forgiveness as a positive religious coping skill was also mentioned by a few of the participants. When asked about resilience and R/S coping, Participant 2 emphasized, "If they value forgiveness, I think that has been huge, being able to forgive the offender of the abuse. I would say forgiveness has been huge in that [resilience]". She described

forgiveness as “their gift.” Other practitioners reflected on the process of forgiveness that brings resilience and contrasted it with pressure to hurry forgiveness. Participant 3 reflected on this process saying, “Forgiveness does not go beyond healing, meaning that we first have to witness the trauma, we first have to re-experience it, feel it and heal it within our body, and then get into the spiritual stuff.”

RQ 3 Theme 4: Resolution of Spiritual Struggles

Seven practitioners reported clients experiencing struggles with their faith or in their relationship with God. Spiritual questioning may be a form of NRC; however, in this study when practitioners discussed this topic, all seven referred to clients positively resolving those struggles. Participants’ illustrations were universally centered around teenaged clients, with a few discussing a lack of questioning by younger children. Participant 3 explained, “Spiritually the younger kid, they don’t really ask the question, ‘Why did God let this happen to me.’ The older clients, they often ask that question…younger clients, spiritually, it’s ‘God still loves me.’”

Practitioners described the challenge for clients in the initial phases of a spiritual struggle. For example, Participant 5 revealed, “What I’ve found in the older kids that have that background, have a strong faith…there’s a sense at least initially of abandonment, ‘How did this happen to me?’” Participant 3 also shared clients expressing, “Oh, God let this happen, so God must not be good. They sometimes come in with that belief in the beginning… ‘This is not good; therefore, God is not good.’” Participant 8 echoed witnessing feelings of anger in clients, stating, “There’s also anger in there sometimes. ‘God why did this happen to me? Why did you allow this?’”

The therapists repeatedly mentioned the subsequent journey of helping clients explore and resolve spiritual struggles. Participant 13 stated, “You have some kiddos start to question, ‘God why did this happen to me?’ And so that’s a process to get them through that and work through that.” Participant 5 described the therapeutic process when there are spiritual struggles:

> So the older kids would bring it up…like, ‘I can’t believe God let this happen to me’ and I’d say, ‘Oh, you think that God let this happen to you, tell me more about that.’ And so then I’d just explore that with them. By the end of our exploration…across several sessions, it’s, ‘This has made me a stronger person. I think God wanted me to learn from this. Now I have this inspiration to go out and do good in the world and help kids and I’m thinking about what I want to do with my life and the support I want to give other kids.’ And so, it does turn around.

Participants indicated that often the resolution of spiritual struggles involved a re-orienting of the attributes of God or God’s overarching purpose. For instance, Participant 8 said, “Coping with that was trying to make meaning out of their experience…asking, ‘How does God fit into my pain? Or my darkness?’” Participant 3 stated that in exploration, “Oftentimes they find God was always there no matter what.”

RQ 3 Theme 5: Meaning Making

The search for meaning and purpose has been defined as “the extent to which one’s life is experienced as making sense” (Shafranske, 2023). Achieving meaning is connected to purpose and feelings of significance (Shafranske, 2023). Nine participants described clients using R/S coping to gain a sense of purpose and meaning for their CSA

experience. Participant 14 reflected on the unique role that spirituality and religion play in deriving meaning:

> We see people turn to their faith a lot when bad things happen or when… challenging things happen. Questions like, 'Why do people do bad stuff?' Those questions that are inherently, it's tougher for psychology to answer that, religion has often more answers, or at least people gravitate towards those answers.

Therapists often used the words "purpose" and "meaning" when describing their clients' experience with R/S coping. Participant 8 stated that with child clients who experienced CSA, "coping was trying to make meaning out of their experience." She added that "there's a need to make sense of that, and if they have a religious worldview, the first thing they go to is God." Participants shared stories of clients who leveraged their sense of purpose or meaning behind their CSA and verbalized ways they would use that experience "for good" or to "help others." Participant 15 shared:

> I think religion kind of gives kids a foundation, a purpose. I have lots of kids say they're gonna help or do good because of what they went through and decide to volunteer at church, or wanna write encouraging letters to other kids who've been sexually abused because of their belief in God.

RQ 4: What aspect(s) of spiritual and religious coping do practitioners believe made the largest contribution to their resilience?

Research question 4 explored the practitioners' perception of what elements of R/S coping make the greatest contribution to resilience in their child clients who experienced CSA. Only nine of the fifteen participants were directly asked the question, although some answered the question through the process of answering other interview

questions. Seven out of nine participants responded to the question by discussing the individual nature of experience and the helpfulness of all R/S coping practices. Participant 13 did not provide a single answer, saying “every kid is different so it’s whatever works for them.” Participant 2 replied:

> All of the above, because again it probably comes back to temperament, and how different temperaments receive information. Some do well with music, and some do well with reading Scripture or memorizing or group activities, so I think it comes down to personalities.

Participant 14 reflected, “I’m learning what is it about their religious or spiritual practice that is helping them be resilient. For them, it may be the part where they are connecting with other kids, or it may be the safety of the church.” Three themes emerged from this question. 1) connection to spiritual community, 2) receive comfort and regulate stress and 3) reframe the CSA and make meaning.

RQ 4 Theme 1: Connection to Spiritual Community

Most practitioners reported engagement in spiritual or religious community activities as making the largest contribution towards resilience. Spiritual or religious communities were described as small groups, youth groups, church community or prayer group. Community was also experienced when a child was connected with a leader in the faith community, or the family and child were heavily involved in faith community. Participant 14 described the benefit of community for CSA victims:

> You know sexual abuse and sexual assault is interpersonal, so the thing that I feel I’ve seen the most is where people have communities of support. So, a lot of religions are embedded with a group of people that are worshiping together, they

> are praying together, they are fasting together, and when that community can come together and say, 'We've got your back, we believe you, we hear you, we see you.' Sometimes it's for the kids but also for the parents as well. I've seen that be a huge asset of resilience for our families.

RQ 4 Theme 2: Receive Comfort and Regulate Stress

Five individuals responded that using various religious practices or their connection with God to regulate emotions and find comfort was the most helpful. Participant 8 shared, "I think so much of the spiritual practices bring comfort, because there's that relationship." Participant 1 emphasized when clients regularly use and receive comfort and calm from prayer, "You can't get a better positive than that!" Some discussed the regulatory impact of spiritual practices. Participant 2 explained, "Tapping into prayer, journaling, or meditation or Scripture because then I think it allows them to get into a place of grounding. That's huge, especially when their bodies get triggered, to be able to ground themselves." Participant 15 discussed the helpfulness of combining techniques, "Use practices like reading or saying Scripture, with things like breathing or stretching just calms them so much."

RQ 4 Theme 3: Reframe the CSA Experience and Make Meaning

Nine participants previously reported R/S coping is helpful in reframing the abusive experience and making meaning, and four participants directly asked RQ 4 cited meaning making as the most resilience building aspect of R/S coping. Participant 2 stated:

> I think the ability to reframe and use their R/S beliefs to reframe, in a positive light, and how people of faith think, 'God will use bad for good' and just being

> able to have that belief in your thought process. That this is hard now, but there's a reason, or He'll use this, I think that's so powerful.

Participant 15 echoed, "And down the road, I think with older kiddos religion helps them make sense and ultimately that is the most healing thing."

RQ 5: How do practitioners encourage and /or facilitate spiritual or religious coping in their CSA clients?

When I questioned therapists about R/S coping and their experiences, all the responders referenced not wishing to impose their views, being careful about asking clients about R/S coping and using caution with incorporating R/S coping practices into session. The fifteen practitioners directly or indirectly referenced the ethical guidelines for licensed counselors established by the American Counseling Association, ACA (2014) regarding counselors being "aware of and avoid imposing their own values, attitudes, beliefs and behaviors." For example, Participant 5 stated directly, "I'm not allowed to impose my beliefs on anybody else." A few practitioners, such as Participant 6, encouraged awareness regarding the possibility that religious or spiritual elements may have been used in the sexual abuse, and suggested using caution saying:

> I think there can be folks who are naïve and heartfelt in believing how powerful, wonderful this had been for them, and think that and then make a big mistake in imposing their views, because so many times abusers have used religion in their rituals and their practices with the child…and you will traumatize and alienate, and lose this client and their chance to possibly have the recovery if you start saying things about God. Even just saying God, because they had to see a picture or a cross while he's [the abuser] saying, "God ordained me to do this to you."

Practitioners reported they would explore R/S coping if it was initiated by the client, despite verbalizing their concerns. During the interviews, the fifteen participants referenced ways they respected the individual R/S views, practices, and coping methods of their clients. However, this apprehension did lead several to avoid all questioning of clients or parents about religious or spiritual beliefs, relying instead on cues from the clients. Participant 12 and others discussed having a “religious or cultural consideration” section on intake form saying:

> I do not directly ask about religious or cultural considerations, because I'll write it in there if they have made it known that there's something there that I need to be paying attention to. If they've already told me very clearly that they're very devout, Baptist or Muslim, or something then I'm gonna write it. But I usually don't question that unless they’ve mentioned it.

Others, for example, Participant 14, directly assessed belief systems in the beginning saying, “I may simply ask a kid or parent, ‘You know in difficult times some people turn to their faith for answers to questions, is that something that is real for you?’”

Nine out of fifteen practitioners verbalized that they directly ask caregivers and /or children about religious and spiritual beliefs, and eight participants were able to provide details of their experiences incorporating R/S coping into practice. Fifteen participants stated they would engage in R/S discussions if initiated by the client, despite some having hesitancy regarding asking about R/S coping. Participant 5 discussed hesitancy in asking R/S questions saying, “Where I am at now that’s not something that’s part of the protocol, so I wait for the parent to volunteer it. I don’t have a religious or spiritual question on the intake.” Other therapists discussed the importance of asking

about religious and spiritual beliefs, explaining that therapy reflects whatever the client brings, therefore it is important to ask. Participant 1 stated that it was important to ask so that the therapist can reflect adding, “I’ve always had this picture in my mind, this image of the therapist as a mirror. A mirror to reflect back who the client is.” Four participants cited the challenge for practitioners when asking about R/S beliefs and not wanting to appear as though they were pushing an agenda. Participant 9 said, “There’s this phobia of bringing up religion and spirituality, and as I get more experienced in the field, I’m realizing how important that is and how we just can’t ignore it.” Participant 15 reported discovering value in asking and incorporating religious beliefs:

> I think incorporating their religious beliefs is so very important, and it gets ignored because I think we’re afraid, but I’ve found if I asked often that can be so healing because sometimes I find out ways they are thinking about their religion that could be harmful, and I can work with the child and parent to manage that negative thinking.

Some practitioners verbalized hesitancy in asking about R/S beliefs and coping methods because of concern they were not knowledgeable about a religious practice. Many participants reported ways they gain understanding about R/S coping, such as participant 9 who shared, “What I do is I talk to the family about their beliefs because I don’t want to contradict. I ask any permission and say, ‘Can I say this? Would this match your religious beliefs, your faith, or spiritual beliefs?’” Participant 15 provided an example of how she navigated an unknown belief system with a client:

> I had this one client who was Native American, and they had beliefs I was unfamiliar with; but even when I don’t know their beliefs, in most religions there

> are a million ways of practicing even one religion, so we have to slow down and not assume we know or that they even want to lean into it., but, we have to ask or we won't know. This kid did, and I just had to ask a lot of questions and she brought in these great stories, I think because I was asking and we ended up using and it was really, I think strengthening for her…but I don't know if she would have gone there if I didn't ask.

The nine practitioners that asked about R/S coping reported they consult with parents when incorporating R/S coping into session. Participant 14 discussed creating that alignment, stating, "What I'd do is when I connect with that parent, I would straight up ask them, 'I wonder how this aligns with your faith beliefs?' The parent will then bring in their perspective; they'll bring a framework around that." Participants also encouraged asking children about their beliefs in addition to asking parents. Some participants discussed differences in caregivers and clients in desire to incorporate R/S coping. Participant 8 stated, "It's very clear if their [the client] religion is a high value, so first is religion a high value in their life, is it a high enough value that they would want to incorporate into therapy? I'm assessing for that." Participant 14 reflected that for him, asking both children and caregivers separately about R/S coping "starts by respecting kids as humans who have world and have the capacity to have thoughts and feelings and beliefs, and it's a willingness to step into that world and see them in that way."

During the analysis of the data, three themes emerged from the interviews. Practitioners reported incorporating R/S coping during 1) relaxation and regulation practice 2) cognitive processing of trauma and 3) through creative methods with young clients.

RQ 5 Theme 1: R/S Coping Incorporated During Relaxation and Regulation Practice

Seven practitioners reported incorporating R/S coping when working with clients on regulating strong emotions and responses to trauma triggers. They discussed not viewing R/S coping differently than when they bring in other ways of coping. For instance, Participant 1 stated she brings in R/S coping "like how you would do anything else with coping…I'm gonna pick up on that and definitely encourage it" (Participant 1). Participant 14 provided an example: "When I'm talking about deep breathing or progressive muscle relaxation, we may come up with a list that also includes praying. We may come up with a list that includes writing down Bible verses and remembering them." Participant 13 shared that R/S coping is used as other coping skills in session and is taught and then applied to areas of struggle outside the session:

> They can use it every night before they go to bed as a routine, when they are sad or feeling strong emotions…used to help with urges or things like that. If you're having a child that is having suicidal ideations and urges, to help them stay present and distract them from their thoughts in the moment.

