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Solace for the Soul: Evaluating a Spiritually-integrated Counselling Intervention for Sexual Abuse

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Abstract

This pilot study examined the effectiveness of a manualized 8-session, spiritually-integrated counselling intervention for female survivors of sexual abuse. Participants completed a comprehensive assessment of psychological and spiritual functioning at baseline, after session 4, post-intervention, and at a 1-2 month follow-up. The four participants demonstrated significant decreases in psychological distress and trauma symp-

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toms across time. In addition, two participants with significant spiritual struggles increased their spiritual well-being by the end of the intervention and at follow-up. Spiritually-integrated counselling interventions, such as Solace for the Soul: A Journey Towards Wholeness show promise in facilitating both psychological and spiritual recovery from sexual abuse.

Résumé

Consolation pour l'âme: évaluation d'une intervention intégrant la spiritualité en abus sexuel

Cette étude pilote examine l'efficacité de 8 sessions (standards) en counseling et spiritualité auprès des femmes survivantes d'abus sexuels. Les participantes ont complété une évaluation compréhensive de leur fonctionnement psychologique et spirituel de base après 4 sessions, une post-intervention et un suivi après 1 ou 2 mois. Les quatre participants ont démontré des baisses significatives au fil du temps de leur détresse psychologique et des symptômes traumatisants. De plus, deux participantes ayant des combats spirituels majeurs ont augmenté leur bien-être spirituel à la fin de l'intervention et dans le suivi. Les interventions en counseling intégrant la spiritualité, comme « Consolation pour l'âme » : un chemin vers l'intégralité, sont prometteuses en ce qui concerne la récupération psychologique et spirituelle dans les cas d'abus sexuels.

Sexual abuse is a prevalent occurrence in the lives of children and adults. Researchers have demonstrated that between 15-70% of females and 3-29% of males have experienced various forms of sexual trauma, ranging from unwanted exposure to sex organs to repeated experiences of rape (e.g., Finkelhor, 1994; Putnam, 2003). In a meta-analysis, the prevalence of childhood sexual abuse averaged 27% for college females and 14% for college males (e.g., Rind, Tromovitch, & Bauserman, 1998). Sexual abuse has been associated with numerous psychological difficulties: depression, post-traumatic stress disorder, dissociative disorders, immune dysfunction, interpersonal difficulties, suicidality, revictimzation, substance abuse, and sexual dysfunction (e.g., Beitchman et al., 1992; Browne & Finkelhor, 1986; Davis & Petretic-Jackson, 2000; Trickett et al., 2001). In a review of 38 published studies, Neumann and colleagues (1996) concluded that childhood sexual abuse was a significant risk factor for the development of adult psychological problems in affective, behavioral, and identity/relational domains.

In addition to the increased ri researchers have started to illu abuse. On the one hand, sexual development of spiritual struggle found associations between sexu being, increased spiritual injury, less stability in religious practices of God (e.g., Chibnall, Wolf, & Heckman, 2005; Kane, Cheston, Pritt, 1998). In general, survivors ness and are less involved in organ Doxey, Jensen, & Jensen, 1997; Fi note, the movement away from spiritual struggle if the survivor is about this in his/her life.

The presence of spiritual struggles psychological well-being. For exar feeling punished and abandoned decreased physical and mental hea Rybarczyk, DeMarco, & Nicholas, 1 1998; Pargament et al., 1998; Pa Hahn, 2001; Smith, Pargament, B anger towards God and alienation f increased depression and anxiety Exline, Yali, & Sanderson, 2000). sexual abuse, spiritual discontent predictive of a greater depressive m

On the other hand, many survivors ity as a valuable coping resource, tu communities during difficult times (have demonstrated that survivors of ality as an important coping resour Falsetti, Resick, & Davis, 2003; K Valentine & Feinauer, 1993). Incr been significantly related to increase involves all of my life"), spiritual sup coping (e.g., Grace & Piedmont, 20 al., 1998; Leitenberg, Greenwald, &

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Spirituality and Sexual Abuse

