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# Addressing Religious and Spiritual Issues in Trauma-Focused Cognitive Behavior Therapy for Children and Adolescents

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Psychologists have become increasingly concerned with the role of religion and spirituality in resolving childhood physical and sexual abuse, particularly religion-related abuse In treating victims of child abuse, trauma-focused cognitive behavior therapy has emerged as a leading treatment for recovery. In this article, we discuss the relevance of religious and spiritual issues in trauma-focused cognitive behavior therapy for children and teens Using three case studies we then present a model for assessing and treating religion and spirituality in trauma-focused cognitive behavior therapy This model focuses on the client's pre-existing religious and spiritual functioning as well as changes in religion/spirituality after abuse We suggest that this approach will assist clients from various religious and spiritual affiliations to process childhood abuse

*Keywords*: trauma-focused cognitive behavior therapy religion and spirituality, child trauma

If a child or adolescent victim of physical or sexual abuse came to therapy and asked you why God had allowed the abuse to occur, how would you respond? A number of studies have demonstrated that for many victims of childhood abuse, religious and spiritual faith is profoundly damaged as a result of the abuse, though paradoxically, many abuse survivors attempt to make use of religious and spiritual resources to cope with and make meaning of the abuse (see Walker, Reid, O'Neill, & Brown, 2009, for a review) Trauma-focused cognitive behavior therapy (TF-CBT) has emerged as the most empirically supported treatment for childhood physical and sexual abuse (for a review, see Cohen, Mannarino, Deblinger, & Berliner, 2009) Given the possibility that victims of childhood abuse may present with salient religious or spiritual issues, we suggest that psychotherapists must be prepared to competently deal with such issues in TF-CBT. In this paper, we propose a model for addressing religious and spiritual issues in TF-CBT with children and adolescents

Consider the following actual clinical examples involving religion and spirituality in the context of child abuse treatment To protect client confidentiality, we have changed identifying information (such as name and age), or used an amalgamation of clients as opposed to individuals First, consider Kristy, a 7-year old Caucasian girl who was a victim of sexual abuse by her father, a deacon within a Baptist church In attempting to intimidate her into silence about the abuse, her father told her that she would "go to Hell and God would hate her" if she ever told anyone of the abuse. Kristy was removed from the abusive situation, referred for psychotherapy, and placed in foster care, but came to view God as angry and frightening

Second, consider Isabel, a 17-year old Hispanic girl who came to psychotherapy having been a rape victim of an older adolescent outside of her family and the church. She had been raised in a religiously committed family. In addition to receiving individual treatment, she received spiritual and emotional comfort by praying, and by reading passages in the Bible that spoke of God's love and protection for her.

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Third, consider Lamar, a 10-year-old African-American boy. Lamar was brought to psychotherapy by his mother, having been the victim of a rape by an older teenage boy in his neighborhood the year before. Lamar's mother was concerned because of his increasingly angry outbursts and defiance at home—behavior problems that were not present before the rape. Although Lamar and his mother had previously been active in church, Lamar had not attended since the rape occurred. However, Lamar's mother continued to attend church and reported that she prayed for strength and for Lamar to get better.

In each of the above situations, religion and spirituality are central elements in the child or teen's clinical presentation, yet each case differed with respect to the possible role of the parent's religiousness, the potential for religion and spirituality to be an aid in healing, and the effect of the abuse on the client's personal religious and spiritual functioning. As can be seen in these examples, religion and spirituality are multidimensional constructs that warrant further explication and attention within the literature on childhood abuse.

## Religion and Spirituality Defined

Psychologists often (though not always) consider religion and spirituality to be separate and unrelated constructs. Spirituality has frequently been viewed as a personal, affective experience with the Divine, or as a search for the Sacred (e.g., Richards & Bergin, 2005). Alternatively, religiousness has typically been considered a multidimensional construct including institutional beliefs and practices in a corporate setting (Richards & Bergin, 2005). Some scholars have reconciled competing definitions of religion and spirituality by suggesting that religiousness/spirituality can be thought of as a personal, affective relationship with the Divine that occurs in a religious context (e.g., Hill & Pargament, 2003). Proponents of this position have noted (and we concur) that many lay people in the United States consider their spirituality to occur in the context of an organized religion, though some do not.

All of our case studies illustrate the interrelatedness of these concepts, though Kristy's is perhaps the best example. Kristy received teaching about God from her church. This instruction served as a foundation for a personal relationship with God that was then damaged by her father's abuse. As we will later describe, Kristy needed church teachings to help her confront the image of God that her father had left her, demonstrating the complex nature of religion and spirituality. Therefore, we will consider individual spirituality as being related to a corporate religious context throughout the paper.

