A Guide to Spiritually Informed Care for Child Abuse Professionals

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Abstract

Religion, spirituality, and child abuse are often intertwined. This is particularly the case when the abuse itself involves religion, such as a physically abusive parent justifying their abuse by referring to Scripture. Separately, religion and spirituality may serve as resources for healing and coping following trauma. As demonstrated in this article, survivors of childhood abuse often experience complicated changes in religious and spiritual faith following abuse. In this article, I present a rationale for child abuse professionals who are mental health providers to provide spiritually informed care following childhood trauma. Then, I discuss spiritually oriented care in treatment for childhood trauma as a form of culturally sensitive psychotherapy for children and their families from various religious cultural backgrounds. Afterward, I provide a model for assessing the potential relevance of religion and spirituality to treatment for survivors of childhood abuse. I conclude by offering examples of spiritually informed, culturally sensitive care in the context of treatment following child abuse.

Keywords: child abuse, religion, spirituality, spiritually informed care

If a child or teenage client who had been physically or sexually abused asked you why God allowed their abuse to occur, how would you respond? Would your response be different if the client told you that they had stopped attending church but continued to pray to God for help working through their abuse? Or would you consider responding differently if the client told you that they never wanted to darken the door of a church again? In considering your potential response, what information would you need to respond in a way that is both culturally sensitive with respect to your client's religious and spiritual faith, as well as simultaneously trauma-informed? In this article, I present a rationale for spiritually informed care following childhood trauma for child abuse professionals who are mental health providers. Then, I discuss spiritually oriented care in treatment for childhood trauma as a form of culturally sensitive psychotherapy for children and their families from various religious cultural backgrounds. Afterward, I provide a model for assessing the potential relevance of religion and spirituality to treatment for survivors of childhood abuse. I conclude by offering examples of spiritually informed, culturally sensitive care in the context of treatment following child abuse.

Rationale for Spiritually Informed Care Following Childhood Abuse

Consider the following case examples, previously presented by Walker, Reese, Hughes, and Troskie (2010). To protect client confidentiality, Walker et al. (2010) used an amalgamation of previous clients and changed identifying information, including client names and ages. First, consider Kristy, a 7-year-old Caucasian girl who was sexually abused by her father, a deacon within a Baptist church. To intimidate her into silence, her father told her that she would "go to Hell and God would hate her" if she ever reported the abuse. Kristy was removed, placed into foster care, and referred for psychotherapy. She subsequently viewed God as angry and frightening.

Second, consider Isabel, a 17-year-old Hispanic girl referred for psychotherapy because she was a rape survivor. Isabel was raped by an older adolescent who was not a member of her family or her church community. Isabel had been raised from her early childhood in a religiously committed family. Besides individual psychotherapy, Isabel coped with her sexual assault by praying and by reading Scriptural

passages in the Bible that referenced God's love and protection of her.

Finally, consider Lamar, a 10-year-old African American boy. Lamar's mother sought psychotherapy for Lamar because he had survived a rape by an older teenage boy in his neighborhood approximately a year before. Lamar's mother was concerned about his increased angry outbursts and defiant behavior at home. These were problems that Lamar had not experienced prior to the rape. Furthermore, although Lamar and his mother had been active in church for years, Lamar had refused to attend church since the rape occurred. Nonetheless, Lamar's mother continued to actively attend church. Additionally, she reported frequently praying for strength and for God to help Lamar.

As Walker et al. (2010) suggested, for each of the above children and adolescents, religion and spirituality are central parts of the clinical presentation. However, each case differed with respect to the potential role of the parents' religiousness, the potential for religion and spirituality to be a resource for healing, and the effect of the abuse on the client's personal religious and spiritual functioning. As illustrated by these examples, religion and spirituality are multidimensional. Additionally, children and teens often experience complicated changes in faith following childhood physical or sexual abuse.

Indeed, previous research has identified multiple ways that survivors of childhood physical and sexual abuse often experience complicated changes in faith afterwards. Walker, Reid, O'Neill, and Brown (2009) reviewed 34 studies of child abuse as they relate to spirituality and religiosity that included information on a total of 19,090 participants. The majority of studies were conducted using research participants from monotheistic belief systems. The studies were classified according to both the form of abuse and the form of religiousness or spirituality that were examined. Several key findings emerged.