Participants reported combining different R/S practices such as listening to music, reciting a verse from a religious text, or calling on the name of their deity while engaging with relaxation techniques. For example, Participant 15 reported combining tapping while saying "be still" or "Jesus," listening to Chrisitan music with progressive muscle relaxation, and engaging clients in "deep breathing with the 23rd psalm, the Lord is my Shepherd, while slowing breath." Participant 2 discussed using music, having clients focus on the music and imagine feeling "God's love washing over them and being freely

given to them." Participant 3 used R/S coping in conjunction with EMDR and bilateral stimulation, having them reflect, "How does God see you," and "How is his gaze towards you?" and "What does he say about this," and stressed use with clients "only if they already have a trusting relationship with God and themselves."

RQ5 Theme 2: Incorporating R/S Coping During Cognitive Processing of Trauma

Nine participants discussed using R/S coping while processing the clients' trauma. The therapists gave examples of integrating R/S coping into the exploration of client beliefs about self, about God, and during exploration of purpose and meaning. Therapists additionally reported using R/S coping to enhance client beliefs about self and healing and the future. Participant 2 stated that in her experience, "The teaching that we're in a broken world helps a lot. Heaven obviously will be a perfect place where there won't be all that pain and abuse." Participant 8 reported she used R/S coping to help answer "why" questions and make meaning. She stated she gets curious about "is God good?" and allows them to say, "no, and that's totally okay…and giving an invitation to them for them to go and question God and talk with Him." She added that this enhances "meaning, because with kids, there's that innocence, and the why…that meaning making is important to explore with them."

Six participants described using R/S coping when working with kids on their cognitions relating to self-worth or view of self after CSA. Participant 2 explained the value for CSA clients:

> A lot of times sexual abuse and self-worth are unfortunately tied together, and not in a positive light. I think it can affect self-esteem and self-worth if that's taken

> place. So having Scripture that reminds them of their worth and just from being born, that they're worthy, I think that's powerful.

Participant 1 provided an example of using the Song of Solomon with a client:

> We read the Song of Solomon in sessions. It was all about perspective, so Song of Solomon you get a lot of perspective on sexuality, human intercourse in a loving relationship, a different perspective on what intimacy, physical attractiveness, rather than what she experienced.

Participant 8 also described an experience where she explored a Bible story with a client, Jesus' encounter with the woman at the well. She asked the client, "What were your thoughts about Jesus in that passage?" Her client replied, "I really liked what he was saying, I really liked how he treated the woman at the well." Participant 8 discussed continuing this exploration with her client and discovering what it was that she liked about the story, the fact that Jesus "listened to her and saw her." She added, "For a sexual abuse survivor, that's huge. That's a big deal for them to be seen and known."

RQ 5 Theme 3: Incorporating R/S Coping Through Creative Methods with Young Clients

Six practitioners integrated R/S coping through creative or alternative methods, especially with younger clients. These methods included using props or symbols, art, movement, drawing, writing and children's books. Participant 14 discussed collaborating with caregivers when incorporating R/S coping with very young children, stating, "the kid may not have the exact faith thing down, but what they [the parents] put out and produce might be something that really does connect with their faith, and reinforcing that becomes a central part of our work." Participant 9 discussed creating a "support crown"

with children asking them to identify "the people who support you, and that can be God or a higher power." Participant 15 also used R/S coping with art: "I've used it [R/S coping] with painting or drawing with kids, asking them how they saw God or to find a picture or miniature that shows or explores how they see God or God sees them." Participant 8 explained how she used props to help her understand her clients' view of God when they share the same religious beliefs. She stated she asks clients, "Describe this object to me, and they'll be like, 'It's yellow.'" She then discusses how the same object can be described differently, eventually leading to a discussion of their personal views on God or religion. R/S books were cited by some to incorporate R/S coping in session. Participant 15 explained:

> I think with young children, they like to hear about God's love. I've used Christan story books that have really great messages about how they don't have to earn God's love, for example, or that God made them special. I've actually read children's Christian stories to older children as well, which has been magical really. They get the metaphor.

A few participants reported encouraging parents and clients to read R/S storybooks outside of session as a way of linking material inside session to the outside.

Summary

The analysis in this chapter reflects the themes that emerged from the fifteen mental health practitioner responses to interview questions. The Practitioners exhibited alignment regarding their view of child clients as resilient and when conceptualizing and answering questions regarding resilience. Participants described their experiences with resilience in questions relating to resilience and RQ1, yielding three themes with several

subthemes: 1) influence of caregiver relationships/ environment, 2) significance of external social networks, and 3) use of active coping.

Participants also provided stories and experiences of clients using spiritual and religious methods of coping. Once again participants exhibited alignment in responses and conceptualization of R/S coping. Research question 2 addressed spiritual coping methods, resulting in four themes 1) connection between mind and body, 2) attunement outside of self, 3) use of non-religious spiritual practices, and 4) engaging in compassionate behavior. The sample provided five themes and several subthemes for RQ3, illustrating their experiences with religious coping and resilience in their clients: 1) spiritual connectedness within religious community, 2) negative religious coping, 3) support from religious practices, 4) resolution of spiritual struggles, and 5) meaning making. Practitioners responded to questions regarding RQ4, which aspect of R/S coping contributed to resilience the most, which resulted in three themes: 1) connection to spiritual community, 2) receive comfort and regulation of stress, and 3) reframe the CSA experience and make meaning.

The last research question explored practitioner experiences encouraging or incorporating the use of R/S coping in practice with their child clients. This produced three themes demonstrating how practitioners incorporate R/S coping: 1) during relaxation and regulation practice, 2) during cognitive processing of trauma, and 3) through creative methods with young clients.

The participant responses reflected that most practitioners view their child clients who experienced CSA through a resilience framework and approached their clinical practice by actively noticing and encouraging resilience. Practitioners also verbalized a

desire to respect client belief systems and emphasized a desire to act according to the counseling and psychological codes of ethics. These practitioners provided rich descriptions that reflected their client's stories of resilience as well as their use of R/S coping methods. Many of the practitioners discussed examples of NRC; however, all fifteen expressed beliefs that R/S coping was an overall positive coping method for their clients to practice.

CHAPTER 5: DISCUSSION

Overview

Chapter Five is a discussion of the findings from my phenomenological qualitative study outlined in Chapter Four. My discussion anchors in the purpose of my study and the five research questions that guided inquiry. The purpose of my study was to gain a substantial and meaningful understanding of practitioners' perspectives on resilience in children who have experienced CSA. I additionally explored the influence of spiritual and religious coping on resilience and the ways clinicians may incorporate R/S coping in their treatment of CSA survivors.

In this Chapter, I will provide a summary of results and interpretations of my findings in relation to existing research. Chapter Five will additionally include a description regarding the way findings connect to the Biblical Foundations outlined in Chapter 2. Throughout the discussion I will provide implications of findings regarding how they inform psychological research, theory, and practice. This chapter will conclude with limitations, recommendations for future research, and a summary.

Summary of Findings

My study explored fifteen mental health practitioners' experiences with resilience in their child clients who experienced CSA. These practitioners shared their experience through semi-structured interviews. The results were organized by research question, providing themes for each question.

In reference to RQ1, participants described their experiences with resilience in their CSA clients to be a reflection of several themes: 1) the influence of caregiver relationships, including the extent clients had safe/stable environments and

nurturing/supportive caregivers, 2) the significant of external social networks, including community-based social networks and supportive individual relationships, and 3) the use of active coping strategies such as having a mastery mindset/grit, leveraging personal resources, emotional regulation, and meaning-making.

Participants provided stories and experiences of clients using spiritual coping methods, contributing to four themes for RQ2: 1) connection between mind and body, 2) attunement outside of self, 3) use of non-religious spiritual practices, and 4) engaging in compassionate behavior. The sample supplied five themes and several subthemes for RQ3, illustrating their experiences with religious coping and resilience in their clients: 1) spiritual connectedness within the religious community (with family, others and God), 2) negative religious coping, 3) support from religious practices, 4) resolution of spiritual struggles, and 5) meaning-making. Practitioners responded to questions regarding RQ4, which aspect of R/S coping contributed to resilience the most, which resulted in three themes: 1) connection to spiritual community, 2) receive comfort and regulation of stress, and 3) reframe the CSA experience and make meaning.

In answering RQ 5, participants revealed their experience in facilitating and encouraging R/S coping in their sexually abused child clients. This produced 3 themes that uncovered how practitioners incorporate R/S coping: 1) during relaxation and regulation practice, 2) during cognitive processing of trauma, and 3) through creative methods with young clients.

Discussion of Findings

Resilience Theory provides a framework for understanding the concept of resilience (Richardson, 2002). Resilience has been defined as the ability in humans to

maintain a path of positive functioning despite experiencing a stressor that would otherwise result in a deviation from a healthy trajectory (Liu et al., 2017; Unger, 2019). The study of resilience represents a paradigm shift that moves from a pathology-oriented lens to a strengths-based lens. Resilience Theory acknowledges the significant impact of stressors and traumatic experiences, while additionally recognizing the way internal and external protective factors influence an individual's ability to return to "biopsychosocial homeostasis" (Richardson, 2002). Suffering is a necessary component of resiliency, and in this study, CSA was the identified suffering of focus (Richardson, 2002). The negative impact of CSA was understood through Attachment Theory and the Four-Factor Traumagenics Model (Bowlby, 1969/1982; Finklehor & Browne, 1985). The Four-Factor Traumagenics Model discusses the unique way CSA impacts a child's development emphasizing traumatic sexualization, betrayal, powerlessness, and stigmatization (Finklehor & Browne, 1985). CSA can distort expected growth across several developmental pathways, one of which is a child's ability to establish a secure attachment with a caregiver (Ainsworth et al., 1978; Grady et al., 2017). These models help to highlight the unique way that CSA threatens normative child development pathways across multiple domains of functioning (Brewer-Smith & Koenig, 2014; Masten, 2018). Resilience theory and the Resilience Portfolio Model additionally helped to guide understanding regarding the dynamic and interactive processes that influence an individual's ability to positively cope with trauma, including the use of R/S coping.

To date, psychological research has an established platform of research on resilience and CSA; however, the majority of studies utilize adult populations with participants retrospectively answering questions regarding childhood events.

Furthermore, this study additionally explored the concept of R/S coping and the influence on resiliency in sexually abused children. The topic of R/S coping in children represents an additional and significant gap in psychological literature. A population of mental health practitioners was utilized to gather meaningful interview data regarding their unique lived experiences with CSA and the constructs of interest: resiliency, R/S coping and incorporating R/S coping in their clinical practice. In this section I will explain the meaning of the study findings and compare the results with existing literature provided in Chapter 2. The study's contribution to scientific research, theory, and practice will be intertwined and highlighted within each section.

Practitioners Experiences with Resiliency from CSA

All practitioners in this study expressed a high degree of positive belief that children who experience CSA can be resilient. This optimistic belief aligns with Masten's (2001) description of resilience as "ordinary magic." Participants expressed a unified belief that "most kids are really resilient," even when they are not demonstrating resilience in the moment. Masten's (2001) commonness of resilience was apparent in statements describing children as "incredible" (Participant 6) and their resilience as "powerful," a "beautiful thing to witness," (Participant 12) and "magic" (Participant 1). Others reported experiencing resilience in their clients that "sustained" (Participant 14), "amazed" and "inspired" (Participant 1) them. Participants displayed tearfulness, laughter, and smiles while recounting the stories of their clients' abilities to overcome their CSA experience. This response from practitioners was consistent with studies on "vicarious resilience" or the ability to derive "hope" and "positive meaning" from others' posttraumatic growth (Hernandez et al., 2010; Silveira & Boyer, 2015). Vicarious

resilience has also been identified as a protective element against vicarious trauma, which mental health practitioners who work with high-risk populations often encounter (Hernandez et al., 2010; Hernandez et al., 2007). Vicarious resilience may have been especially sustaining for this seasoned sample; with most therapists practicing with children 16 or more years.

Three themes emerged from the interview data regarding the essence of how practitioners understood resilience in their clients who experienced CSA: 1) influence of caregiver relationships, 2) significance of external social networks and 3) use of active coping strategies. Themes 1 and 2 represent the influence of external systems that children are embedded in, specifically the support from caregivers, the stability of their caregiving environment, other supportive relationships, and community network support. Theme 3, use of active coping strategies, encompasses practitioners' experience with children using a wide array of internal strategies and characteristics to cope with their CSA experience. The responses from participants representing the conceptualization of resilience and the three themes were highly congruent both within this sample and within existing resiliency research. The results of this study are supported by Resilience Theory and research indicating a "transactional interaction" between internal and external assets and resources available to CSA survivors (Grych et al., 2015; Richardson, 2002). I will review practitioner conceptualization of resilience in relation to the literature; then organize and explain themes by external and internal characteristics of resilience from CSA in the subsequent paragraphs. Last, theoretical, empirical, and practical implications from the findings regarding resilience from CSA will be highlighted throughout the discussion, with overarching implications summarized at the end of the section.