## Overview of TF-CBT

In presenting our model for addressing religious and spiritual issues within TF-CBT, it is important to remember that TF-CBT has a number of treatment components, summarized using the PRACTICE acronym. According to Cohen et al. (2009), the PRACTICE acronym stands for Psychoeducation, Parental treatment, Relaxation, Affective Expression and Modulation, Cognitive Coping Skills, Trauma narrative and cognitive processing of the trauma, In-vivo desensitization to trauma reminders, Conjoint parent-child sessions, and Enhancing safety and future development. Treatment is typically preceded by one or more assessment sessions, and is often presented in a linear, session-by-session format in theory (with the parental treatment component occurring early in psychotherapy). However, these components are intended to be applied flexibly, so that psychotherapists can choose to apply one component at any point in treatment (Cohen et al., 2009).

We will introduce each of the TF-CBT components and discuss potential religious and spiritual issues to be addressed within each treatment component. In presenting this model, we acknowledge that it would be impossible to comprehensively consider every religious affiliation or ethnically diverse cultural background (or combination thereof). Rather than attempting this, we present an overarching model flexible enough so that religious and spiritual issues can be addressed for clients from a variety of religious and spiritual backgrounds as well as ethnically diverse cultures. We then highlight religious and spiritual issues for clients from varying religious and ethnic cultures. In keeping with the collaborative spirit of TF-CBT, we encourage psychotherapists to ask clients about their specific culture early in treatment (and as often as needed afterward) to learn more about their specific religious and cultural beliefs, values, and practices.

## Assessment

Prior to beginning treatment, Cohen, Mannarino, & Deblinger, (2006) encourage psychotherapists to evaluate several trauma and non-trauma related domains. First, the extent of trauma exposure should be assessed through a clinical interview or standardized assessment instruments. In addition, the nature of potential post-traumatic stress symptoms should also be assessed, and differentiated from axis I disorders such as depression or anxiety. Finally, particular attention should be paid to possible suicidal ideation or substance abuse that may occur transiently during the client's presentation.

During the assessment phase of treatment, we encourage psychotherapists to ask about client religion and spirituality. Inquiring about religion and spirituality demonstrates respect for client personal religion and spirituality in accordance with ethical principles of the American Psychological Association (Gonsiorek, Richards, Pargament, & McMinn, 2009; Hathaway & Ripley, 2009; Plante, 2009). In the context of trauma treatment specifically, Walker et al. (2009) suggested assessing the potential role of religion and spirituality in exacerbating or relieving the client's trauma-related symptoms. To do this, they proposed modifying a religious and spiritual assessment procedure originally developed by Richards and Bergin (2005) specifically for use with victims of abuse. This involves asking clients several broad, open-ended questions related to religion and spirituality during their initial assessment. If the client responds affirmatively, or if the psychotherapist suspects that client religiousness is related to the client's presenting problems (as could be the case in instances of clergy sexual abuse, for example), then this initial broad assessment should be followed up with additional assessment questions.

For example, consider a religious and spiritual assessment with Jamal, the 10-year-old African-American boy we referred to earlier, and his mother. His psychotherapist met with Lamar's mother before meeting with Lamar individually. Examples of open-ended questions that his psychotherapist asked are "is your religious faith important to you?" and "are there any religious and spiritual issues that you would like to discuss in therapy?" Lamar's mother re-

sponded affirmatively, and, as a result of this initial probe, revealed that although she was attending church, Lamar had refused to attend church since the rape, providing his psychotherapist with valuable information about their psychosocial and spiritual functioning Later, his psychotherapist asked Lamar if he had talked to God about the abuse or if he wanted to talk about God or faith during their individual sessions. Lamar stated that he wasn't sure God could help, and that he didn't want to talk about it

In addition to assessing the role of client religion and spirituality with respect to the client's presenting problems, Walker et al (2009) also suggested that respect for client religion and spirituality could be demonstrated by initially maintaining an open but supportively neutral stance toward client personal religiousness and spirituality They proposed that religious and spiritual beliefs and values may change over time as the trauma itself is processed, and urged psychotherapists to reassess these changes over time. In Lamar's case, maintaining an open but supportively neutral stance meant respecting Lamar's refusal to attend church or to discuss his feelings about God at this stage of treatment, while also allowing for the possibility that Lamar might later decide to do so