First, most studies identified damage to one's religiousness or spirituality (N = 14) following childhood abuse. When abuse damages personal religiousness/spirituality, it appears to do so by specifically harming the individual's view of and relationship to God. Walker et al. (2009) reviewed several studies that found that adult participants who experienced childhood abuse report having more distant relationships with God and are less trustful of God than non-abused participants (Kennedy & Drebing, 2002; Reinert & Edwards, 2009; Rossetti, 1994). In addition, adult survivors of childhood abuse also report believing that God is punitive, unfair, wrathful, distant, and less loving than individuals who have not suffered abuse (Kane, Cheston, & Greer, 1993; Lawson, Drebing, Berg, Vincellette, & Penk, 1998; Hall, 1995; Pritt, 1998).

Second, several moderators emerged for the link between physical or sexual abuse and spiritual decline following childhood abuse. For instance, several studies have suggested that the degree to which the abuser symbolically or actually represents a religious institution or deity is a significant factor in spiritual decline resulting from abuse. Rossetti (1994) studied adult Catholics in the United States, comparing those who had not been victims of childhood sexual abuse (N = 1376) with those who had been sexually abused as children but not by a priest (N = 307), and with those who had been sexually abused by priests (N = 40). Those who were sexually abused by priests were more likely than those in the other two groups to report difficulty trusting priests and, by extension, difficulty trusting God. Additionally, participants who were sexually abused as children showed a decline in trust in the priesthood, church, and God compared to those who were not abused; however, this decline was less than those who had been abused by priests.

In addition, there is some evidence that physical or sexual abuse by a father or father-figure is particularly damaging spiritually when compared to abuse by some other family member or by a non-relative. Kane et al. (1993) examined the impact of incest committed by a father figure upon 33 adult women survivors' perceptions of God. Father figures included a biological or adoptive father, biological

or adoptive grandfather, a stepfather, or a long-term live-in boyfriend of the survivor's mother. 61% of the incest survivors had left the religious faith community of their fathers. In comparison to a control group of 33 adult women, survivors of childhood incest were also more likely to report that God had negative or ambivalent feelings toward them.

Third, some studies (N = 12) suggested that the participants experienced a combination of simultaneous increase and decrease in different aspects of their personal religion and spirituality. In studies that reported on simultaneous damage and increase in personal religion and spirituality, most participants reported less frequent participation in organized religion with an increase in personal spirituality (such as prayer). For instance, Ryan (1998) interviewed 50 women who survived childhood maltreatment. Almost half reported no current religious affiliation. The others endorsed Judaism, Buddhism, Protestantism, and pagan circles. Three fourths of the women who were raised in an organized religion reported that they left the religion of their childhood. Half of the participants (25) reported questioning a God that could allow abuse to occur. At the same time, 64 percent reported that their spirituality was stronger after their experience of abuse (as opposed to before or during the abuse that occurred). Sixteen respondents (nearly one-third) specifically reported that God had been an agent for survival and healing.

Finally, seven studies gave preliminary indications that religiousness/spirituality can moderate the development of posttraumatic symptoms or symptoms associated with DSM Axis I disorders. In those studies, participants who maintained some connection to their personal faith (even if it was damaged from abuse) experienced better mental health outcomes compared to adult survivors of abuse who did not. For example, Doxey, Jensen, and Jensen (1997) surveyed 653 adult women who had been sexually abused as children as part of a larger sample. Emotional functioning was measured using several items designed to assess symptoms of depression. Personal religiousness was measured with three survey questions asking about the importance of religion in their lives. Doxey et al. found that religion moderated the relationship between abuse and depressive symptoms. Doxey et al. also found that women who were abused self-reported having better mental health than non-abused women, if they were religious. Among victims of childhood sexual abuse, those who were highly religious were less depressed than participants reporting moderate or low personal religiousness.

Spiritually Informed Care as a Form of Culturally Sensitive Therapy

Across professions, psychologists, counselors, and social workers are all ethically mandated to respect and support clients' individual differences, including religious and spiritual differences (American Counseling Association, 2014; American Psychological Association, 2017; National Association of Social Workers, 2021). We encourage child abuse professionals to carefully consider what respect for individual religious and spiritual differences looks like when client changes in personal religiousness and spirituality are expected following exposure to trauma.