In addition to the increased risk of psychological concerns, recent researchers have started to illuminate the spiritual realm of sexual abuse. On the one hand, sexual abuse creates a fertile ground for the development of spiritual struggles. In support of this, researchers have found associations between sexual abuse and decreased spiritual well-being, increased spiritual injury, increased negative religious coping, less stability in religious practices and beliefs, and more negative images of God (e.g., Chibnall, Wolf, & Duckro, 1998; Hall, 1995; Fallot & Heckman, 2005; Kane, Cheston, & Greer, 1993; Lawson et al., 1998; Pritt, 1998). In general, survivors of sexual abuse endorse less religiousness and are less involved in organized religion than nonsurvivors (e.g., Doxey, Jensen, & Jensen, 1997; Finkelhor et al., 1989; Hall, 1995). To note, the movement away from organized religion only represents a spiritual struggle if the survivor is ambivalent, confused, or conflicted about this in his/her life.

The presence of spiritual struggles may lead to poor physical health and psychological well-being. For example, negative religious coping (e.g., feeling punished and abandoned by God) has been associated with decreased physical and mental health across diverse samples (Fitchett, Rybarczyk, DeMarco, & Nicholas, 1999; Koenig, Pargament, & Nielsen, 1998; Pargament et al., 1998; Pargament, Koenig, Tarakeshwar, & Hahn, 2001; Smith, Pargament, Brant, & Oliver, 2000). In addition, anger towards God and alienation from God have been associated with increased depression and anxiety (e.g., Exline, Yali, & Lobel, 1999; Exline, Yali, & Sanderson, 2000). In a study of survivors of childhood sexual abuse, spiritual discontent (e.g., abandonment by God) was predictive of a greater depressive mood (Gall, 2006).

On the other hand, many survivors of traumatic events rely on spirituality as a valuable coping resource, turning to God/the Divine and faith communities during difficult times (see Pargament, 1997). Researchers have demonstrated that survivors of sexual abuse frequently use spirituality as an important coping resource (e.g., Fallot & Heckman, 2005; Falsetti, Resick, & Davis, 2003; Kennedy, Davis, and Taylor, 1998; Valentine & Feinauer, 1993). Increased severity of sexual abuse has been significantly related to increased prayer, religiosity (e.g., "my faith involves all of my life"), spiritual support, and positive forms of religious coping (e.g., Grace & Piedmont, 2004; Falsetti et al., 2003; Lawson et al., 1998; Leitenberg, Greenwald, & Cado, 1992).

In addition, turning to spiritual beliefs and practices may be helpful to survivors of sexual abuse. For example, in a study focused on spiritual coping among survivors of childhood sexual abuse, seeking spiritual support, active surrender, and seeking religious forgiveness were associ-

ated with less angry and depressed moods (Gall, 2006). Additionally, spiritual coping predicted unique variance in the prediction of negative mood states above and beyond demographics, abuse characteristics, cognitive appraisals, and support satisfaction (Gall, 2006). In general, methods of positive religious coping (e.g., forming a collaborative relationship with God, seeking spiritual support) have been related to better mental health, increased stress-related growth, lower levels of mortality, and less hostility in people struggling with major life events (e.g., Bush et al., 1999; Koenig et al., 1998; Pargament, Koenig, & Perez, 2000; Thompson & Vardaman, 1997).

To summarize, spirituality can be both a resource and burden in coping with sexual abuse. Religion and spirituality can enhance the coping process for individuals struggling with the impact of sexual abuse, leading to improved health. In contrast, spirituality may create unique challenges while coping with the effects of sexual abuse, threatening and potentially harming spiritual, physical, and emotional health. Overall, the complex and multi-faceted role of spirituality is important to consider when working with sexual abuse survivors. Despite recent advances in the treatment of PTSD, most current treatment approaches do not integrate spirituality as a substantive component. The purpose of the development of *Solace for the Soul: A Journey Towards Wholeness* (Murray-Swank, 2003) aimed to address this neglected aspect of recovery.