## Psychoeducation

Psychoeducation for the client and his or her parent(s) is typically the first treatment component within TF-CBT Cohen et al (2006) minimally provide information regarding the frequency of the trauma that the client has experienced, who typically experiences it, and what causes it Other common information includes common emotional and behavioral responses after trauma, the child's diagnosis itself, and aspects of available treatments

As others have noted when writing about treating religiously and ethnically diverse clients in general, psychotherapists should assess the client's level of acculturation, inquire about client concerns related to cultural differences between psychotherapist and client, and ask about any other concerns related to treatment (see Richards & Bergin, 2000; Sue & Sue, 2003, for reviews involving various religious and ethnic cultures) With parental consent and a release of information, it may be helpful to occasionally consult later in treatment with a non-offending clergy member to obtain information about the client's religious and ethnic culture Indeed, in instances of non-religion related abuse, some highly conservative religious clients might need reassurance from a clergy member that treatment is congruent with their religion

Isabel's case highlights the necessity of addressing cultural variables in the psychoeducation phase of TF-CBT Although Isabel was born in the United States and spoke both English and Spanish fluently, her parents were from Mexico Isabel was being seen in a community setting, and, during this treatment component, her psychotherapist arranged to have a translator present, then used the translator to help provide psychoeducation For example, several weeks after the rape, among other symptoms, Isabel had become increasingly irritable and angry at home Using the translator, her psychotherapist explained that this was a common emotional reaction after trauma This helped her parents to understand Isabel's other trauma reactions better, and to feel that psychotherapy could be beneficial

In addition to addressing ethnic cultural considerations, clients should also be informed that it is common for people to have difficulty maintaining their spiritual beliefs when threatened by experiences such as abuse, a phenomenon that some have referred to as spiritual struggle (see Pargament, Murray-Swank, Magyar, & Ano, 2005, for a review). According to Pargament et al , spiritual struggles may take several forms including intrapsychic (such as religious doubts about the nature of God), interpersonal (for example, conflicts with others at one's synagogue, mosque, or church), or with the Divine (as in questioning why God would allow events such as trauma to occur)

Kristy's case demonstrates the relevance of normalizing spiritual struggles as part of psychoeducation in TF-CBT Kristy came to psychotherapy projecting her relationship with her abusive father onto her experience of God Her psychotherapist was able to normalize this for Kristy, and in doing so, enabled Kristy to begin to question her wrathful and angry image of God Later in treatment her psychotherapist was able to explicitly question and correct Kristy's God image.

## Parenting Skills

As Cohen et al (2006) point out, when children presenting for TF-CBT demonstrate significant behavior problems, psychotherapists should assess whether the behavior problems are manifestations of the child's trauma-related symptoms, or were present prior to the traumatic event When a non-offending parent brings a child for treatment, resolving problematic child behavior may be more important to the parent than addressing trauma-related issues Such parents commonly struggle with concerns over how to discipline their children They may wonder about appropriate expectations for behavior after abuse for fear of causing further damage, or may not realize the extent to which their child's behavior is being caused by unprocessed traumatic reactions It is essential for parents to become aware of their child's need for empathic support, as well as the necessity of routine consequences for acting out behavior

Published TF-CBT protocols emphasize the treatment of externalizing behavior in the parenting skills components Cohen et al (2009) review four behavior management strategies recommended to address child behavior problems within TF-CBT These four strategies are (1) praise, (2) selective attention, (3) time-out, and (4) contingency reinforcement programs

Psychotherapists should be aware that highly religious parents often imbue their parenting role with sacred significance–a process some have referred to as sanctification of parenting (Mahoney, Pargament, Murray-Swank, & Murray-Swank, 2003) Because religiously committed parents frequently view their role as a sacred calling, it can be important for psychotherapists to help them understand parent training in light of that importance Parent training with Lamar's mother illustrates this point Since she self-identified as an active member of an African American church, her psychotherapist engaged her in the process of parent training by using a story from her religious tradition—the Parable of the Talents (Matt 25:14-30, New International Version Bible, 1993).

In this parable, two tenants are given additional responsibility after demonstrating that they are capable of appropriately managing a small amount of responsibility This idea is consistent with the notion of allowing children to earn more rewarding privileges after demonstrating compliance with a range of smaller parental requests Explaining contingency management in this way was

congruent with Lamar's mother's view of her parenting role as a sacred calling. She readily engaged in parent training, and, within a few weeks, Lamar's behavior gradually improved. Parents from other religions such as Judaism or Islam could be helped to view secular behavior management interventions in a similar way using references to their own religions. This could be done with the assistance of the parent or (with a release of information) in consultation with a clergy member from their religion.