Practitioner Conceptualization of Resilience

Practitioners demonstrated views of resiliency that are widely accepted in theory and the literature; with resilience as a transactional process with a child interacting within their system(s) and is both influenced and an influencer in those systems (O'Doughtery-Wright et al.,2013; Richardson, 2002). Practitioners contributed to the understanding of resilience theory and portfolio model, as well as research by providing descriptive illustrations. For example, Participant 14 along with all participants, labeled children as being "embedded," however all practitioners, such as Participant 1, recognized there was a "part we play with who we are as individuals…how we view life." Participant 5 described this transaction, "I know this sounds external, but it's really internal, if they have loving relationships in their lives, they can take those pieces out of what a healthy relationship is and build on that." Practitioners were able to provide descriptions of children who appeared to have a deficit of external assets such as supportive caregivers but were identified as resilient. Some participants, such as 12, verbalized anger when deficits result in a "lack of hope based on the quality of the family" adding "we're not going to give up on a kid's progress just because mom and dad are being foolish." Practitioners then provided other forms of active coping or external relationships that supported adaptive functioning.

Participants additionally recognized a potential for resilience to ebb and flow across domains or across development, with a child exhibiting resilience in one stage of development and challenges in the next. For example, Participant 8 discussed taking a "long view" of therapy with sexually abused children that involves "creating space" for the goal when they are not a child anymore. Recognizing, "as we evolve as people, that

pain also evolves" (Participant 8). This pattern of resilience is consistent with Resilience Theory and longitudinal studies where children and young adolescents may struggle with emotional and behavioral regulation, however in maturation develop more sophisticated coping strategies (Richardson, 2002).

External Characteristics of Resilience from CSA

The experience of childhood is impacted by entrenched social systems. According to Attachment Theory, a child's social connections begin with a caregiver bond, which a child then extends that attachment, or lack thereof to others and then the community (Bowlby, 1969/1982; Southwick et al., 2014). When CSA occurs and is disclosed, these systems experience disruption, especially when an offender is a parent, family member or a significant member of the community (Vilvens et al., 2021). The participants all referenced the influence of positive external relationships and environments as significant contributors towards resilience and positive adjustment in children. The practitioners' nuanced descriptions of caregivers and environmental support was so highly mentioned, it was necessary to subdivide this theme into safe/ stable environments and nurturing / supportive caregivers. It was also necessary to create a separate theme for external support and subdivide this theme into community-based networks and supportive individual relationships. These reports from participants regarding the powerful role of supportive relationships and environment were consistent with previous research on resilience, as well as research specific to resilience from CSA.

Caregiver Support and Resilience. Practitioners cited the importance of caregivers in the role of providing care, nurturing, positive modeling, and attachment as well as influencing environments that were predictable, safe, and supportive of disclosure

and therapy. Participant 6 described belief upon disclosure, a supportive caregiver, and good therapy as "the icing on the cake," adding that then "they'll probably be good to go!" Support from caregivers has been identified as a "buffer" towards the negative impact of CSA (Chandy et al., 1996; Domhardt et al., 2015; Dillard et al., 2021). Caregiving, support, and the relationship to the caregiver has been connected to positive outcomes for maltreated children including fewer externalizing behavior problems, lower levels of depressed mood and anger, and higher rates of functioning (Asgeirsdottier et al., 2010; Gower et al., 2020; Yoon, 2018). The findings from this study and comments from participants such as Participant 9 that children with supportive caregiving do "a thousand times better than without having that connection" serve to validate the existing perspective on Attachment Theory and resilience research.

Findings of my study also highlight the need to enhance caregiver support following a child's disclosure of CSA. Studies indicate that support for the non-offending caregiver(s) following a disclosure of CSA elevates the stability in caregiving and the environment (Vilvens et al., 2021). When parents are supportive/protective and can manage the emotional symptoms of their experiences, children are more resilient (Haiyasoso &Moyer, 2014; Vilvens et al., 2021). However, if caregivers lack support, they experience a diminished ability to cope, and place a sexually abused child at greater risk (Sapienza & Masten, 2011). Results of this study indicate that focusing solely on the abused child alone can be helpful but may result in slower or diminished recovery (Vilvens et al., 2021). Eleven out of fifteen participants worked in CACs and verbalized the helpfulness of being able to more regularly incorporate caregivers in treatment with the child. For example, Participant 15 discussed her belief in the benefit of CACs, "they

may offer free therapy given by highly trained experts in the field, that's so helpful to families. I could work with the parent and the child and whoever needed help!" Despite the benefit of involving caregivers in treatment, there are often barriers to incorporating them, such as financial and time limitations.

Non-Familial External Support. Participants did not cite caregivers as the sole positive support that elevated resilience in their clients. The fifteen participants discussed experiencing higher resilience in kids who had support outside their family with examples including: positive peers, mentors, neighbors, teachers, religious leaders, the therapist, and support within their community. These findings are also congruent with current research on CSA and social support. In a large quantitative study, Hebert et al. (2014) found, higher rates of perceived social support predicted lower rates of PTSD in sexually abused males and females. Participants frequently referenced the importance of their clients "finding that person that's always available, that's readily available to them" (Participant 1). In literature relating to CSA and maltreated youth, support from nurses, teachers, caseworkers, peers, and peers' homes was correlated with resilience and post-traumatic growth (Chandy et al., 1996; Eisenberg et al., 2007; Hetzel-Riggin et al., 2021; Leon et al., 2008). Participants also highlighted the helpfulness of participation in supportive community activities, such as sports, clubs, and religious activities. The experience of support within group community activities such as sports, clubs, school, or religious activities is also recognized in research as having positive influence on resilience (Chand et al., 1996; Williams & Nelson-Gardell, 2012). Practitioners in my study emphasized the experience of "belonging" as the factor that was beneficial for children. Resilience Theory proposes that external connections interact with a child's

internal systems in several ways such as elevating self-worth and self-esteem by helping a child build trust and interpersonal skills, which are especially important following a CSA experience (Grych et al., 2015). The results from my study serve to amplify the existing research by describing the benefit of positive external support systems on maltreated children, especially when caregiver support is lacking.

Internal Characteristics of Resilience from CSA

Resilience Theory acknowledges the role of factors that are internal to a child's ability to be resilient. Internal characteristics represent coping characteristics of the child that may influence the probability of displaying resilience (Dillard et al., 2021). In the results, this theme was identified as "use of active coping" strategies by the child; with all participants identifying examples of active coping in children they recognized as resilient from CSA. Active coping is a broad term tied to Stress and Coping Theory and used to describe individuals taking a more involved role in creating change to a problem or managing the negative emotional states associated with the problem (Lazarus & Folkman, 1984; Walsh et al., 2010). Participants spoke about these children using language such as "little warriors" (Participant 9), "giants" (Participant 6), "optimistic" (Participant 10), "gritty" (Participant 8), and having a bit of "rebellion" (Participant 12 and 14). The use of active coping involves a range of thoughts, behaviors, and strategies that the child uses to actively manage the impact of a trauma or stressor. In CSA research, the use of active coping methods has been demonstrated to promote resilience, where avoidant or more passive styles of coping such as denial or dissociation have related to a reduction of resilience (Domhardt et al., 2015). An active coping method that has been connected to resilience is R/S coping; however, given R/S coping relates to separate

research questions, I will detach it from this section. Participants provided ample data surrounding theme 3, which resulted in four subthemes: 3A) practice self-determination/grit/optimism, 3B) leverage interpersonal resources, 3C) use of emotion regulation strategies to manage trauma symptoms and 4D) engage in meaning-making. I will review the first three active coping subthemes in comparison with existing research and discuss implications. Subtheme 4D, engage in meaning making, will be examined during the discussion of R/S coping.

Mastery Mindset/ Grit. Active coping is related to optimism, mastery, self-esteem, and internal locus of control (Lazarus & Fokman, 1985). The concept of "grit" was an active-coping descriptor used by several participants and stems from the popular work of Duckworth (2016). Grit, according to Duckworth, includes "passion" and "perseverance," which contain emotion and behavioral components required in persevering in the face of challenge. The participants verbalized children who displayed a mastery mindset or grit in terms connected with strength and resilience, such as "warriors" (Participant 9) and "giants" (Participant 6). Participants additionally described client's displaying optimism or hope in an ability to overcome or have a positive future. The belief that one can persevere or be resilient is particularly important in those who have experienced CSA. Consistent with Finkelhor and Brown's (1985) Four-Factor Traumagenics Model, sexual abuse involves elements of powerlessness, secrecy and stigmatization that weaken a child's ability to feel a sense of control over their lives. Thus, it is not surprising that most practitioners reported witnessing growth when child clients engaged in methods of coping that involved mastery and optimism. Participants described children as having "hope," a "positive outlook" (Participant 15), and "grit"

(Participant 12), as well as “showing up” (Participant 8) and “moving forward” (Participant 14).

These findings are consistent with standing CSA research, which reports that self-esteem, self-efficacy, and control beliefs are predictive of lower mental health challenges in adolescents (Agaibi & Wilson; Asgeirsdottier et al., 2010; Domhardt et al., 2015). Practitioners often discussed children “engaging in their power” (Participant 1) when they moved toward resilience. Participant 15 explained that the positive beliefs of resilient children were “realistic,” did not “deny the bad,” and were associated with a belief they could “overcome.” This statement supports results from CSA quantitative research, showing optimistic beliefs about the future were positively associated with resilience in child samples. (Edmond et al., 2006; Williams & Nelson-Gardell, 2012). Other participants such as 3 and 6, reported a need for children to connect with the “vulnerability” of their experience and integrate that with their “power.” These participant descriptors are congruent with qualitative research using samples of adults who experienced CSA. Survivors in these studies report a “reclaiming” of their power and control through self-acceptance, integration, sexuality, and identity (Crete & Singh, 2015; Newsome & Myers-Bowman, 2017; Singh et al., 2012). In quantitative research using adult samples, survivors with internal locus of control compared to those with external locus of control exhibited less PTSD symptomology (Agaibi & Wilson, 2005). The explanations from participants regarding their child clients provide support for current mastery-related research with sexual abuse survivors. This study also adds value, as there are fewer studies describing how children engage with a mastery-mindset and how that assists children in the building of resilience.

Leveraging Interpersonal Resources. Practitioners used the word "openness" most frequently to describe resilient clients' ability to socially connect. This "openness" was used to describe the methods clients used to actively engage with the therapist, their trauma experience, and when seeking and maintaining social support. Interpersonal strengths are described as an individual's ability to develop and maintain close relationships (Grych et al., 2015). Social support was identified by participants and in existing research as one of the most important factors in resilience from trauma (Grych et al., 2015). Thus, it appears the active cultivation and maintenance of relationships serves to enhance connections, thereby strengthening social support survivors received. Social competence has been described in resilience theory as an example of a "person x environment interaction" in the process of resilience (Agaibi & Wilson, 2005; Richardson, 2002).

This belief is supported in CSA research with children. For example, early prosocial skills, such as cooperation, were correlated with fewer internal and external behavioral problems in young children, which were maintained over time (Lansford et al., 2006; Yoon, 2018). The ability to maintain interpersonal connections is important for resilience from CSA, because sexual abuse is an "interpersonal crime" (Participant 14) associated with "betrayal" by person in power (Finklehor & Brown, 1985). Participant 1 discussed the risk when clients "brood" and "deal with things all internally," which she said was more harmful for children because of their "lack of experience" because they don't have the life experience to "fight" their trauma. Most of the practitioners described clients being able and open to "share their story" as evidence of growth. This view aligns with adult CSA research, showing interpersonal trust, social competence, and working

well with others were predictive of resilience (Aspelmeier et al., 2007; Banyard et al., 2002; Simpson, 2010). Further, my study extends research by illustrating the way children leverage their interpersonal resources in resilient building ways.

Use of Emotion Regulation Strategies. The use of strategies to reduce the intensity of emotions has been defined as emotion-focused coping (Lazarus and Folkman, 1984; Schoenmakers et al., 2015). The fifteen participants discussed these strategies through a therapeutic lens, but reported benefits for clients when clients practiced these methods of coping actively in or outside of session. For instance, Participant 13 claimed when a child is “able to deal with their emotions, you could say that they would be more resilient.” Practitioners discussed the importance of children having the “ability to cope before they can process any of those traumatic experiences” (Participant 1). CSA creates a disruption in several areas of functioning, and places children at risk for emotional and behavioral problems including depression, anxiety, and PTSD; thus, the ability to actively regulate emotional states is essential for healing (Domhardt et al., 2015). This view is reinforced in CSA research. In a longitudinal study by Yoon (2018) with maltreated children, regulation and prosocial skills were individually identified as reducing children’s externalizing behavior over time. In adolescent populations, emotional intelligence was a moderator between CSA and suicidal ideation and attempts in adolescent populations (Cha et al., 2009).