Solace for the Soul: A Spiritually-integrated Counselling Intervention

Solace for the Soul: A Journey Towards Wholeness (Murray-Swank, 2003) was developed to address both the spiritual struggles that can result from sexual abuse, as well as to enhance spiritual coping and spiritual well-being. This counselling intervention reflects a non-denominational perspective that is rooted in a theistic, spiritual worldview. Therefore, it was designed for individuals with a spiritual belief system that included a concept of God/Higher power/Divinity in life. More specifically, it integrates humanistic, cognitive-behavioral, and emotion-focused therapeutic paradigms within a spiritual coping framework. *Solace for the Soul* addresses six themes related to sexual abuse: Images of God/Higher power, spiritual struggles such as abandonment and anger at God, spiritual connection, shame, the body, and sexuality. Overall, the counselling intervention includes focused breathing/mindfulness, opening and closing prayers, spiritual imagery, poems and reflections, two-way journaling to God/Higher power, spiritual rituals, and discussion throughout the eight sessions. For more specific information on each session, please refer to Table 1. This spiritually-integrated intervention extends beyond traditional approaches by integrating both

psychological and spiritual com
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Solace for the Soul: A.

Session Number
Session 1: Solace for the Soul
Session 2: Who is my God?
Session 3: God, Where are You?
Session 4: Spiritual Connection
Session 5: Letting Go of Shame
Session 6: God's Beautiful Creation
Session 7: Restoring Sexual Wholeness
Session 8: Moving Forward

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The primary aim of this pilot study
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psychological and spiritual components as substantative elements in the counselling process (see Murray-Swank, 2003).

Table 1

Solace for the Soul: A Journey Towards Wholeness

Session Number	Session Content
Session 1: Solace for the Soul	Gain information about program Discuss goals Identify areas of strength and wholeness
Session 2: Who is my God?	Map of spiritual journeys Explore current images of God Explore varied images of God (e.g., God as a spirit of freedom; God's love as a waterfall within)
Session 3: God, Where are You?	Reflect on and express spiritual struggles (e.g., abandonment and anger at God) Two-way journaling to God Coping with spiritual struggles
Session 4: Spiritual Connection	Enhance a sense of spiritual connection with God/the Divine and others Loving kindness meditation
Session 5: Letting Go of Shame	Explore distorted cognitions about the self Reduce shame-based views Use spiritual affirmations and rituals to reduce feelings of shame
Session 6: God's Beautiful Creation	Restore healthy connection to body Reduce body disparagement and loathing Use spiritual affirmations to counter negative thoughts about the body
Session 7: Restoring Sexual Wholeness	Increase ability to say no in sexuality Decrease sexual dysfunction Use spiritual affirmations and exercises to separate the abuse from the positive nature of sexuality Enhance sacredness in sexuality
Session 8: Moving Forward	Solidify progress Plan for future areas of growth

Current Study

The primary aim of this pilot study was to evaluate the effectiveness of *Solace for the Soul* as a counselling program for female survivors of sexual abuse. Overall, it was expected that participation in the spiritually-integrated intervention would result in decreased psychological distress and trauma symptoms across time, as well as a more positive connec-

tion with God/Divinity, improved spiritual well-being, and increased use of positive religious coping methods. In addition, we hypothesized that participants would report decreased spiritual distress and use of negative religious coping across time. In summary, the current study extends research on effective interventions for survivors of sexual abuse by including spirituality as an important dimension in the counselling process.

Method

Procedures

Advertised as an adjunct treatment for individuals in ongoing psychotherapy, therapists at community agencies in the Midwest referred clients to the program. Interested clients called the investigator to schedule a screening interview. At the screening interview, potential participants learned about the spiritually-integrative counselling intervention and research, and written informed consent to participate was obtained. The project was reviewed by the Human Subjects Review Board at a large, Midwestern University.

Two therapists conducted individual weekly counselling sessions with the participants, following the structure of the manualized intervention: *Solace for the Soul: A Journey Towards Wholeness* (see Murray-Swank, 2003). Sessions ranged from 1.5-2 hours each time. Participants completed comprehensive questionnaires at the beginning of the baseline period (T1), after Session 4 (T2), at the end of the spiritually-integrated intervention (T3), and at 1-2 month follow-up (T4).

Participants

Five adult female survivors of sexual abuse (ages 28-49) were referred from mental health agencies in the Midwest to participate in the spiritually-integrated intervention, *Solace for the Soul: A Journey Towards Wholeness* (Murray-Swank, 2003). The initial screening session allowed interested participants to gain more information about the program and to decide if they wanted to participate. Individuals who believed in some form of a God/Higher power, and who stated that they were comfortable discussing spiritual content and using spiritual approaches, were included in the spiritually-integrated program. Exclusion criteria included individuals who had been exposed to sexual trauma within the previous two months, active psychoses, and imminent suicidality. One potential participant was excluded from this study due to psychosis, resulting in four clients who completed the intervention.