## Relaxation

The standard protocol for TF-CBT involves the teaching of focused breathing, mindfulness, and meditation to alleviate trauma reactions that are creating stress reactions for the client (Cohen et al., 2006). According to Cohen et al., this component is typically taught using a structured script in which children are taught to engage in "belly breathing" by closing one's eyes and breathing in through one's nose. This allows the stomach to expand, followed by exhaling and pulling in the stomach. During the process in TF-CBT, children are also taught to refocus their thoughts on their breathing patterns as opposed to allowing their thoughts to wander. This process helps children of various ages to relax while focusing their attention on the relaxation itself, allowing for generalization of the experience beyond the therapy setting.

Mindfulness practices are inherently compatible to some degree with religious traditions that incorporate meditative practices as part of a person's spirituality (Siegel, 2007). Some religious traditions might require minimal modification for these practices to fit within their normal spiritual practices. For example, Buddhism encourages mindfulness meditation as part of their spiritual practices. This may be particularly relevant for Asian-American clients, a number of whom practice Buddhism (Iwamasa, Hsia, & Hinton, 2006).

Other religious traditions might require some further degree of modification. Highly conservative parents from monotheistic religions (Judaism, Islam, or Christianity) might be alarmed at the idea that their child's psychotherapist is teaching them to meditate without a focus on the Divine (i.e., Yahw-h, Allah, or Jesus). Such parents could be put at ease by modifying the standard practice to include such a focus.

Considering the example of Isabel, as a Pentecostal client, she was encouraged to pray the "Jesus prayer" while engaging in deep breathing. This prayer is found in the New Testament, and involves praying "Lord Jesus, have mercy on me". Isabel completed the prayer, both in session and at home during times when she became anxious in thinking about the rape. She reported that praying in this way helped her to focus on Jesus, and to feel more peaceful and relaxed. Similar modifications of standard meditative techniques have been reported in the literature for adult Islamic clients (Khalid, 2006), and could be used with children and teens.

## Affective Expression and Modulation

This portion of the standard manualized TF-CBT treatment protocol involves teaching feeling identification, thought interruption, and positive imagery to child and adolescent clients, as well as teaching affective expression to their parents (Cohen et al. 2006). As they indicate, there are several ways to help child clients of various ages express their feelings. One game involves asking the child to identify as many feelings as they can within a specific time frame (such as two or three minutes). Afterward, the psychotherapist and child choose different feelings and share times when they felt that way. Cohen et al. also describe the "Color Your Life" technique in which the psychotherapist asks the child to choose different crayon or marker colors to represent separate feelings before filling in an outline of a human figure to show where the child experiences each emotion.

Thought interruption and the use of positive imagery are other cognitive behavioral techniques that are utilized within this segment of the TF-CBT treatment manual. Cohen et al. (2006) describe stopping an unwanted thought using either verbal means (such as telling a thought to "go away") or physical means (such as snapping a rubber band on one's wrist). These thoughts are then replaced with positive imagery in the form of a special event, place, or experience. Children are also taught to practice positive self-talk within this part of the treatment module, a skill that is built upon in the later treatment components.

Several specific cognitive-behavioral techniques used in TF-CBT are compatible with broader elements of religion and spirituality across religious affiliations (see Tan & Johnson, 2005, for a review). We believe that thought stopping, positive imagery, and coping self-talk could all be potentially more powerful if stories, songs, or passages from sacred texts from the client's personal religious tradition were incorporated into treatment. If clients are unable to generate these sorts of images from their personal faith traditions on their own, they could be encouraged to ask a non-offending clergy member from their religious or cultural tradition for assistance without disclosing the specific reason for asking. If necessary, the psychotherapist may obtain informed consent and assent from the client and his or her parent in order to consult with a clergy member to identify potentially helpful passages to be incorporated in treatment.

For example, Nielsen (2004) presented a case study with a 24-year-old Islamic woman (Aisha) who had been date raped while attending college. Although not a teenage client, the case illustrates the use of a sacred text in teaching positive self-talk to clients. During the course of treatment, it became apparent that Aisha blamed and condemned herself for the rape. Although not a Muslim himself, Nielsen read passages from the Qu'ran that indicated to him that, within her religious tradition, Allah alone was responsible for judgment. Nielsen then challenged Aisha's right to condemn herself for the rape using those passages from the Qu'ran.