Implications on Resilience from CSA

Current empirical understanding of CSA and resilience is vast; however, the history of research on CSA relies heavily on reports from adults retrospectively examining their childhood experiences (Vilvens et al., 2021). Qualitative research

designs provide an opportunity for descriptions of the lived experiences of participants. Unfortunately, qualitative studies exploring CSA with child participants are almost non-existent. Thus, the use of mental health practitioners in this study captured firsthand descriptions of resilience in children from experts in the field. These descriptions provided illustrations of how external and internal factors contributed to the resources of a child. Their contributions added to the understanding of resilience theory by discussing how external support, such as statements of belief or caregiver nurturing led to resilient outcomes. This study also contributes empirically and theoretically by sharing how children used a variety of internal active coping methods to heal from CSA. Further, consistent with resilience theory and research, internal resources were enhanced when used in conjunction with external supports.

These findings have practical implications for the way mental health practitioners can support children and their non-offending caregivers. First, findings of this study highlight the direct and indirect role that caregiver support plays in the adjustment and recovery from CSA (Vilvens et al., 2021). Many child advocacy centers involve caregivers in session, provide education, and provide non-offending caregivers with individual or group support. Although it is the mission of many advocacy centers to provide these supports, they face challenges of funding, time, and adequate staffing to fulfill the needs of the caregivers as well as the children (Haiyasoso & Moyer, 2014; Vilvens et al., 2021). In private practice there may be less support provided to caregivers due to the financial restraints of the family, time or theoretical views of the practitioner that emphasize individual rather than family systemic treatment. When designing interventions for sexually abused children, practitioners can extend intake assessments to

identify areas that could create problems with resilience such as insecure attachments, lack of belief in a child's disclosure, or maladaptive coping strategies (Beaujolais et al., 2021). Private practice practitioners can consider reaching out to local CACs and victim rights advocates to help identify additional options and support for families.

Practitioner Experience with the Role of R/S Coping on Resilience from CSA

Spiritual and religious beliefs play a meaningful role in most cultures and may help individuals gain a sense of community, encouragement, guidance, and purpose (Gower et al., 2020; Peres et al., 2007). Practicing R/S coping is tied to resilience theory, as resilience is viewed as an extension of coping that involves a transaction between internal and external factors that the individual utilizes to manage a stressor (Goldstein & Brooks, 2013; Lazarus & Folkman, 1987; Pargament et al., 2011). The Resilience Portfolio Model is a model that focuses on resilience from violence; it includes the contributions of Lazarus and Folkman's (1987) model of stress and coping to understand how resilience may be fostered through an individual's appraisals and coping behavior (Grych et al., 2018). In this model, R/S coping is viewed as a strength that facilitates growth in three domains: self-regulation, interpersonal strengths, and meaning-making (Grych et al., 2018).

Within the field of research, the use of R/S coping to recover from CSA has been related to resilience as well as post-traumatic growth (Schafer et al., 2018). However, greater empirical attention has been given to adult R/S coping, as adult perspectives are more easily captured (Bryant Davis, 2013; Gower et al., 2020). Exploring R/S coping in children who have experienced CSA represents a significant gap in scientific inquiry (Gower et al., 2020). To answer this gap, research questions two, three, and four were

related to how practitioners described and experienced R/S coping in their clients, R/S coping's role in the development of resilience, and what aspects of R/S coping they believed made the biggest difference in resilience from CSA.

Participants reported child clients drew upon a wide array of spiritual and religious coping methods to deal with the impact of their sexual abuse. As with resilience, practitioners displayed similarities in their experiences, including how practitioners conceptualized R/S coping and R/S coping in children and adolescents. Participants in this study viewed the use of R/S methods as an overall positive form of coping. Practitioners, despite most additionally mentioning the use of NRC, primarily discussed examples of R/S coping that led to resilience from CSA.

R/S coping represents several complex methods of coping that are "neither simple nor uniform" (Pargament et al., 2015). Methods of R/S coping are characterized in many ways including methods that are active, passive, and interactive (Pargament et al., 2000). Forms of R/S coping are grouped into two categories, positive or negative (Pargament et al., 2015). PRC has been connected in research with both resilience and post-traumatic growth and reflects a "secure relationship with God" as well as a "connectedness with others" (Ano & Vasconcellos, 2005; Pargament et al., 2015, p. 563). PRC, and using God as an attachment figure may provide a secure substitute for an insecure attachment in a study with adults (Kirkpatrick et al., 1999). Consistent with research, the participants in this study described the benefits for their clients when they engaged in PRC. Participant 8 discussed an example saying some of her clients would say, "God is good, there's a meaning and purpose for my life, and there were positive outcomes."

Negative religious coping was also described by twelve participants. NRC involves an insecurity regarding spiritual matters and beliefs about God and in research is negatively correlated with resilience factors (Ano & Vasconcellos, 2005; Pargament et al., 2015). NRC is associated with maladaptive outcomes and linked with higher rates of depression, anxiety, and PTSD in a variety of populations in addition to CSA samples (Ano & Vasconcellos, 2005; Korbman et al., 2022). The stories of NRC participants provided were related to damaging messages and behaviors from individuals within their religious community, which resulted in spiritual struggles. Practitioners used words such as “spiritual abuse,” “religious abuse,” and “moralism” to describe the behaviors of others; and reported the fallout for the child was “devastating” and “damaging.”

In the following section, the discussion of findings will begin with an explanation of the way participants conceptualized R/S coping in relation to existing research. A discussion of participant interview results is then divided into NRC and PRC and compared with current research.

Practitioner Conceptualization of R/S Coping

Most practitioners initially combined the concepts of R/S coping, providing examples of spiritual coping through a religious lens. Their conceptualizations of religion and spirituality are not uncommon, as these concepts are highly interrelated (Pargament et al., 2013). When non-religious spiritual coping was separated from religious coping, practitioners primarily described spiritual practices in children as grounding or relaxation methods used to regulate intense emotions associated with their CSA trauma. For example, participants described mindfulness, breathing, meditation, verbalizing calming phrases, or practicing yoga. These practices were often taught in therapy by the

practitioner, and not directly identified by the children as “spiritual.” For example, Practitioner 8 stated, “there’s a big connection between self-care and spiritual” adding she could not imagine a child saying, “these are my spiritual practices” so she identified and labeled it as “self-care.”

The second most common response was discussing ways children connected with nature, the therapist, or in caring for others. This view of spirituality relates to the definition of “spiritual” as finding meaning, purpose, significance in a moment or in relation to the connection of self, others, nature or the scared (Oman, 2013). In these examples, however, it was the participants’ perspective, not the child’s perspective, that these were spiritually impactful or connected. Only six practitioners shared examples of non-religious spiritual practices that adolescents verbalized they used to help cope, such as crystals or numerology. This response from the practitioners may be because of the frequent “fuzzy” definition of what non-religious “spiritual” practices entail, especially in Western cultures (Hood & Chen, 2015). Participants’ reactions are also consistent with the process of children’s religious and spiritual development. Some research indicates that children may not make “sharp distinctions between spirituality and religion” in the way adults can hold these complex ideas to be separate and connected (Bryant-Davis, 2012; Mercer, 2006).

R/S Coping and Child Development

Fourteen participants referenced experiencing R/S coping from adolescent clients more frequently than children under the age of ten. Practitioners directly referenced child development. They reported children need the capacity to hold abstract concepts such as “suffering” simultaneously with R/S beliefs. For example, Participant 12 said, “I think

adults developmentally are more capable to translate, 'this is a suffering I'm going through and this the way I'm choosing'" to receive comfort. Participant views align with research on R/S coping in children. During development, a child's cognitive abilities interact with their attachment, social, and environmental systems, which shape a child's use of R/S coping (Bryant-Davis, 2012; Richert & Granqvist, 2015). As children mature, their shared cognitive systems shift and become internalized working models. These models help children incorporate religion and spirituality into their coping (Richert & Granqvist, 2015). This explanation supports participants witnessing children use R/S coping more frequently when there was parent modeling and/or they were highly connected with a religious community. For instance, Participant 3 stated, "a lot of it comes down to parents instilling it into to them" and Participant 10 said she sees it in young children when "parents are actually teaching their children HOW."

Eight participants shared examples of children under the age of 10 using R/S coping, despite witnessing the use of R/S coping more frequently in older children. Current understanding of young children's use of R/S coping may be "challenged" by narrow views regarding the significance of the religious and spiritual lives of young children (Mercer, 2006). Studies utilizing child samples are rare, however, one study by Holder et al. (2010) of 8–12-year-old children showed a positive relationship between spirituality and happiness. Mercer (2006) reported that the use of R/S coping in young children may be "brushed off as cute" or viewed as merely mimicking adult behavior. In my study, practitioners shared stories of young children who used elements of R/S coping that were helpful. For example, Practitioner 1 discussed a story of a girl around 7 or 8 who had a profound faith saying, "sometimes I thought I was speaking to a 30-year-old!

It was very important for her, and she'd say, 'healing comes from God' so we definitely incorporated that into therapy sessions." Other practitioners reported experiences with young children where a spiritual "wisdom" was felt; or children expressed comfort in their beliefs that God was a friend, healer, or a protector. Indeed R/S coping can provide a sense of stability and anchoring for young children who often demonstrate a preference for creation versus evolutionary explanations for things (Evens, 2000; Richert & Granquist, 2014). Adult CSA survivors retrospectively report the use of PRC in childhood in qualitative studies (Bryant-Davis, 2005; Singh et al., 2012). Young children have a limited capacity to express their understanding of R/S concepts verbally and cognitively; however, as this study implicates there is a continued need for researchers and practitioners to "pay attention to" the unique R/S coping methods young children practice (Mercer, 2006; Pargament et al., 2015).

Negative Religious Coping

Participants revealed several examples of negative spiritual and religious responses that children received from individuals within their religious communities, including caregivers. The impact of these responses on children was described as "very damaging" (Participant 6). Participants compared and contrasted the negative experiences children received with the potential for faith institutions to promote positive messages and healing. For example, when Participant 9 was asked about her experience with R/S coping she stated, "I'm gonna tell you where it went wrong and what I wish would have happened, is that okay?" The examples represent "interpersonal spiritual struggles," where children experience tension and conflict within their religious community (Pargament et al., 2014).

Participants identified several dismissive messages that children received such as, "you just have to pray a little bit more" that minimized their traumatic experience (Participant 6). Practitioners witnessed their clients experience pressure to forgive perpetrators prematurely, judgment around their behavior, harmful messages when experiencing same-sex CSA, congregations that ignored an abuse allegation, or displayed support for the offender. Several practitioners also reported examples where the offender was a leader in a religious organization, or the offender used religious messages in sexual abuse. In qualitative studies, adult survivors frequently describe the importance of their R/S beliefs to positively reframe their sexually abusive experiences; however, accounts in these studies also mention a need to reframe harmful messages and experiences from religious communities (Newsome & Myers-Bowman, 2017; Singh et al., 2013).

Survivors of child maltreatment and CSA have reported lower levels of spiritual well-being and more NRC compared with non-survivors (Gal et al., 2007; Korbman et al., 2022; Walker et al., 2009). The betrayal, powerlessness, and stigmatization of CSA may present challenges to belief systems at the same time R/S development is maturing (Bryant-Davis, 2013; Finklehor & Brown, 1985). As previously discussed, children's religious and spiritual development is a process of internalizing models of R/S beliefs, thus the negative messages they receive following disclosure of CSA may directly influence the development of NRC. Judgement, dismissal, or denial of a CSA experience by "spiritual" people is especially painful for children. Negative responses towards children can influence divine appraisals. Individuals who view God as out to judge or condemn them experience higher rates of shame and guilt (Pargament et al., 2014). As

Participant 12 stated, "nobody needs to increase feelings of shame and guilt" in children who have been sexually abused.

Empirical studies show clear and consistent links between distress and interpersonal conflict within spiritual communities (Pargament et al., 2014). Individuals facing challenges who experience interpersonal spiritual struggles are at risk for lower self-esteem, higher anxiety, and depression (Pargament et al., 1998; Pargament et al., 2014). Interpersonal spiritual struggles can lead to feelings of guilt and shame. Individuals fear condemnation and judgment of their faith, which can lead to a lack of openness (Pargament et al., 2014). In adult CSA research, punishing appraisals of God led to a risk of depression in adults who experienced CSA, while benevolent appraisals of God led to less anger and depression (Dye, 2012). The voice of the participants in this study uncovers messages from faith communities that are supportive and lead to resilience. It is also apparent, given the number of examples, that negative actions and messages from "spiritual and religious" individuals have the power to negatively influence a child's spiritual orienting system that is both developing and at risk due to their CSA.

Positive Religious Coping

The fifteen participants shared numerous reports of positive ways their clients had engaged with religion and spirituality to cope with their CSA. The sample provided examples of PRC that were consistent with what research has identified as the "functions" of R/S coping including search for meaning, mastery/control, comfort, intimacy, and transformation (Pargament et al., 2013). In the paragraphs below, participant stories regarding clients' use of R/S coping to gain support from others,

receive comfort from religious practices, resolve spiritual struggles, and make meaning of their CSA experience will be discussed in relation to existing research.