All participants reported either childhood and/or adolescent sexual abuse, with three out of the four experiencing family-perpetrated childhood incest. The females in thi
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More specifically, Client One
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Client Two was a 33-year-old,
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Client Three was a 39-year-old C
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From the ages of 10-15, she expe
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Client Three reported a history of s
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Finally, Client Four was a 28-year
considered herself as "very spirit
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molestation and forced touching of
between the ages of 16-20 years ol
cluded depression and PTSD.

Measures

Demographics. Participants answer
age, marital status, number of chil
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hood incest. The females in this study reported severe and long-term sexual abuse, often starting in early childhood. Overall, the participants described themselves as very spiritual, while reporting diverse religious affiliations.

More specifically, Client One was a 39-year-old, single, Caucasian woman who described herself as "very spiritual" and "slightly religious." She chose "none" as her religious affiliation, and reported experiencing forced intercourse with her brother and sister (vaginal and oral) and weekly molestation between the ages of 5-12. Her psychological diagnoses included severe depression, PTSD, and borderline personality disorder.

Client Two was a 33-year-old, married Caucasian female with two special-needs children. She described her religious preference as "Nazarene," and considered herself "moderately religious" and "very spiritual." She attended religious services several times a week, and prayed several times a day. Client Two reported multiple perpetrators of sexual abuse, including molestation, forced touching of genitals, and attempted intercourse by her father from the ages of 9-13. In addition, a neighbor molested her at the age of 7. Finally, she reported forced exposure and touching of sexual organs by her pastor at the age of 14. Her psychological diagnoses included depression and PTSD.

Client Three was a 39-year-old Caucasian divorced female with one daughter. She described "none" as her religious preference, and considered herself "very spiritual" and "moderately religious." Client Three reported weekly molestation by her father between the ages of 5-10. From the ages of 10-15, she experienced weekly forced touching of sexual organs, as well as forced intercourse on a monthly basis. Lastly, Client Three reported a history of satanic ritual abuse on a regular basis. Her psychological diagnoses included bi-polar disorder and PTSD.

Finally, Client Four was a 28-year-old, single Caucasian female who considered herself as "very spiritual" and "slightly religious." She described her religious preference as "Unitarian Universalist," and attended services several times a year. Client Four reported monthly molestation and forced touching of sexual organs by an acquaintance between the ages of 16-20 years old. Her psychological diagnoses included depression and PTSD.

Measures

Demographics. Participants answered interview questions about their age, marital status, number of children, religious affiliation, medications and health status, therapy status, and past experience with counselling.

Sexual abuse history. Leserman, Drossman, and Li's (1995) screening instrument includes six items to assess childhood (13 and younger) and adult (14 and over) sexual abuse. This instrument has good test-retest reliability (86% agreement) and construct validity when compared with a structured clinical interview of abuse history (81% agreement). In addition, several items provided supplemental descriptive information on each participant's sexual abuse history: duration of the sexual abuse, relationship of the abuser(s), age at which abuse first began, the most frequent abuser, and total number of abusers.

Psychological distress. The Brief Symptom Inventory (BSI; Derogatis, 1993) is a 53-item self-report inventory designed to measure psychological distress and to monitor therapeutic change in a treatment setting. As such, it has good temporal stability, yet is sensitive to therapeutic change (Derogatis, 1993). The Global Severity Index (GSI) combines nine symptom dimensions (e.g., depression, anxiety, hostility, phobic anxiety) into an overall score reflecting general distress intensity. Participants rated their level of distress during the past seven days on a 5-point scale ranging from "not at all" to "extremely." The Brief Symptom Inventory has demonstrated good internal consistency coefficients (e.g., Alphas = .71-.85) and test-retest reliability (r = .90; Derogatis, 1993). Adult community norms, outpatient psychiatric norms, and inpatient adult psychiatric norms have been developed for the BSI (Derogatis, 1993).