Returning to the earlier case examples, Isabel's psychotherapist engaged in a similar process. Isabel had been raped while at a friend's house. Prior to the rape, in keeping with her religious tradition, she had embraced sexual abstinence before marriage. Now, she worried that she was damaged and unlovable. In addressing her fears, her psychotherapist helped her to identify passages in the Bible that spoke to God's unconditional love for her. Similar passages from the Torah or the Quran could be identified in therapeutic collaboration with Jewish or Islamic clients, and adapted for the client's developmental level. Sacred texts can be used to challenge and replace dysfunctional thoughts in the later TF-CBT cognitive coping and processing components as well.

## Cognitive Coping and Processing I

At the broadest level, this portion of the TF-CBT manual involves three steps. Building on the teaching of self-talk in the previous component, psychotherapists help clients to see the relationship between their thoughts (reflected in their self-talk), behaviors and feelings (Cohen et al., 2006). Afterward, children replace maladaptive thoughts with alternative thoughts that could lead to more positive feelings and behavioral outcomes. Cohen et al. encourage psychotherapists to focus on non-trauma related thoughts at this stage in treatment, as trauma-related cognitions will be identified through the telling of the trauma narrative and corrected during the second round of cognitive coping and processing.

This treatment component builds on the preceding TF-CBT components to prepare the client to discuss the trauma narrative itself, a process that is usually intense for most clients. People often use religious and spiritual resources to cope with trauma (Pargament, Ano, & Wachholtz, 2005). However, some children and teens have cognitive distortions related to religion and spirituality that must be addressed during this TF-CBT component before they can discuss their trauma or utilize religious or spiritual resources to cope with the stress of describing the abuse in the trauma narrative component. For example, in Kristy's treatment, her father's religious threats needed addressed before she could talk about the actual abuse. Kristy believed that God would abandon her and be angry with her if she discussed the abuse with her psychotherapist. In addressing her fears, Kristy and her psychotherapist engaged in a collaborative process whereby they identified the discrepancies between the God described by her father and what Kristy learned about God at church. This provided a foundation to challenge many of the other harmful statements her father had made to her. Despite the correction of cognitive distortions related to religion in this case example, psychotherapists should be aware of the power of cultural injunctions against disclosing abuse from various religions (see Frawley–O'Dea, 2007; Lev, 2003; Plante, 1999 for reviews).

## Trauma Narrative

Prior to creating a trauma narrative, Cohen et al. (2006) suggest first discussing with the child the need to talk about the abuse to resolve the child's ambivalence about speaking about it. After processing the need to discuss the abuse, they typically read a psychoeducation book written for childhood victims of trauma before beginning the trauma narrative itself. Next, they have the child create a book about the trauma, beginning with non-trauma related events in the child's life. Cohen et al. recommend having the child relate the least threatening aspects of the abuse before building up to the worst moments involved. The psychotherapist is encouraged to ask the child to include in the book aspects of the trauma that they thought they would never tell anyone. Cohen et al. also suggest asking the child to identify what they were thinking and feeling during those moments.

Although a book is often made to tell the trauma narrative, it is also possible to have children create a song or a poem, or to construct a book as a series of pictures as opposed to a number of written chapters. For example, some African-American men reporting retrospectively on their abuse indicated that creating a song was helpful to them in communicating the personal significance of the abuse and helping them to resolve it (Bryant-Davis, 2005).

Prior to concluding the narrative, Cohen et al. (2006) encourage the psychotherapist to ask the child to write about what is different in his or her life since the abuse and since psychotherapy began. To help the child integrate the trauma into his or her own experience, children are also asked to reflect on what they have learned and what advice they might give to other children in a similar situation. Afterward, the psychotherapist explores trauma-related cognitive distortions that need to be corrected in the second cognitive coping and processing section.

Because the primary purpose of the trauma narrative is to help the client integrate the traumatic experience into his or her life, we also suggest exploring parallels to their own narrative in stories from their religions, perhaps using a sacred text(s) as a guide. Most religious traditions have stories that serve to make meaning of suffering and overcome adversity through faith. Gaining a spiritual and emotional connection with such stories might help clients of various ages to make meaning out of their own experience of suffering, if processed in an age-appropriate way.