R/S Coping to Gain Support from Others. Practitioners overwhelmingly cited examples of clients experiencing benefits from R/S coping practiced within community. Additionally, the sample listed the use of R/S coping to gain support and connection with others as one of the largest contributors to resilience. Practitioners reported clients received benefits from community practices such as religious service attendance, small group experiences, group worship, group prayer, and connection with religious leaders. Participants' stories regarding positive messages their clients heard included words and phrases such as, "we support you" (Participant 9), "we got your back" (Participant 14), and "you're brave" (Participant 15). The value of a supportive faith community is echoed in adolescent research. For example, religious involvement was correlated with better psychosocial adjustment, greater sense of self-worth, and less anger following CSA (Good et al., 2011; Holder et al., 2010; Sigurvinsdottir et al., 2021). Participant 14 discussed the "interpersonal" nature of CSA, and believed one of the main advantages for clients and families was in that religious communal experience, which was also "interpersonal."

Religious community involvement was also tied with a decrease in risky behaviors, as verbalized by a few in my sample. In research, involvement in religious activities is correlated with lower use of substances and risky sexual activity as well as higher academic achievement (Kogan et al., 2008; Langer et al., 2001; Milot et al., 2009). The protective benefits may be especially helpful for children who have experienced CSA who have an increased risk for negative views of self and acting out behaviors.

Connection and religious community support are uniquely beneficial for children and adolescents due to their stage of development. Children are "in process" as Participant 12 stated and "in process" of internalizing their R/S belief systems. Messages of self-worth from religious communities become internal working models for a child's view of self in relation to God (Richert & Granquist, 2013). They are then more likely to view God as a source of comfort, strength, and benevolence (Pargament et al., 2013; Richert & Granquist, 2013). External messages of self-worth and esteem in relation to a loving God are extremely restorative for sexually abused children, who feel stigmatized and isolated by their experience. The relationship with a benevolent God can be a source of a secure attachment figure for a child during crisis and compensate for a disrupted attachment or an unsupportive caregiver (Kirkpatrick, 1994; Kirkpatrick & Shaver, 1990). This was demonstrated in comments made by participants who witnessed clients receive support from a small group or religious leader when a caregiver was less available or supportive.

In my study, and consistent with resilience theory, participants reported children were more resilient when they used PRC with the aid of parental modeling. Parents frequently received support from their religious community, which provided the parents with more resources to comfort and support their child. For example, Participant 12 stated, "There are lots of strengths for the families that have a strong faith…faith grounds the parents and the parents ground the children!" Indeed, the trauma of CSA is not limited to the child and can create a dramatic disruption of functioning in the caregiver upon learning their child is a victim (Fuller, 2016; Vilvens et al., 2021). The stability of the family is additionally vulnerable when a financial provider is the sexual abuser. If this occurs, non-

offending caregivers face emotional and financial consequences that penetrate the stability of the environment and impact the child's recovery. Religious communities can serve as a resource that can provide financial assistance, shelter, or food for those in need (Bunge, 2014). All participants in this study and in previous studies identify non-offending caregivers as vital to the resilience of the CSA survivor (Dillard et al., 2021; Fuller, 2016; Vilvens et al., 2021). Religious community support serves to help children directly and indirectly by the encouragement, comfort, and resources they provide.

Receive Comfort from Religious Practices. Practitioners reported that clients engaged with a variety of individual religious practices such as praying, quiet time with God, reading religious texts, memorizing Scripture, listening to religious songs, and religious journaling. Religious rituals and practices have been described as "multidimensional forms of communication" that include behaviors that serve to strengthen systems of beliefs, provide "social cohesion," and calm instability in stressful or uncertain situations (Ladd & Spilka, 2015). Religious rituals and practices often translate to individuals experiencing a sense of well-being, safety, and control, and can serve as a foundation for making meaning (Ladd & Spilka, 2015). In this study, many practitioners believed the comfort children gained from engaging in R/S practices was one of the largest contributors to resilience. This belief is echoed in general empirical research, where practices of prayer and worship are positively correlated with elevated levels of well-being and personal control (Jackson & Bergeman, 2011).

Participants reported children received cognitive coping benefits from R/S practices, saying these rituals were "speaking back to the negative voices" (Participant 15) and "rewiring the brain" (Participant 2). Practitioners also mentioned that the use of religious

rituals and practices helped to regulate or "manage the emotional elements of trauma" (Participant 14). Several participants described the use of prayer and religious practices as a collaboration with God, helping clients see "they're not alone" (Participant 9), "someone is always there" (Participant 11), or "there is someone [God] who sees them as worthy" (Participant 2). The impact of these practices on children was described using words that indicate strength, such as "powerful," "huge" and "big." Participants shared that these practices routinely served as a launching point that strengthened their belief systems and moved them towards a sense of meaning and purpose for their pain.

The impact of PRC rituals and practices has been recognized in CSA and child maltreatment research. For example, in a sample of sexually abused adolescents, higher levels of spirituality, as assessed by questions regarding internal religious beliefs, was associated with lower levels of anger (Sigurinsdittur et al., 2021). In another study with adolescent CSA survivors, "divine support" was positively correlated with resiliency. In quantitative and qualitative adult research, the use of prayer and other religious practices has been cited as a form of coping connected with resilience from CSA (Bryant-Davis, 2012; Gall et al., 2007; Schaefer et al., 2018; Singh et al., 2012). The use of religious rituals and practices to cope with CSA can serve to enhance belief in a "benevolent" God and help a person manage negative aspects of their sexual abuse (Gall et al., 2007). Benevolent reappraisal of God positively impacts one's "spiritual orienting system," which serves as an individual's blueprint for coping with and managing stressful events (Ladd & Spilka, 2015; Pargament et al., 2014). There are a few adult CSA studies showing benevolent appraisals of God are associated with less negative mood, and more personal growth, self-acceptance, and hope (Gall et al., 2007). This study adds to that

research by helping to identify the ways children use religious practices to build resilience following CSA.

Resolve Spiritual Struggles. Several practitioners in my study witnessed their clients' experiences to resolve spiritual struggles. Participants described spiritual struggles using phrases such as, "they felt abandonment" (Participant 5), "this isn't good, therefore God's not good" (Participant 3), and "God why did you allow this?" (Participant 8). Spiritual and divine struggles are forms of NRC that reflect conflict towards one's deity or beliefs (Exline & Rose, 2015). In research with adult and adolescent populations spiritual struggles are related to more depression and lower levels of adjustment after trauma (Ano & Vasconcelles, 2005; Carpenter et al., 2012; Dew et al., 2010; Jouriles et al., 2020). In longitudinal studies with adolescents, "loss of faith" predicted lower improvement in depression after 6 months; indicating potential consequences for teens struggling spiritually include a deterioration of functioning (Dew et al., 2010).

In adolescent research, the experience of CSA correlates with higher rates of spiritual struggles (Jouriles et al., 2020; Korbman et al., 2022). Betrayal by an adult in a position of trust or authority disintegrates the child's sense of faith in others (Finklehor & Browne, 1987). The violation of trust results in the child feeling abandoned, which leads to questions regarding the protection, care, and goodness of God (Jouriles et al., 2020). This interpretation is affirmed in adolescent research demonstrating greater "divine spiritual struggles" are related to more adjustment issues in adolescents who were sexually abused (Jouriles et al., 2020; Korbman et al., 2022).

Spiritual struggles can result in maladaptive functioning; however, the practitioners in this study more frequently reported clients' resolution of spiritual struggles. Participants described client struggles as an evolutionary process, where the client struggles, resolves the conflict, and then re-connects with their belief system. Participant 13 discussed spiritual struggles in the context of the therapeutic process saying it was "a process to get them through that and work through that." Other participants used similar language describing their role as helping clients resolve spiritual conflicts. For example, when describing the "twisty turny" road to resolving spiritual struggles, Participant 8 stated, "This is where the counseling part comes in!"

The practitioners' descriptions of exploration and resolution of spiritual conflict has implications for clinical practice, especially if clinicians are not asking about spiritual or religious beliefs during the assessment process. In this study, only seven participants described the process of helping clients explore questions regarding their spiritual struggles. Additionally, responses from participants in this study, as well as research, indicate that clinicians often self-report not feeling competent in incorporating R/S coping, or fear that inquiring about R/S beliefs would inadvertently impose personal beliefs on the client (Bryant-Davis et al., 2012; Jouriles et al., 2020; Polzer et al., 2012). These implications will be further explored in the section related to clinicians incorporating R/S coping into practice with sexually abused clients.

Meaning Making. Meaning-making is identified as a "craving" and "desire" of all humans (Park, 2015, p.357). According to the Meaning Making Model, humans develop global meaning starting in the early attachment stages, which evolve with subsequent accumulation of experiences and interactions resulting in an organized framework (Park

& Folkman, 1997; Park, 2015). Global meaning thus informs an individual's view of self and influences their interpretation of people, events, and stressors (Park & Folkman, 1997; Park, 2015). The experience of sexual victimization "shatters" a child's basic assumptions about self, others, and the world (Janoff-Bulman & Frieze, 1983). Individuals experience low self-worth and self-esteem, and view the world as less benevolent, which leads to negative transactions between self and others (Janoff-Bulman & Frieze, 1983). To achieve resilience a child must "reintegrate" their experience and transform the self to withstand the stressor (Calhoun & Tedeschi, 2006; Richardson, 2002). Reintegration is frequently achieved through religious and spiritual meaning-making (Calhoun & Tedeschi, 2006; Park, 2015).

Demonstrating this point, Participant 14 eloquently stated, "It's tougher for psychology to answer" ultimate meaning and purpose questions, adding "religion has often more answers." In my study, many participants acknowledged the valuable influence of R/S coping on clients finding purpose and meaning. Religious meaning-making can influence a person's identity and inform their beliefs including their understanding of God, people, and the world, as well as encourage hope in the next world (Park et al., 2015). For example, Participant 9 discussed a client who experienced sexual abuse by a religious leader, which resulted in a split within the congregation. Her client ultimately found healing in her ability to "separate" her belief in God "from the followers," which reattached her with "a loving deity," allowing her to find healing and meaning from her pain. Participant 8 stated that meaning-making was "probably at the core of religious coping." Reporting when children engaged in R/S practices, "there's a trying to understand why" and make meaning whether recognized by the child or not.

Qualitative research shares many stories of adults who experienced CSA and who report they found meaning and purpose through their R/S beliefs and practices (Bryant-Davis 2005; Newsome & Myers-Bowman, 2017; Singh et al., 2012; Singh et al., 2013).

Studies with children and adolescents using R/S beliefs to make meaning are scarce; however, research exists that examines factors that can promote a greater sense of purpose and meaning. For example, R/S coping in adolescent groups is tied to higher levels of resilience, and lower levels of anxiety, depression, and anger (Chandy et al., 1996; Freeny et al., 2021; Gower et al., 2020; Sigurvinsdottier et al., 2021). R/S coping may provide ingredients that "trigger" the enhancement of an individual's coping ability by helping them activate "cognitive processing," which fosters growth (Tedeschi et al., 2018). For example, in a study of adults victimized in childhood, more PRC was tied to greater levels of resilience as well as post-traumatic growth (Schaefer et al., 2018). The meaning-making elements of PRC may help shape CSA survivors' identities and beliefs about their future (Schaefer et al., 2018). Participant 14 shared thoughts that seem to align with this thinking:

> I think even more so than coping [R/S coping is] integral to identity for kids…in terms of understanding who they are, being a kid in adolescence is such an identity developing time, and I've seen kids who will really begin to rely on it for answers to questions and begin to embrace it as a part of them.

Implications for Role of R/S Coping on Resilience from CSA

R/S coping in children and adolescents represents a "neglected" area of study and this provided significant implications for research, theory, and practice (Pargament et al., 2013). In my study, practitioners provided details of children and adolescents using R/S

coping, which enhanced the understanding of the way youth incorporate R/S coping in their recovery of CSA. Practitioners' descriptions of both PRC and NRC contain important information regarding the way external messages can serve to support or inhibit resilience in this population. Significantly, although practitioners reported primarily witnessing R/S coping from adolescents, several also provided details regarding young children's use of R/S coping. Participants' descriptions of the way children displayed fewer spiritual struggles and at times great depth of faith despite their young ages, reveals unique information regarding the use of R/S coping in young children.

The experiences of practitioners add to the understanding of PRC and NRC and illustrate the way children incorporate messages and teaching from parental figures and spiritual communities. Consistent with resilience theory, children used R/S coping more when modeled. Additionally, positive and negative forms of religious coping demonstrated personal x environment interaction effects (Richardson, 2002). For example, when children displayed an active leveraging of social support by speaking to a church youth leader about their CSA experience, they received external positive messages, which elevated their connection. Conversely, when individuals in faith communities expressed judgment or doubt regarding a child's behavior or disclosure, a child internalized these messages and experienced spiritual struggles. The use of R/S coping was also reported as a helpful substitute when there was a lack of caregiver support, with participants discussing examples of adolescents finding substitute supports in the forms of mentors, youth leaders, clergy, or lay counselors.

These reports from practitioners' support resilience theory and research by providing more holistic knowledge regarding the way children adolescents engage with

their spiritual selves, and how PRC and NRC impact healing from CSA. Results have several practical implications for mental health practitioners, which will be explained at the end of the next section on incorporating R/S coping into practice. The results also have practical implications for R/S communities. Practitioners reported several examples of support that faith communities provided CSA survivors that contributed to their resilience. Participants described the way leaders, small groups, prayer groups and community groups encouraged healthy processing of CSA experience, connection with the divine, spiritual connection with others and PRC. These experiences all positively impacted client feelings of self-worth, belonging, purpose and meaning. Despite examples of the positive role of faith communities, most practitioners also provided examples of the negative role these communities can play, which can lead spiritual struggles.