Trauma symptoms. The trauma symptom checklist-40 (TSC-40; Elliot & Briere, 1992) is a 40–item self-report inventory on the adult symptom patterns associated with a history of childhood sexual victimization (Whiffen, Benazon, & Bradshaw, 1997). The TSC-40 uses a 4-point frequency rating scale ("never" to "very often") to assess various trauma symptoms (e.g., "nightmares"; "fear of men"). The TSC-40 has demonstrated convergent validity with several other measures of traumatic stress and PTSD (e.g., Gold & Cardena, 1998). Elliot and Briere (1992) demonstrated an alpha coefficient of .89 for the entire scale.

Religious coping. The RCOPE (Pargament et al., 2000) is a comprehensive, multi-dimensional measure of how people use religion to cope with major life events. The RCOPE has demonstrated incremental validity above measures of general religiousness, and the subscales have demonstrated adequate internal consistency and reliability (Pargament et al., 2000). Three subscales were used to assess positive religious coping in the current study: Collaborative religious coping (5 items), seeking spiritual support (5 items), and spiritual connection (5 items). The spiritual discontent subscale (5 items) and two additional items (i.e., "Wondered what I did for God to punish me" and "Believed the devil was responsible for my situation") captured negative forms of religious coping. Participants ra
ing the past two weeks on a 4-p
"a great deal." Total scores were
Coping scale (PRC; 15 items) an
(NRC; 7 items).

Image of God. Twenty-five adjecti
(Gorsuch, 1968) reflected both p
negative (NGI; e.g., "Distant") i
age subscale (PGI) portrays a kin
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Spiritual well-being. Lawrence's
items) provides a comprehensive
of spiritual well-being, including
Challenge, and Acceptance. The
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In addition, the scale has been
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Data Analyses

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od to punish me" and "Believed the
ation") captured negative forms of

religious coping. Participants rated their level of religious coping during the past two weeks on a 4-point scale ranging from "not at all" to "a great deal." Total scores were generated for the Positive Religious Coping scale (PRC; 15 items) and the Negative Religious Coping scale (NRC; 7 items).

Image of God. Twenty-five adjectives from the Religious Concepts Survey (Gorsuch, 1968) reflected both positive (PGI; e.g., "Comforting") and negative (NGI; e.g., "Distant") images of God. The positive God image subscale (PGI) portrays a kind, loving, nurturing image of God. In contrast, the negative God image subscale represents a wrathful, distant image of God. Participants circled a response to indicate how well each adjective described God on 3-point scale from "does not describe God" to "describes God particularly well." This scale has demonstrated good internal consistency and reliability (e.g., Ladd & Spilka, 1999).

Spiritual well-being. Lawrence's (1997) God Image Scale (GIS; 36 items) provides a comprehensive assessment of each participant's level of spiritual well-being, including subscales to measure God's Presence, Challenge, and Acceptance. The total score was used in this study. Internal consistency coefficients for the scale have ranged from .84 to .94 in several samples (Hall & Sorenson, 1999; Lawrence, 1997). In addition, the scale has been negatively correlated with extrinsic religiousness (Hall & Sorenson, 1999; Lawrence, 1997) and positively correlated with objects relations development and self-esteem (Hall, Tisdale, Ball, Tisdale, & Brokaw, 1994).

Data Analyses

Critical Difference Scores. Critical Difference Scores provide a way to assess statistical change in single-case designs (Mueser, Yarnold, & Foy, 1991; Nishith, Hearst, Mueser, & Foa, 1995; Yarnold, 1988). Based on classical test theory, this statistical methodology utilizes the test-retest reliability of the measure to assess reliable change. Yarnold (1988) demonstrated that any change is statistically significant ($p < .05$) if the absolute value of change equals or exceeds the value of the Critical Difference (CD) score. When using this statistical method, z-scores are computed based on the population means and standard deviations. Next, the critical difference score is computed: $CD = 1.64\ (J\ (1\text{-}r))^{1/2}$. In this formula, J reflects the number of measurement times, and r denotes the test-retest reliability of the test, determined from a prior norm group. If the value of change exceeds this critical difference score, a statistically significant change has occurred (See Gorman & Allison, 1996; Mueser, Yarnold, & Foy, 1991; and Yarnold, 1988 for further details). In this study, the Brief Symptom Inventory (BSI; Derogatis, 1993) represents the only scale with appropriate standardized norms

and test-retest reliabilities. Therefore, we focused on the critical difference scores for this measure. For the remaining measures, we calculated changes in raw scores.