For example, in attempting to resolve spiritual struggles, some have suggested that the story of Job might be particularly beneficial for Jewish and Christian clients to discuss in psychotherapy (Pargament, Murray-Swank et al., 2005). The book of Job is an ongoing discussion between Job and God about Job's suffering. In a related vein, psychotherapists treating Buddhist children and teens could consider explicitly asking them to meditate upon the Buddha's Four Noble Truths as they relate to the traumatic experience. Also, Islamic clients could be helped to view their suffering as a temporary condition that will later be rewarded by Allah (Hamdan, 2008).

Rather than attempting to answer for a client why God might have allowed his or her suffering, we view the role of the psychotherapist as one in which they bear witness to the client's spiritual struggles related to meaning, purpose of the trauma, and suffering. We discourage psychotherapists from attempting to answer those questions for the client. Rather, we suggest that clients might be significantly helped in processing their feelings about God if encouraged to ask God how God could have allowed the abuse to occur, and by inviting the client to write down thoughts about how God may respond to those questions. Psychotherapists could also consider asking the client where Yahw-h, God (or Jesus), or Allah was during the trauma, and how Yahw-h, God, or Allah feels about it. This could also be done using an empty chair technique in which the client alternates between asking God questions and stating what they think God's responses would be (Walker et al., 2009).

Such a discussion could occur as part of a trauma book in which the client draws his or her idea of Heaven or draws a personal image of God and has an ongoing discussion with God in the trauma book. For example, Kristy and her psychotherapist decided to complete a trauma narrative by making a story book in which the psychotherapist wrote what Kristy described while Kristy drew the pictures. During her telling of the trauma narrative, Kristy talked with her psychotherapist about where God was when the abuse occurred. In contrast to her fears about God before the initial cognitive coping and processing component, Kristy decided that God should be represented as a star in the sky, helping her in the midst of the abuse.

## Cognitive Coping and Processing II

During this part of treatment the psychotherapist identifies, explores, and corrects trauma-related cognitive errors For example, Cohen et al. (2006) note that children often believe they should have been able to prevent the trauma, and that the world will never be safe again following abuse. We encourage psychotherapists to explore trauma-related cognitive errors that have religious or spiritual content For example, in asking about God during the client's trauma narrative, some religiously committed clients could have discussed maladaptive cognitions with a religious content (e.g., "What sin did I commit to deserve this?")

Furthermore, we believe that it is more probable that clients will discuss religious and spiritual issues if they have experienced religion-related abuse as part of the traumatic experience itself. For example, some clients might have been physically or sexually abused by a parent or clergy member who used sacred writings to justify the abuse. In these instances, we feel that it is particularly important for psychotherapists to inquire about religious and spiritual cognitions related to the abuse, so that these cognitions can be challenged (e g, "The Bible doesn't say that mommy can hit you—we have laws against that" or "You don't have to do everything an authority figure tells you to do if it makes you feel uncomfortable or you know that it is wrong"). As we indicated in the first cognitive coping section, confronting religious cultural beliefs about child abuse or parental rights with children may be particularly important.

Returning to Kristy's case example, as we noted earlier, several cognitive errors related to her image of God needed correction before she could even discuss the abuse with her psychotherapist. In addition, one of Kristy's other problems was being in foster care and no longer attending her church. Although, as Cohen et al. (2006) indicate, some children wonder if the world will ever be safe again, Kristy worried if God knew where she was and continued to care for her. In addressing her concerns, Kristy's psychotherapist reflected to her that most people would agree that God is everywhere and knows everything that we do. Her psychotherapist also reassured her that God was with her all of the time, and that Kristy could talk with God whenever she wanted to simply by praying. This helped her to cope more effectively with being in foster care.

## In Vivo Exposure

Cohen et al. (2006) point out that some reactions to threatening situations serve the purpose of protecting people. For example, when confronted by an assailant with a weapon, the accompanying anxiety is adaptive. Thus, Cohen et al. suggest that the purpose of in vivo exposure is to prevent generalization of anxious reactions to nonthreatening stimuli in situations that are not adaptive (e g, a child who was sexually abused in her bedroom at a previous house refusing to sleep in a bedroom in an entirely new home).

In incorporating religion and spirituality into treatment, we encourage psychotherapists to consider whether some form of mindfulness meditation or prayer might help children to soothe themselves while allowing exposure to the feared stimulus (in the above example, the new bedroom). For example, Follette, Palm, and Pearson (2006) have suggested that a mindful form of meditation (often associated in the Western world with Buddhism) could be helpful for adult clients in addressing avoidance symptoms or emotional dysregulation in the presence of threatening stimuli. Alternatively, some parents (and children) might feel more compelled to participate in the in vivo exposure if the psychotherapist discussed writings from sacred texts that encourage the believer to live a courageous life and to not be afraid. Finally, clients could also pray for strength in the context of exposure to threatening situations.