Faith communities can use results from this study as indicators regarding the helpful and unhelpful ways to support CSA survivors. Fostering partnerships with mental health practitioners, especially individuals from child advocacy centers, can benefit children in faith communities. Mental health practitioners can contribute information regarding child development, child victimization, and ways faith communities can protect and support victims of CSA and their families. Faith communities can supply knowledge to mental health practitioners concerning religious beliefs and practices, as well as help explain to practitioners how their faith explains trauma or helps to resolve spiritual struggles. Communication between these groups can serve as a springboard for learning and cooperating with one another that can enhance resilience from CSA in children.

Practitioner Experiences with Incorporating R/S Coping into Clinical Practice

Integration of R/S coping in clinical practice with children represents a large gap in the psychological literature (Pargament et al., 2015; Walker et al., 2010). Therefore, research question five inquired whether practitioners incorporated R/S coping into practice with their child and adolescent clients who experienced CSA, and if yes, the ways in which they have integrated R/S coping into practice. Practitioners viewed R/S coping primarily as a positive form of coping, and all verbalized ways they supported their clients' use of R/S coping; however, only nine directly assessed clients and/or their caregivers regarding R/S beliefs and practices. Additionally, when asked about R/S coping, all practitioners verbalized a desire to follow their ethical guidelines of clinical practice, which state practitioners should not impose "values, attitudes, beliefs, and behaviors" on clients (American Counseling Association, 2014). A discussion regarding participant assessment and incorporation of R/S coping into clinical practice will be explored in conjunction with existing literature.

Assessment of R/S Beliefs and Coping

Religion and spirituality are an important and meaningful part of many people's lives, including children and adolescents (Bryant-Davis et al., 2012; Vieten & Lukoff, 2022). Empirically, the use of R/S coping is tied to resilience from CSA in child and adult populations (Chandy et al., 1996; Gower et al., 2020; Sigurvinsdottir et al., 2021). R/S coping is linked with Resilience Theory as well as Post-Traumatic Growth by shaping appraisals and coping behavior, which impact a person's interpersonal and community supports, emotional regulation, and meaning-making (Calhoun & Tedeschi, 2006; Grych et al., 2015; Park & Folkman, 1997). R/S coping can impact children and adolescents who have experienced sexual abuse both positively and negatively, as

indicated by this study and in the empirical literature (Walker et al., 2009; Bryant Davis et al., 2012). Thus, including R/S coping in assessment can be beneficial even when working with child clients. Further, the American Psychological Association (2017) and American Counseling Association (2014) view R/S as forms of multicultural diversity. These organizations encourage psychologists and professional counselors to integrate a client's culture and preferences, including their religion and spirituality, into clinical practice. This study demonstrates that client R/S beliefs and coping strategies may not be a part of regular assessment, especially when working with children. The caution of subjects' assessment of R/S beliefs and coping in this study may point to needed understanding and training regarding how mental health clinicians can inquire about R/S coping strategies in accordance with their ethical guidelines. Therefore, this section will focus on reasons why R/S may not be assessed, the importance of assessing R/S beliefs and coping, and how to assess R/S coping using suggestions from practitioners in this study in conjunction with literature.

Why R/S Coping May Not Be Assessed. All fifteen participants verbalized respect for a clients' R/S beliefs. Respect was evidenced by practitioners providing examples of clients discussing R/S beliefs in session and the therapist describing their support. Nevertheless, not all the sample assessed clients' R/S coping, practices, or beliefs. Nine reported assessments of R/S coping, however within that subset, only a few regularly assessed R/S coping. Some participants described the hesitation stating there was a "phobia of bringing up religion and spirituality" (Participant 9). Others made statements such as, "I think we're afraid" (Participant 15). Those who did assess or incorporate R/S coping emphasized the consent they had obtained saying "if I'm

allowed" (Participant 2), "only if I have permission" (Participant 13), and "I asked the parents first" (Participant 15). Many listed reasons they do not always ask, for example they "wait for the parent to volunteer it" or they ask a question such as, "What has helped you cope in the past" and "see how they respond." Other participants reported they did not have a direct question because "if it was important" to the family, parent, or child it would be brought up. Additionally, some verbalized caution when incorporating R/S coping due to lack of familiarity about an individual's beliefs systems or expressed a desire not to appear as "judging" a person's lack of spiritual beliefs by bringing it up.

The development of the child was also listed as a roadblock to the assessment of R/S coping. Some expressed caution when incorporating R/S coping with children due to the pressure or influence of a parent. For example, they avoided the topic because they did not wish to appear to be aligning with the parent or moralizing an adolescent's behavior. Regarding young children, some expressed concern their beliefs were a form of "magical thinking." Participant 12 stated, "To be talking about spiritual practices, that just doesn't feel a great fit. Kids are more concrete." She added the challenge when working with CSA and children was "trying to get the abstract and bring it into the concrete," thus adding abstract concepts could be "more of a problem."

The caution this sample displayed in asking about R/S coping is representative of the overall population of psychologists. Though most mental health professionals now report they view religion and spirituality as important aspects of development, they are often hesitant to ask and discuss R/S issues in therapy (Shafranske & Cummings, 2013; Vieten & Lukoff, 2022). One reason cited in the literature is the lack of adequate training in counseling and psychological programs regarding religion and spirituality (Schaefer et

al., 2011). Accredited programs contain education on diversity and multicultural competence, however, most lack thorough education regarding psychology and religion and spirituality, leaving many budding practitioners "spiritually illiterate" (Shafranske, 2015, p. 597). Though likely not a large factor in this study, research also indicates that psychologists may be less religious than clients (Shafranske & Cummings, 2013; Vieten & Lukoff, 2022). In research, practitioners who reported more religious and spiritual beliefs are more likely to ask clients about their religious and spiritual beliefs (Shafranske & Cummings, 2013; Shafranske, 2015). In this study, all the participants indicated in the demographic survey they identify with some form of major religion, with the large majority identifying as Christian. Therefore, this sample may have been more likely to assess R/S coping than other samples of practitioners.

Importance of Assessing R/S Beliefs and Coping Strategies. In 2007, the American Psychological Association created a resolution to reduce prejudice and discrimination and suggested religion and spirituality be included as part of multicultural training (American Psychological Association, 2019; Vieten & Lukoff, 2022). Spiritual assessment and integration in mental health counseling has been documented for some time, yet therapists are often reluctant to inquire about spirituality (Pargament, 2007). Spiritual assessment draws on holistic views of the individual, considering religion and spirituality as sharing and contributing to their other cultural identities, which contribute to a client's meaning, identity, and affiliations (Shafranske, 2015; Vieten & Lukoff, 2022). This viewpoint is echoed by Participant 14 who stated that spirituality was "similar to race, similar to sexual orientation" that represent "basic questions of identity that hold such a cultural richness" and that drawing upon it "can only improve our work."

Participant 14 additionally stressed not solely asking parents about R/S beliefs, but also encouraged asking children, “respecting them as humans,” and suggested taking a “willing” stance and “stepping into that world and see them in that [spiritual] way.”

Spiritual assessment requires the clinician to adopt an “intentional orientation” and recognize that religion and spirituality may contribute to their client’s worldview (Oak & Raphel, 2008; Shafranske, 2015). This approach does not minimize, replace, or compete with other forms of psychological approaches, but views R/S coping strategies as “relevant variables” to treatment (Pargament, 2007; Shafranske, 2015, p. 595). The “intentional orientation” requires practitioners to directly ask about religious and spiritual beliefs (Shafranske, 2015). Individuals in therapy may be hesitant to bring up their R/S beliefs with mental health professionals, fearing judgment either for their beliefs or for their spiritual struggles (Vieten & Lukoff, 2022). Adolescents and children can be less willing to engage in R/S discussions in therapy due to their CSA, their developmental level, or their therapists’ position of power (Bryant Davis et al., 2012; Walker et al., 2010). There are indications in research of positive responses toward the interviewer when adults are asked about spiritual beliefs, including viewing the person as more warm, empathic, and trustworthy (Terepka & Hatfield, 2020).

Spiritual assessment can uncover healthy resources that may be incorporated in session or support a client outside of session (Oak & Raphel, 2008). For example, several therapists in this study referenced the value of clients engaging and receiving support from religious communities, using R/S practices to manage stress symptoms, or using their R/S beliefs to combat negative cognitions. Participant 15 shared about a child who was of Native American ancestry and how they found strength from learning about

Native American spirituality. She reported feeling "so very glad" that she engaged the child in that discussion because it was not initiated by the child. In that situation, the openness from the therapist possibly enhanced the child's engagement with that spiritual practice, which gave her "strength."

Spiritual assessment can also assist the therapist in discovering unhealthy R/S coping that may contribute to a client's difficulties (Oaks & Raphel, 2008). Results from this study indicate many of the participants experienced clients having spiritual struggles, receiving negative messages from faith communities, or having had R/S elements being brought into the CSA. In psychotherapy with abuse victims, it is important for therapists to encourage discussions that can reveal elements of NRC or spiritual struggles (Bryant-Davis et al., 2012; Walker et al., 2010). Sexually abused adolescents are especially important to evaluate for spiritual struggles (Bryant-Davis et al., 2012). Adolescence is a period of rapid cognitive and spiritual development that can be deeply impacted by the experience of CSA, leading to external judgment, anger, and low self-esteem (Bryant-Davis et al., 2012; Gower et al., 2020; Sigurvinsdottir et al., 2021). Further, spiritual struggles in sexually abused adolescents may not be mentioned by clients yet are correlated with adjustment problems over time (Jouriles et al., 2020). An example of the potential benefit of assessment of spiritual struggles in children was cited by Participant 15. This participant mentioned she was cautious about assessing R/S coping, however when she did remember to ask, she could uncover, "they are thinking about their religion in a way that could be harmful, and I can then work with the child to manage that negative thinking."

How to Assess R/S Coping. Participants in this study offered rich insights regarding asking clients and caregivers about R/S beliefs and coping. Several therapists reported initiating spiritual conversations first with caregivers. Participant 9 stated, “I talk to the family about their beliefs because I don’t want to contradict.” Participant 14 said, “It starts with assessment. I simply ask a kid or a parent, ‘in difficult times some people turn to their faith for answers to questions, is that something real for you?’” Participant 8 discussed taking a “curious” stance with adolescent clients, being open in asking about belief in God or a higher power, and then asking, “Is God good? You can say no, and that is totally okay.” A challenge may occur when practitioners only assess R/S coping with the caregiver, as caregiver and child beliefs may not align. Following caregiver interviews, a few participants revealed they also do assessments with children. For example, Participant 15 stated she asked her “little clients if they believe in God, and I say that’s okay if they don’t believe” but felt it was “an important question because then I find out how they see God” outside the parent’s perspective. Participant 14 and 8 discussed deepening assessment with child clients and continuing to assess even when beliefs appear to align. Participant 8 described using objects in R/S assessment, having she and the client describe them in different ways, demonstrating how two individuals can view God or the same belief differently.

These methods of asking about R/S coping agree with recommendations in research. For example, Vieten & Lukoff (2022) recommend asking broad questions such as, “For some people, religion and spirituality are a source of strength and comfort in dealing with life’s challenges, are they for you?” (p. 33). If the client answers no, they suggest asking, “What are your sources of hope and strength when you face life’s

challenges?" If an individual indicates R/S beliefs or practices, Vieten & Lukoff (2022) also recommend asking if clients belong to religious or spiritual communities, providing examples from organized religion or other community groups such as bible studies or yoga studios. Participant 14 mentioned asking clients about what they were doing that was "helpful or hurtful for you?" to inquire further about PRC or NRC. This questioning is also in line with suggestions from research, recommending practitioners ask, "What aspects of your religious or spiritual community and beliefs are helpful and not so helpful to you?" and "Do you have any spiritual needs in your life that are not being met?" (Vieten & Lukoff, 2022, p. 34). When questioning children, questions may have to be altered according to the development of the child (Walker et al., 2010).

Considerations with CSA. Practitioners in this study displayed awareness and caution when bringing in elements of R/S coping into clinical practice, especially when children had R/S elements incorporated into their abuse experience. Participant 6 described "naïve and heartfelt" therapists who view R/S coping only as "powerful and wonderful" because it had been for that therapist, but without awareness and sensitivity can risk "traumatizing and alienating" a client who had experienced sexual abuse and religious abuse. Twelve of the practitioners reported examples of harmful messages and behavior by individuals in faith communities that negatively impacted client functioning. It may be that exposure to negative external R/S messages may elevate hesitancy in practitioners assessing and incorporating R/S coping into practice.