Clinical Significance. In addition to the critical difference scores, the literature on clinical significance emphasizes the importance of returning to "normal functioning" after therapeutic interventions (e.g., Jacobson, Roberts, Berns, & McGlinchey, 1999; Kendall, Marrs-Garcia, Nath, & Sheldrick, 1999). When considering clinical significance, change should be (a) statistically reliable (e.g., beyond chance and measurement error) and (b) by the end, the participant falls within the normative range on important measures (Jacobson et al., 1999). On the BSI, (Derogatis, 1993), a t-score that corresponds with the 90th percentile of a normative community population identifies a positive "case." In this study, as shown in Table 2, clinical significance is indicated when a participant changes from a score consistent with the 90th percentile and above, to below the clinical cut-off level.

Results

Psychological functioning: psychological distress and trauma symptoms

As demonstrated in Table 2, three of the four participants demonstrated statistically significant decreases in psychological distress by the follow-up measurement. In addition, by the end of the intervention, and at follow-up, three of the four participants changed status from a clinical "case" (90th percentile and above) to a level of psychological distress within the normative range in the community (below the 90th percentile; see discussion above).

More specifically, Client One started the intervention with a high level of psychological distress. Her Z-score of 3.90 placed her in the 98th percentile when compared to a standardized community population (see Table 2). The Critical Difference score for 4 measurement points was CD = 1.03. Therefore, any change above this CD score represents a statistically significant change at the $p < .05$ level (see discussion above). By the end of the intervention, Client One's Z-score of 1.90 placed her in the 90th percentile when compared with the general community population. By the follow-up period (1-2 months after the intervention), her reports of psychological distress decreased substantially. Her Z-score was -0.06, which corresponded with the 54th percentile. This placed her in the average range of psychological distress in the community, and represented a significant decrease in psychological distress. Client One no longer reported psychological distress above the clinical range on the Brief Symptom Inventory (90%). In summary, Client One demonstrated significant decreases in psychological distress at Time 2

Table 2
Client changes on the Brief Symptom Inventory and the Trauma Symptom Checklist

	Client 1				Client 2				Client 3				Client 4			
	GSI	Z	%ile	TSC	GSI	Z	%ile	TSC	GSI	Z	%ile	TSC	GSI	Z	%ile	TSC
T1	80	3.90	98	85	54	2.32	95	85	15	0.06	58	50	44			
T2	35	1.16*	87*													

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When considering clinical signifi-
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Table 2

Client changes on the Brief Symptom Inventory and the Trauma Symptom Checklist

	Client 1			Client 2			Client 3			Client 4		
	GSI	Z	%ile	TSC	GSI	Z	%ile	TSC	GSI	Z	%ile	TSC
T1	80	3.90	98	85	54	2.32	95	85	15	0.06	58	50	44	1.70	90	61
T2	35	1.16*	86*	63	40	1.45	88*	69	3	0.77	14	40	41	1.52	90	64
T3	47	1.90*	90	71	34	1.10*	84*	78	2	0.83	12	42	37	1.29	86*	63
T4	15	-0.06*	54*	59					1	0.90	4	37	25	0.55*	76*	58

Note. GSI = raw scores on the Global Severity Index of the Brief Symptom Inventory; Z = the Z-scores for the GSI, computed with the normative population means and standard deviations; %ile = the percentile of psychological distress when compared to the community normative population; TSC = raw scores on the Trauma Symptom Checklist-40. The * for Z scores denotes a statistically significant change on the GSI, $p < .05$ level, for a one-tailed hypothesis; The * for the %ile denotes a change from a "clinical case," to a score within the normative range on the BSI

(after Session 4), Time 3 (at the end of the intervention), and Time 4 (at 1-2 month follow-up).

Client Two started the intervention in the 95th percentile of psychological distress (Z = 2.32). By the end of the intervention, she significantly decreased in psychological distress (Z = 1.10; 84%). To note, Client Two did not complete the follow-up. Therefore, the Critical Difference score to denote a statistically significant change at the $p < .05$ level was 0.90. Additionally, Client Two moved from the 95th percentile to the 84th percentile in psychological distress, representing a clinically significant change.

Client Three revealed a decrease in psychological distress, and evidenced a floor effect in the measurement of psychological distress (i.e., she reported minimal psychological distress after session 4). Thus, while she moved from the 58th percentile (Z = -0.06) of psychological distress to the 4th percentile at follow-up (Z = -0.90), these changes were not statistically significant.