This approach to addressing religion and spirituality in TF-CBT is most appropriate with clients who are using their religion and spirituality to cope with the traumatic event. Thus, of the examples that we cited, this approach would be most appropriate for Isabel. In the actual case, Isabel chose to pray and recite a verse from the Bible that gave her strength. Clients from other religious traditions could assist their psychotherapist in identifying passages from sacred texts that give them strength and courage.

## Conjoint Sessions with Parents and Children

According to Cohen et al. (2006), the purpose of the conjoint sessions is to improve the child's ability to talk with his or her parent about the trauma, as well as address any issues that the parent and child want to discuss. Simply put, the psychotherapist facilitates the parent hearing the child's trauma narrative as well as an open discussion between parent and child about the narrative. We believe that if the client has been assessed and religion and spirituality are relevant to the case then psychotherapists should encourage an open discussion between the parent and child as to the spiritual meaning of the trauma for both parties. This discussion allows for mutual support and spiritual healing. Such a discussion also allows the family to process questions related to meaning and suffering, and to allow parents to voice their feelings about God and how God may feel about the abuse.

From the cases that we have cited as examples, consider the potential benefit of openly discussing religious and spiritual issues in a conjoint session with Lamar and his mother. Having this discussion allowed Lamar to express his anger at God for allowing the rape to occur, as well as offering him a chance to hear his mother's prayers for his healing. During these sessions, she also expressed her anger at his rapist, which helped Lamar feel supported. Discussing the meaning of the abuse with his mother appeared to help Lamar return to his previous functioning in a number of areas. Afterward, Lamar suddenly began attending youth activities at his church. When the first author asked about his attendance at church, Lamar simply stated that he felt like going back.

## Safety Planning and Future Development

This treatment component focuses on developing specific skills for safety planning. The first step in safety planning is to help children learn to verbalize their feelings in range to a variety of situations, so that they can report it if they are victimized in the future (Cohen et al., 2006). Next, children are helped to identify external warning signs that abuse might occur (such as a physically abusive parent becoming angry), and to pay attention to internal warning signs (such as feeling one's stomach tighten). Afterward, the psychotherapist typically models and role plays appropriate responses for keeping oneself safe in a variety of threatening situations.

We wish to highlight ways in which religion and spirituality can be used to enhance a child's sense of safety in general. However, this aspect of treatment necessarily involves practical safety planning to assist the child should a specific danger (such as abuse from a non-custodial parent) re-occur. We in no way wish to minimize the importance of this aspect of treatment and have in fact engaged in safety planning quite early in treatment with our own clients when prudence suggested doing so.

However, in addition to these practical ways to enhance a child's sense of safety, our clinical experience has been that, for some children and teens, creating a nighttime ritual involving prayer often helps to foster a sense of safety within religiously committed families. We have had several preschool-aged clients who took comfort in praying with a parent, though the practice of prayer has been powerful for clients of various ages. Returning to our case examples earlier, in IF-CBT with Isabel, she also reported that praying at night made her feel safe.

## Conclusion

Earlier, we provided several case examples involving religion and spirituality. Through our discussion, we have demonstrated the importance of several religious and spiritual issues in treatment, including the role of parental religiousness, how religion and spirituality may aid in healing, and the effects of the abuse on the client's personal religious and spiritual functioning. Though Kristy's faith was damaged as a result of the abuse, it was repaired during the course of psychotherapy and used as a resource for healing. Isabel's faith had not been damaged, and was used to cope and make meaning of the abuse. Finally, Lamar's faith was damaged, but repaired through the process of working through the abuse itself.

We believe that trauma psychotherapists may undergo a particular challenge maintaining their personal religious faith or spirituality in the face of child physical and sexual abuse. We commend psychotherapists who are willing to enter into a world of pain and suffering with children and teens of various ages. Beyond the goal of symptom reduction, we hope that the approach that we have advocated promotes meaning and hope for both psychotherapists and clients within their faith tradition.

## References


Bryant-Davis, T. (2005). Coping strategies of African American adult survivors of childhood violence. *Professional Psychology: Research and Practice, 36,* 409–414.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York: Guilford Press.