To address the unique elements of child sexual victimization, Bryant-Davis et al. (2012) and Walker et al. (2010) recommend therapists be mindful of the ways children's R/S development may be impacted by CSA. Bryant-Davis et al. (2012) indicated several

areas where a child may be at risk of being triggered by spiritual and religious questions. The following examples were also provided by multiple participants in this study. Children are especially at risk when sexually abused by a leader in a spiritual community, by a member of a spiritual community, or when rejected or not supported by that community (Bryant-Davis et al., 2012). Additionally, some children are threatened with God's anger or hell if they talk about their abuse (Bryant-Davis et al., 2012; Walker et al., 2010). Religious objects or artifacts can be used or observed while a child was being sexually abused. For example, Participant 6 discussed a child looking at a cross during their abuse. Children may be told that the sexual abuse was "God's will" or "ordained" and read religious texts seeming to validate their sexual abuse (Bryant-Davis et al., 2012). Participant 15 discussed a client who was sexually abused from infancy by her father who was reading Bible verses seeming to teach her compliance with her abuse. Last, as also indicated in this study, children may feel extra shame if they believe their feelings, behavior, or CSA experience violates a belief held by their religion, as may be the case with statutory rape, same sex CSA, promiscuity, or questioning their sexual orientation (Bryant-Davis et al., 2012).

Religion and spirituality may be a trigger for some children who experienced CSA; however, that does not mean R/S concepts should be avoided in therapy. R/S coping can provide victimized individuals with a wide array of resources that enhance mental, physical, and interpersonal functioning and are connected both with resilience and post-traumatic growth (Grych et al., 2015). Walker et al. (2010) recommends maintaining an "open but supportively neutral stance toward client personal religiousness and spirituality." This was represented by clinicians in this study who were not afraid to

ask about R/S coping and beliefs in both caregivers and child clients, but also indicated a willingness to respect client beliefs. For example, Participant 8 discussed exploring religious triggers with a client, "is God a trigger? Is Jesus a trigger?" and treating religious triggers non-judgmentally in session, as with other triggers. Walker et al. (2010) also encouraged clinicians to incorporate understanding about the normalcy of questioning spiritual beliefs or God following abuse in the psychoeducational portion of Trauma Focused Cognitive Behavioral Therapy. Bringing spiritual struggles into the psychoeducation portion of therapy may be beneficial when engaging in discussions about R/S coping and beliefs with clients. It can also serve to help caregivers understand child resistance towards engaging with their religious practices or communities (Walker et al., 2010).

Incorporating R/S Coping in Clinical Practice

The therapists in this study incorporated R/S coping through a variety of approaches. All the therapists in this study followed trauma-informed protocols when treating their child clients who experienced CSA. Therefore, it is not surprising that they integrated R/S coping into treatment using methods that aligned with protocols such as trauma-focused cognitive behavioral therapy. Many of these therapists engaged the parents in helping coordinate the integration of R/S coping into sessions that used techniques that were congruent with their beliefs. For example, Participant 9 reported that she has asked parents, "Why does God…or your higher power…let bad things happen in your beliefs?" to help clients address "why God" questions in a way that supports family belief systems. Participant 13 described educating caregivers about relaxation practices and engaging them to help connect that practice with a R/S belief.

Participants verbalized willingness to learn about different spiritual beliefs. For example, Participant 1 reported learning about becoming a nun from a client who had that desire and sought education regarding the process. Participant 8 discussed learning about meanings behind crystals with her client, Participant 14 described learning how individuals incorporate wisdom of ancestors in their coping, and Participant 15 discussed learning about Native American spiritualism. Practitioners expressed willingness to bring in religious leaders for children or families who were experiencing spiritual struggles or struggles with a religious community. Walker et al. (2010) suggests that when appropriate, therapists sign release of information forms to speak with religious leaders to help coordinate care. Practitioner 9 discussed encouraging parents to connect with religious communities to help add additional support outside therapy.

Therapists in this study reported they used R/S coping strategies in relaxation and emotional regulation exercises. Practitioners used “belly breathing” while listening to religious music or reading religious texts. Using words from texts has been identified as a practice that reduces dissociation and helps children connect their mind, body, and spirit (Poyser, 2004; Walker et al., 2010). Walker et al. (2010) cites some conservative parents from monotheistic religions may be concerned if their children were practicing meditation or mindfulness outside of a religious context. It was suggested that alterations can be made so the child focuses on the divine or reads out of a religious text while engaging with that practice, as cited by the participants in this study.

Therapists in this study used R/S coping in helping the child reduce maladaptive thoughts. Child sexual abuse primes a child to experience low self-esteem and self-blame creating a vulnerability that can deteriorate functioning longitudinally (Ferguson et al.,

2013). Practitioners reported witnessing a benefit when using religious practices in session to combat negative thoughts regarding self and their abuse. Descriptors were used such as “powerful,” “so helpful,” “amazing,” and “magic” to describe the impact of using words from religious texts, poems, music, or writings that discussed a client’s “worth.” Practitioners reported being able to use these methods with both adolescents and young children. Practitioner 15 suggested using young children’s religious storybooks that discuss positive messages with older children, calling the experience in session “magical” because adolescents were more able to understand the metaphor. Walker et al. (2010) discussed ways to incorporate R/S coping during the cognitive processing and trauma narrative sections of trauma focused cognitive behavioral therapy. It was suggested, as the therapists in this study explained, that using stories or elements from religious text can help clients address and make meaning for their suffering. For example, Participant 1 used the Song of Solomon to help discuss healthy sexuality with a client, Participant 15 used the story of Joseph from the Bible to discuss suffering, and Participant 2 used Jesus’ experience to discuss suffering and children’s Bible stories with younger children to demonstrate God’s love. These methods can be combined with many religions. For example, Walker et al. (2010) suggested having Buddhist children meditate on the Four Nobel Truths.

Young children’s R/S coping was less integrated in sessions than with older children. Clinicians listed reasons relating to their concrete development, lack of verbalizing spirituality, and inherent “trust” in God that led to less overt spiritual struggles. Nevertheless, six therapists cited ways they have incorporated R/S coping with younger children or used creative techniques in sessions. These techniques included

exercises using art, miniatures, guided imagery, sand trays, and stories. Some used God in children's creations of "support" or witnessed children draw and use heaven as their safe place in eye movement desensitization and reprocessing therapy. Bryant-Davis et al. (2012) recommends when integrating religion and spirituality into sessions with young children to consider Fowler's (2006) stages of faith development, which coincide with a child's developmental stage. The participants in this study were able to cite examples where young children have engaged with R/S coping, yet few verbalized incorporating R/S coping in sessions with young children. Spiritual integration in therapy with young children may be an overlooked or undervalued practice that could serve to enhance resilience in young children, thus it warrants further exploration.

Implications for Incorporating R/S Coping into Clinical Practice

Practitioner reports regarding incorporating R/S coping into clinical practice have empirical and practical implications. The description of the way mental health practitioners in this study assessed and incorporated R/S coping informs existing knowledge. First, examples of assessment questions provided by participants elevate both existing research and practice by highlighting the way practitioners can approach the assessment of R/S coping in children and adolescents. Second, this study added value to existing research through the stories that practitioners provided regarding the way they incorporated R/S coping into clinical practice.

Although all participants reported witnessing the use of R/S coping in clients, not all participants assessed or incorporated R/S coping into practice. The results of this study indicate understandable hesitancy from practitioners regarding questioning about religion and spirituality. This hesitancy has important implications for CSA survivors who are

more likely to experience spiritual struggles (Jouriles et al., 2019). This study demonstrates that through assessment and incorporation of R/S coping, practitioners can address NRC and enhance use of PRC, which can elevate resilience from CSA.

Practitioners can benefit practically from this study, by seeking to adopt an “intentional orientation” and recognize the role that R/S coping can play, even in children (Bryant-Davis et al., 2012). As implied by this study, practitioners may gain confidence and enhance their treatment of children and adolescents by seeking continuing education and consultation regarding spiritually integrated therapy. Mental health practitioners can also benefit from partnerships with individuals from faith communities. Practitioners can receive guidance regarding how to answer challenging questions around meaning, drawing upon a child’s spirituality in session, or addressing spiritual struggles. As this study indicates, the practitioner’s willingness to address the diverse identities of children, including their spirituality can better inform the practice of counseling in a way that enhances resilience from CSA.

Discussion of Biblical Foundations

“What I’m trying to say is I think that [resilience from CSA] it’s ALL spiritual!” (Participant 1). Psychology and Christianity have not always co-existed peacefully. Understandably, Christians have questioned psychology’s reduction of the mystery of faith to mere variables that can be quantified or explained (McMinn, 2017). My study represents a more recent age of thinking about religion and spirituality in psychology by gaining a deeper understanding regarding the role that R/S coping plays in resilience from CSA. This study is rooted in the foundation of Christianity, understanding that this world is a fallen world, and in this fallen world, there is a separation between God and all

of creation that leads to sin (*New International Version Bible,* 2011, Genesis 3). In this study, the obvious sin and consequences of CSA were prevalent. Therapists expressed feelings of anger, sadness, and disbelief regarding the circumstances they bravely encounter with children daily. Yet, as sin abounds, so does grace. 2 Corinthians 4:8-9 states, "We are hard pressed on every side; but not crushed; perplexed, but not in despair; persecuted, but not abandoned; struck down, but not destroyed." Participant 6 stated, "They were pretty smart! They were incredibly smart and figured out many ways before we ever came along about how to survive!" On earth, individuals cannot ultimately escape suffering, and there is no formula to explain why some suffer more than others; however, Jesus is not just a mere observer, but a participant in that suffering. He is our bridge between the fallen state of this world, our connection with God, and the promise of redemption. Romans 8:18 speaks of the hope that our "present sufferings are not worth comparing with the glory that will be revealed in us" (McMinn, 2017; *New International Version Bible*, 2011).

Resilience is conceptualized as "bouncing back" from adversity, and there is no greater picture of resilience than the power that God provides through His Son to help his people survive the unimaginable (Calhoun & Tedeschi, McMinn, 2017). Yet, suffering and resilience in children is a topic less explored. Romans 5:3-5 states:

> Not only so, but we also glory in our sufferings, 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 (*New International Version Bible*, 2011)

In this study, the spirituality of children and adolescents was explored. Participants described children of all ages who possessed deep and devout faith that helped them become resilient from their CSA experience. Most of the stories told were regarding children using Christian practices. Participant 11 discussed a client involved in middle school church youth activities saying, “That was a really important part of her life, and it really helped her to be resilient when a lot was going against her.” Practitioners witnessed children experience support from a variety of R/S coping methods such as worshiping, participating in community, reading religious texts and writings, and listening to music. These children used these methods of coping to experience belonging, support, relaxation, emotional regulation, cognitive restructuring, and finding meaning and purpose. This study contributes to the understanding biblical foundations by illuminating children’s use of spiritual and religious coping and encouraging practitioners to recognize the unique role that R/S coping plays in resilience.

Limitations

As with all qualitative research, there were limitations. The focus of my study was intended not to test a hypothesis, but to expand current knowledge about resilience from CSA by illustrating practitioners’ lived experiences with resilience in their child clients and the role of R/S coping in that resilience process. Results of qualitative inquiry serve to elevate understanding of a phenomenon and to illuminate areas for further exploration (Moustakas, 1994). Therefore, results from this study may not be used to draw correlations or causal relationships. Additionally, due to qualitative data sampling, results may not be generalizable to all sexually abused children or all practitioners who work with sexually abused children.

A second limitation surrounds the recruitment and homogeneity of the sample. The sample consisted of fifteen mental health practitioners who regularly worked with children who had experienced CSA. A sample size of fifteen represents a normative sample size for qualitative research design, where samples may vary from five to twenty participants on average (Creswell & Poth, 2018). Participants were recruited using an initial convenience sample from one geographic region of the southeastern United States that led to a snowball sample, resulting in fifteen participants. An initial concern was a lack of male practitioner perspectives; however, two male therapists contributed to the interviews. Additionally, variance in race was not an initial concern, however participants almost all identified as white. The sample represented the voices of clinicians that had been practicing 3 years to twenty plus years, thus a range of mental health practical experience was achieved. The group also represented both individuals working in private practice and in CACs in urban and rural areas. The total sample, however, was almost all white females, identifying as Christian, and practicing in one area of the United States. Thus, the perspectives of the practitioners may represent those in a specific region and the characteristics of the youth may not be generalizable to the population of all sexually abused children. Additionally, practitioners self-selected to participate and may represent a subset of practitioners who hold unique perspectives compared to colleagues who chose not to participate. For example, all participants identified with a major religion, predominantly Christianity, and it may be that practitioners’ who practiced a formal religion were more likely to volunteer to participate in a study regarding resilience and R/S coping.

Whenever a researcher interacts face-to-face with participants, there is the possibility of bias in responding from both the participants and researcher (Creswell & Poth, 2018). Steps were taken to reduce researcher bias as well as encourage participants to describe their lived experiences without judgment from myself, the interviewer. For example, I used and reviewed consent forms with participants, explained the goals of the interview, used open ended questions, and encouraged all types of responses. Nevertheless, even when strategies are employed to enhance rigor and reduce bias, there is always a potential for researcher and participant bias.

A limitation of this study was the length of interviews. Practitioners were asked semi-structured questions relating to the five research questions that anchored this study. Interviews were lengthy, resulting in less time spent on questions that came at the end of the interviews. Although data from the interviews was robust, questions regarding R/S coping and integration were provided towards the end of the interview. These questions could have been impacted by participant fatigue, which may have impacted participants' ability and/or desire to recall or expand on responses.