Client Four began the intervention in the 90th percentile of psychological distress (Z = 1.70). By the follow-up period, she demonstrated a significant decrease in psychological distress (Z = 0.55, $p < .05$). In addition, her changes represented a clinically significant change. She moved from the 90th percentile to the 86th percentile at the end of the intervention (Time 3), and then demonstrated further decreases consistent with the 76th percentile in the general population (Time 4).

Finally, regarding trauma symptoms, Table 2 demonstrates that three of the four participants reported decreases across the course of the spiritually-integrated intervention and at the follow-up period. In summary, the results indicate a pattern of significant decreases in psychological distress and trauma symptoms across the intervention, and at the 1-2 month follow-up.

Spiritual functioning: images of God, religious coping, and spiritual well-being

Table 3 displays the results regarding spiritual functioning. First, participants who started the intervention with a high level of spirituality and spiritual well-being maintained this throughout the intervention and at follow-up. More specifically, Client Two maintained a high level of positive religious coping (PRC), a positive image of God (PGI), and a high level of spiritual well-being (GIS) at all three time points (See Table 3). In addition, she demonstrated a low level of negative religious coping (NRC) and negative God image (NGI). Whereas Client Three demonstrated a decrease in positive religious coping (PRC) across the course of the spiritually-integrated intervention and at follow-up, she maintained a positive image of God (PGI) and a high level of spiritual well-being (GIS). To note, Clien
tive religious coping and did not
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Spiritual functioning: Spirit
and relig

	Time	GIS (36-144)	PR((0-4
Client 1	T1	81	25
	T2	84	15
	T3	88	21
	T4	111	31
Client 2	T1	141	34
	T2	137	34
	T3	136	32
	T4	---	---
Client 3	T1	144	45
	T2	143	29
	T3	144	34
	T4	144	35
Client 4	T1	108	23
	T2	111	29
	T3	113	34
	T4	118	29

Note. Ranges are presented in parentheses.
Religious Coping; PGI = Positive God Image
Negative God Image; T1= Baseline; T2 = Aft
1-2 month follow-up.

The second pattern emerged among
vention with a marked degree of spi
One demonstrated increases in her
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up. In addition, she increased her use
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up. Lastly, she decreased in her neg
time and at follow-up. Client Four d
of negative religious coping (NRC)
return to her baseline level at follow-
an increase in positive religious copi
(GIS) across time. She maintained a
(NGI), and a positive image of God
at follow-up. Overall, the females wi

well-being (GIS). To note, Client Three did not report any use of negative religious coping and did not describe God in a negative way at any point during the counselling intervention or at follow-up.

Table 3

Spiritual functioning: Spiritual well-being, images of God, and religious coping

	Time	GIS (36-144)	PRC (0-45)	PGI (19-57)	NRC (0-21)	NGI (9-27)
Client 1	T1	81	25	24	6	20
	T2	84	15	31	6	16
	T3	88	21	42	6	13
	T4	111	31	51	1	9
Client 2	T1	141	34	55	1	9
	T2	137	34	57	0	9
	T3	136	32	57	1	9
	T4	---	---	---	---	---
Client 3	T1	144	45	57	0	9
	T2	143	29	57	0	9
	T3	144	34	57	0	9
	T4	144	35	57	0	9
Client 4	T1	108	23	44	1	11
	T2	111	29	45	5	9
	T3	113	34	45	4	11
	T4	118	29	44	1	11

Note. Ranges are presented in parentheses. GIS = God Image Scale; PRC = Positive Religious Coping; PGI = Positive God Image; NRC = Negative Religious Coping; NGI = Negative God Image; T1= Baseline; T2 = After Session 4; T3 = End of intervention; T4 = 1-2 month follow-up.