Cohen, J. A., Mannarino, A. P., Deblinger, E., & Berliner, L. (2009). Cognitive-behavioral therapy for children and adolescents. In E. B. Foa, T. M. Keane, M. J. Friedman, & J. A. Cohen (eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (pp. 223–244). New York, NY: Guilford Press.

Follette, V., Palm, K. M., & Pearson, A. N. (2006). Mindfulness and trauma: Implications for treatment. *Journal of Rational-Emotive and Cognitive-Behavioral Therapy, 24,* 45–61.

Frawley-O'Dea, M. G. (2007). *Perversion of power: Sexual abuse in the Catholic church.* Nashville, TN: Vanderbilt Press.

Gonsiorek, J. C., Richards, P. S., Pargament, K. I., & McMinn, M. R. (2009). Ethical challenges and opportunities at the edge: Incorporating spirituality and religion into psychotherapy. *Professional Psychology: Research and Practice, 40,* 385–395.

Hamdan, A. (2008). Cognitive restructuring: An Islamic perspective. *Journal of Muslim mental health, 3,* 99–108.

Hathaway, W. L., & Ripley, J. S. (2009). Ethical concerns around spirituality and religion in clinical practice. In J. Aten and M. Leach (Eds.), *Spirituality and the therapeutic process: A comprehensive resource from intake to termination* (pp. 25–32). Washington, DC: American Psychological Association.

Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization of and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist, 58,* 64–74.

Iwamasa, G. Y., Hsia, C., & Hinton, D. (2006). Cognitive-behavioral therapy with Asian Americans. In P. A. Hays and G. Y. Iwamasa (Eds.), *Culturally responsive cognitive behavioral therapy: Assessment, practice, and supervision* (pp. 117–140). Washington, DC: American Psychological Association.

Khalid, S. (2006). Counselling from an Islamic perspective. *Healthcare counseling and psychotherapy journal, 6,* 7–10.

Lev, R. (Ed.). (2003). *Shine the light: Sexual abuse and healing in the Jewish community.* Boston, MA: Northeastern University Press.

Mahoney, A., Pargament, K. I., Murray-Swank, A., & Murray-Swank, N. (2003). Religion and the sanctification of family relationships. *Review of Religious Research, 40,* 220–236.

Nielsen, S. N. (2004). A Mormon rational-emotive behavior therapist attempts Qur'anic rational emotive behavior therapy. In P. S. Richards and A. E. Bergin (Eds.), *Casebook for a spiritual strategy for counseling and psychotherapy* (pp. 213–230). Washington, DC: American Psychological Association.

New International Version Bible. (1993). Grand Rapids, MI: Zondervan.

Pargament, K. I., Ano, G. G., & Wachholtz, A. B. (2005). The religious dimension of coping: Advances in theory, research, and practice. In R. F. Paloutzian and C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 479–495). New York, NY: Guilford Press.

Pargament, K. I., Murray-Swank, N. A., Magyar, G. M., & Ano, G. G. (2005). Spiritual struggle: A phenomenon of interest to psychology and religion. In W. R. Miller and H. D. Delaney (Eds.), *Judeo-Christian perspectives on psychology: Human nature, motivation, and change* (pp. 245–268). Washington, DC: American Psychological Association.

Plante, T. G. (Ed.). (1999). *Bless me father for I have sinned: Perspectives on sexual abuse committed by Roman Catholic priests.* Westport, CT: Praeger Publishing.

Plante, T. G. (2009). *Spiritual practices in psychotherapy: Thirteen tools for enhancing psychological health.* Washington, DC: American Psychological Association.

Richards, P. S., & Bergin, A. E. (2000). *Handbook of psychotherapy and religious diversity.* Washington, DC: American Psychological Association.

Richards, P. S., & Bergin, A. E. (2005). *A spiritual strategy for counseling and psychotherapy* (2nd ed.). Washington, DC: The Psychological Association.

Siegel, D. J. (2007). *The mindful brain: Reflection and attunement in cultivation of well-being.* New York, NY: WW Norton and Company.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice.* New York, NY: Wiley & Sons.

Tan, S. Y., & Johnson, W. B. (2005). Spiritually oriented cognitive-behavioral therapy. In L. Sperry & E. P. Shafranske (Eds.), *Spiritually oriented psychotherapy* (pp. 77–103). Washington, DC: American Psychological Association.

Walker, D. F., Reid, H. W., O'Neill, L., & Brown, L. (2009). Changes in personal religion/spirituality during recovery from childhood abuse: A review and synthesis. *Psychological Trauma: Theory, Research, Practice, and Policy, 1,* 130–145.


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