Recommendations for Future Research

` A significant strength of this study was the robust nature of the interview data, which supplements gaps in existing research and expands understanding of CSA, resilience, R/S coping and practitioners' use of R/S coping in practice. Results of the data hold suggestions for multiple areas of future research.

The use of practitioners in this study demonstrates the importance of utilizing mental health practitioners as participants, as clinicians are often early responders and play a contributing role in building resilience in sexually abused children. This study

highlights several areas where practitioner voices can be beneficial to research. Due to the homogeneity of sample, replication is needed with practitioners that represent diverse races, genders, R/S beliefs, and geographic regions. Additionally, the demographic survey did not assess the degree of practitioner religiosity or question the primary demographic of the children that the practitioners treated. These elements are unknown in this study; therefore, it may be beneficial to provide practitioners with brief questionnaires to capture these factors.

A notable strength of this study was the exploration of the role of R/S coping in children and adolescents. R/S coping represents a large gap in research with children. Therefore, much more understanding is needed, including studies where interview questions focus primarily on the use of R/S coping in sexually abused children. Findings additionally reveal a need for inquiry regarding young children's use of R/S coping. To enhance understanding, exploration can include interviews with practitioners who work with children and adolescents of different races, religions, and nationalities. Research on R/S coping and resilience may also benefit from interviews with practitioners who treat children experiencing other traumas or losses, such as major and life-threatening illnesses, physical abuse, or death of a caregiver. Additionally, the voice of caregivers, teachers, nurses, and members of religious communities can provide supplemental knowledge regarding the way children engage with R/S coping from various traumas outside the therapy office. Last, the results of this study should be extended using quantitative research designs exploring relationships between key variables identified in this study.

Descriptions from participants revealed the influence that faith communities have on those who experienced CSA and their PRC and NRC. Results reveal more information is needed to understand the opportunity faith communities have in influencing PRC and ways to prevent NRC in CSA survivors. The opinions and perspectives from church leaders and youth leaders could provide valuable understanding both quantitatively and qualitatively. Qualitative research can include interviews with major and minor leaders who serve in religious communities, discussing their experiences with survivors of CSA and R/S coping. Quantitative research may also be advantageous to use when exploring opinions and behaviors regarding CSA with larger groups of participants from various faith communities around the United States.

Summary

CSA is a form of child maltreatment that primes a child for negative functioning across multiple domains throughout the lifespan (Marriott et al., 2014). The impact of CSA reverberates from the child to the family and out into the community and society at large (Vilvens et al., 2021). Yet not all those who experience CSA will display maladaptive development (Dillard et al., 2021). In fact, estimates show up to fifty percent of those who experienced CSA will have a lack of negative outcome, and even experience positive outcomes despite childhood victimization (Domhardt et al., 2015). The capacity to thrive despite experiencing deprivation and adversity is defined as “resilience” (Garmezy et al., 1984).

Research regarding resilience from CSA has expanded over the past 30 years and has identified multiple factors that serve to promote or reduce resilience (Masten, 2018). The available CSA resilience research, however, primarily focuses on adult or older

adolescent samples, and does not fully explore the unique role of R/S coping on resilience in children (Gower et al., 2020). R/S coping is related to constructs that represent forms of coping such as PRC, which enhance resilience. It is also related to those that decline levels of resilience, such as NRC (Pargament et al., 2011). Religious and spiritual variables represent some of the most understudied in children and adolescent CSA survivors (Gower et al., 2020; Pargament et al., 2013). Given the dearth of research, the detrimental impact of CSA, and the critical period of child and R/S development, my study sought to qualitatively explore mental health practitioners' experiences with resilience and how they understood the role of R/S coping in their work with children who experienced CSA. A phenomenological qualitative design was selected due to the scarcity of research on R/S coping in children, allowing for an expanded understanding of resilience and R/S coping that may guide future research. Direct qualitative inquiry with children may present investigational challenges, thus mental health practitioners were selected due to their regular interaction with child clients experiencing CSA and their expertise in trauma, child development, and mental health outcomes.

Five research questions grounded this study and explored practitioner experience with resilience, the role of R/S coping in resilience development, aspects of R/S coping that made the largest contribution to resilience and how practitioners facilitate R/S coping in clinical practice. Interviews with fifteen mental health practitioners who regularly work with sexually abused child clients resulted in several themes. Regarding resilience, practitioners revealed their resilience mindset and their experiences with resilient sexual abuse survivors creating three themes. Two themes emphasized the role of external assets such as nurturing and supportive caregivers, others, and supportive group activities. The

third resilience theme, active coping, was developed from clinician descriptions of internal resources children actively displayed that contributed to their healing. Concerning R/S coping, practitioners primarily viewed the use of R/S coping as positive and provided rich details about the way children and adolescents engaged with spiritual methods of coping. This exploration resulted in five themes and several subthemes relating to PRC and NRC. Last, I investigated mental health practitioners' facilitation of R/S coping and clinical integration, resulting in three themes. These three themes emerged from the examples provided by participants regarding the way they assess, explore, and integrate a child's religious and spiritual beliefs.

The results of this study serve to enrich the body of resilience literature, by adding the stories of mental health practitioners who work directly with child CSA survivors. Additionally, the findings inform understanding of the use of R/S coping in children, how R/S coping may foster resilience from CSA, and methods to incorporate R/S coping in mental health sessions. It is my hope that the findings from this study provide a significant contribution to the literature by illuminating the experience of resilience from CSA, highlighting the important role of R/S coping, and informing future research, interventions and outreach that can improve resilience outcomes for children who experienced CSA.

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APPENDIX A
RECRUITMENT LETTER

Date

Dear Student/ Practitioner/ Gatekeeper:

As a graduate student in the School of Psychology at Liberty University, I am conducting research as part of the requirements for a doctoral degree in Social Psychology and am writing to invite eligible participants to join my study.

Purpose of Research
The purpose of my research is to examine the lived experiences of mental health practitioners who work with children and adolescents who have experienced child sexual abuse and their experience with resilience as well as spiritual and religious coping.

Participation Requirements
1 – You must have a degree in mental health counseling of master's level or higher
2 – You must have worked with children and /or adolescent clients who have experienced child sexual abuse for a minimum of one year (at any point in your career)

Do you meet these qualifications or know someone who does? If so, then I would love to speak with you!

Procedures
Participation will involve a semi-structured interview at a date and time convenient for you. The interview with me may last from 40-60 minutes, will be conducted via the Zoom platform, and will be audio recorded. The recording will be transcribed for data collection and research purposes. All data will be removed of all identifying markers and stored in a secure location in a password protected file.
After data analysis, I will email participants a summary of the results to review. I will ask participants to make additions, corrections, and deletions within 10 days of receiving the summary. The responses may be used when discussing findings to help validate results.

Compensation
Participants will receive a $10 Amazon gift card and a raffle ticket for a $50 Amazon gift card drawing.

Interested in participating or know someone who would be?
Please respond to this message via email if you are interested in participating or know someone who may be interested at [redacted] If you agree, and are eligible to participate, a consent form will be attached to the reply email. When you receive the

consent form please print the form, sign it, and scan or take a photo of the form. Keep a copy for your records and send it back to me.

Again, if you are interested in participating or have any questions regarding this study, please email me at [redacted]

Kind Regards,

Lauren S. Hamrick, MS, EdS, LPC, RPT, CPCS

Lauren S. Hamrick, MS, EdS, LPC, RPT, CPCS
PhD Student

APPENDIX B

Consent Form

Title of the Project: A Qualitative Exploration of Practitioner Perspectives on Resilience in Children Who Have Experienced Child Sexual Abuse and the Role of Spiritual and Religious Coping
Principal Investigator: Lauren Hamrick, School of Psychology/ Doctoral Candidate, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you 1) must be a mental health provider with a minimum of a master's degree, 2) must have worked with child clients under age 18 as a mental health practitioner, and 3) must have or have had employment as a mental health practitioner at a Child Advocacy Center or have worked regularly with children who have experienced child sexual abuse for at least one year. Taking part in this research project is voluntary.

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

The purpose of the study is to explore the lived experiences of mental health practitioners and their perspectives regarding the role of resilience in children who have experienced child sexual abuse, and the way that spiritual and religious coping can influence resilience.

What will happen if you take part in this study?

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

1. Complete a demographic questionnaire. This will take no more than 5 minutes to complete. If you are participating in person, you will complete this at the beginning of our scheduled meeting, prior to the interview. If you are participating remotely, then I will email you the questionnaire, you will be asked to return it to me via email prior to our scheduled interview time.
2. Participate in a semi-structured interview via Zoom platform or face-to-face, which will take no more than one hour. Interviews will be audio-recorded.

Review the transcript of the interview to check for accuracy and confirm agreement. This will occur through email. Participants will have up to 10 days to complete the interview check.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include elevating understanding within the psychological research community regarding resilience and spiritual and religious coping in children. Additionally, practitioners' ability to work with child clients who have experienced child sexual abuse may be improved by enhancing understanding regarding factors that promote resilience in child clients. This study may contribute to a better understanding of

the positive use of spiritual and religious coping and ways it can contribute to resilience. Additional benefits include providing knowledge regarding the way practitioners may use spiritual and religious coping in therapy with their child clients and providing increased understanding regarding spiritual and religious coping to communities outside the mental health community, such as faith communities, to improve understanding regarding ways they may support children experiencing child sexual abuse in a way that fosters resilience.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. A potential risk is discomfort discussing the topic of child sexual abuse. If this topic is distressing to you, you may choose to not answer a question and may withdraw from the study at any time. As a mandated reporter, I am required to report child abuse, child neglect, elder abuse, or intent to harm self or others if I become privy to information that triggers mandatory reporting requirements.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that would make it possible to identify a participant. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential using pseudonyms. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer and in a locked filing cabinet. The data may be used in future presentations with all identifiers removed. After three years, all electronic records will be deleted, and all physical records will be shredded.
- Interviews will be recorded and transcribed. Recordings will be stored on a password-locked computer for three years and then erased. Only the researcher will have access to these recordings.

How will you be compensated for being part of the study?

Participants will be provided a $10 Amazon gift card as compensation for participating in this study. The gift card will be mailed to you or handed to you at the completion of the interview. Participants will also receive a raffle ticket to participate in a drawing for a $50 Amazon gift card. Participants will receive the raffle ticket via mail or handed to you at the completion of an in-person interview. The participant winning the raffle will receive the $50 gift card via email or US mail, as preferred. Any participant who chooses to withdraw from the study after beginning the interview, but before completing the interview, will still receive the $10 Amazon gift card and raffle ticket.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. 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 and 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 Lauren Hamrick. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted]. You may also contact the researcher's faculty sponsor, Natalie Hamrick [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 IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

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-record me as part of my participation in this study.

____

Printed Subject Name

____

Signature & Date

APPENDIX C:

DEMOGRAPHIC SURVEY

Please answer by circling the correct response,

or by filling in the blank and return to the researcher

1. Age: 20-30 31-40 41-50 50+

2. Gender: Male Female Other Prefer Not to Answer

3. Ethnicity: Black White Asian Latin+
Native American

4. Highest Level of Education: Master's Specialist Doctorate Other

5. Total years working with Children & Adolescents as a Mental Health Practitioner:

a. 0-5 **b.** 6-10 **c.** 11-15 **d.** 16-20 **e.** Over 20 years

6. State of Employment: ____________________

6. Spiritual / Religious Affiliation: Christian Jewish Muslim

Buddhist Hindu Atheist

Agnostic Other: ____________________

APPENDIX D:
INTERVIEW QUESTIONS

Introduction & Work History

1. Please introduce yourself and tell me about yourself, your training and background as a mental health practitioner who works with children and adolescents.
2. Tell me about your current position and how long you have been employed in this capacity.
3. Tell me about your work experience with children who have experienced CSA.
4. Is there a specific protocol or theory that you use when treating CSA victims? If so, please describe it.

Resilience

5. Resilience has been defined as a person's ability to "bounce back" after adversity. Please describe in as much detail as possible, a situation or situations where you have experienced /witnessed a child's ability to bounce back from CSA.
6. In your experience, how is a child who is resilient from CSA different from a child who is not resilient?
7. Please describe what you believe influences a child's ability to be resilient.
8. What are some strategies or coping skills that have helped your child clients emerge from their CSA experience resilient?

Spiritual and Religious Coping

9. Spiritual and religious coping are similar, yet different ways of coping, with spirituality being a private experience involving the connection to "sacred" or a higher power to cope and may or may not take place in an institution, and religious coping involves exploration of the "sacred" that involves leaning on a more instituted set of religious beliefs to cope with adversity. Based on these definitions, how have you seen your child clients display spiritual or religious coping?
10. How have you experienced children and adolescents use spiritual and/or religious methods or ideas to heal /recover from CSA?
11. If there is mention of God/ religion - How have you experienced child/adolescent clients seeking help from God or their religion?
12. What aspects of R/S coping have helped your child clients rise above their abuse experience the most?

Encouraging the Use of R/S Coping in Treatment

13. Do you ever use R/S coping in your treatment of child clients?
14. If yes - What are some ways you have encouraged or facilitated spiritual or religious coping in your clinical work with CSA survivors?