The second pattern emerged among participants who entered the intervention with a marked degree of spiritual struggle. For example, Client One demonstrated increases in her positive image of God (PGI) and spiritual well-being (GIS) throughout the intervention, and at follow-up. In addition, she increased her use of positive religious coping (PRC) and decreased her use of negative religious coping (NRC) at the follow-up. Lastly, she decreased in her negative image of God (NGI) across time and at follow-up. Client Four demonstrated an increase in her use of negative religious coping (NRC) during the intervention, with a return to her baseline level at follow-up. In addition, she demonstrated an increase in positive religious coping (PRC) and spiritual well-being (GIS) across time. She maintained a uniformly low negative God image (NGI), and a positive image of God (PGI) across the intervention and at follow-up. Overall, the females with spiritual struggles entering the

intervention demonstrated positive changes in their spiritual functioning across time.

Discussion

The primary aim of this research endeavor was to evaluate the impact of a spiritually-integrated counselling intervention for female survivors of sexual abuse. Overall, it was expected that participation in the program *Solace for the Soul: A Journey Towards Wholeness* (Murray-Swank, 2003) would lead to decreased psychological distress, trauma symptoms, and spiritual distress. In addition, it was hypothesized that the four clients would demonstrate increases in spiritual well-being, positive images of God, and use of positive religious coping.

In general, the participants demonstrated significant decreases in psychological distress, psychopathology (e.g., depression, anxiety), and trauma symptoms across the course of the intervention and at follow-up. This is particularly noteworthy given that the clients had been in long-term psychotherapy before the start of the intervention. Regarding spiritual functioning, the two participants who began the intervention with significant spiritual struggles surrounding their abuse histories increased their use of positive religious coping across time and demonstrated increased spiritual well-being at the end of the intervention and the follow-up. The remaining participants maintained a uniformly positive image of God and a high level of spiritual well-being throughout the counselling intervention. This study provides preliminary evidence that the program *Solace for the Soul* may be beneficial for female survivors of sexual abuse who express an interest in spirituality.

Limitations

This study provided an in-depth analysis of four female sexual abuse survivors with diverse religious backgrounds. While this research methodology provides a rich way to examine individual differences and the complex process of therapeutic change, the small sample size limits the generalizability of the results. In addition, regression to the mean is an important consideration when interpreting the results. As a next step, it would be beneficial to conduct randomized, controlled studies with larger samples of women (and men), including diverse types of sexual abuse experiences, psychological diagnoses, ages, ethnicities, and religious backgrounds. Lastly, the pilot program attracted participants who defined themselves as "very spiritual." Although the participants varied in their religious affiliations (Unitarian Universalist to no affiliation) and concepts of the Divine, it remains unknown how the results would generalize to people who report themselves to be only minimally spiritual. Additionally, spiritual and religious values are often central

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in the lives of people. Therefore, the spiritual meaning of the intervention may have contributed to the positive outcomes. Thus, this type of counselling intervention may be particularly beneficial to those who identify spirituality as important in their lives, whether struggling with spirituality and/or relying on their spiritual beliefs and practices as a resource.

Conclusions

The results of this pilot study highlight the integral role that spirituality plays in the lives of sexual abuse survivors, across diverse stages of healing. All four clients voiced their desire for a spiritual perspective, and commented how their current therapies lacked this essential component. The results of this study provide preliminary support that spiritually-integrative counselling interventions, such as *Solace for the Soul: A Journey Towards Wholeness* (Murray-Swank, 2003), can be helpful to survivors of sexual abuse. This particular intervention seems promising for those in the midst of spiritual struggles, such as those who are questioning God, angry, or desiring to restore/create a sense of spiritual connection in their lives. The current endeavor represents an initial step towards discovering and implementing effective ways to restore wholeness in body, mind, and spirit for survivors of sexual abuse.

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Kenneth I. Parga
Psychotherapy: U
Sacred, New York

There is no doubt that many clin
an important dimension of humar
significantly to the questions and
spiritual dimension appears suffic
left to the mystics and those who
would that leave clients who come
spiritual questions?

Ken Pargament argues that spirit
human functioning, but it is a way
book *Spiritually Integrated Psychoth*
the Sacred makes a significant cor
book provides an in-depth analysis
in the narratives of clients, when t
its role. The most striking aspect of
and authenticity. Pargament finds
nebulous and seemingly inexplicat
encounters with the sacred. This an
it is validating to any reader who at
just the right words to describe spirit
way. Pargament indicates that in th
psychotherapy it would be imperativ
tolerance and spiritual literacy. Wh
most therapists, the latter requires d
stand the depth and the breadth of sp
understand how a client might desc
places, sacred moments, and spiritua