As Walker, Courtois, and Aten (2015) pointed out, psychotherapists, on average, tend to report participating in organized religion less than the American public that they serve. Additionally, psychotherapists, more than members of the public generally, tend to gravitate toward individual spiritual practices without an organized religious context. Despite this, most Americans practice their personal spirituality in the context of organized religion without differentiating between religion and spirituality (Hill & Pargament, 2003; Walker, et al., 2015).

Therefore, Walker et al. (2009) suggested that, when psychotherapists work with clients from religious and spiritual backgrounds that significantly differ from their own, they may unwittingly or even intentionally "push" them away from organized religious

participation toward personal spirituality. This pull to encourage client movement from previously held religious values, beliefs, and behavioral participation in organized religion may be particularly strong in trauma psychotherapy. As indicated earlier, changes in personal religion and spirituality are expected following childhood abuse. When traumatized clients experience movement away from organized religion toward personal spirituality or ambivalence about different parts of their faith, this may serve to reinforce previously held therapist beliefs about how spirituality should be practiced. Walker et al. (2009) suggested that psychotherapists seeking to provide culturally sensitive trauma therapy should, at a minimum, be able to recognize their own countertransference to client religion and spirituality.

Additionally, psychotherapists might also consider that "persistent and exaggerated negative beliefs or expectations about oneself, others, or the world" is itself a DSM-5 symptom of Post-Traumatic Stress Disorder (American Psychiatric Association, 2013, p. 72). As I will discuss later, such persistent, exaggerated, negative beliefs are typically targeted for intervention in trauma-focused treatment for survivors of childhood physical and sexual abuse. In the context of evolving religious and spiritual beliefs following trauma exposure, psychotherapists need to carefully create a "holding environment" for child and adolescent clients, as well as their non-offending parents, to explore and resolve changes in religious and spiritual beliefs and values. As part of such a therapeutic holding environment, psychotherapists should carefully assess client and non-offending parents' pre-trauma religious and spiritual functioning. Then, psychotherapists should evaluate changes to such functioning following trauma. Finally, they should continue to monitor and then formally reassess changes to religious and spiritual functioning during and after treatment.

Child abuse professionals should also recognize and support pre-abuse religious and spiritual functioning to the extent that such functioning would be considered healthy *within their clients' organized religious backgrounds*. To assess whether that was the case, psychotherapists may need to consult with other psychotherapists from an individual client's religious background, a trusted clergy member from their client's religious background, or published online resources. An example of an online resources is a series of publications from the American Psychological Association on religion and spirituality as well as individual journals devoted to this topic. Journals from the American Psychological Association include Psychology of Religion and Spirituality as well as Spirituality in Clinical Practice. With respect to potential clergy members, psychotherapists should take care to avoid consultations with clergy that might reinforce abusive aspects of religion. For example, it is Biblically supported to avoid a clergy consultation from a clergy member who suggests the physical abuse of children or women is acceptable. Ideally, clergy consultation is best accomplished by having relationships with several clergy members in the community. If a therapist does not know any clergy personally or professionally, the therapist can consider consulting with multiple clergy members from the same religious background as their client, aggregate those responses, and consider the aggregate of those responses against published resources to get an idea of whether a child or family's pre-abuse religious and spiritual beliefs and practices were considered normative and healthy by their own religious community.

Assessing the relevance of religion and spirituality in treatment with traumatized children

As alluded to earlier, psychotherapists need to assess whether and how religion and spirituality is meaningful to a particular client's presentation. To do so, psychotherapists should begin by applying what Richards and Bergin (2005) refer to as a Level 1 versus Level 2 assessment of religion and spirituality to childhood physical and sexual abuse survivors. As Richards et al. (2014) explain, a Level 1 assessment is a broad assessment of clients' religious and spiritual background, their current religious

and spiritual functioning, and their own report of the potential importance of spiritual issues to their treatment. A Level 2 assessment is a more detailed, multidimensional assessment of client religiousness and spirituality. This part of the assessment can include client and/or parent completion of specific measures of varying aspects of religiousness and spirituality.

In completing a Level 1 assessment, psychotherapists should begin by obtaining basic information about whether a client considers themselves to have a religious background, and, if so, what their background is. The nature of a client's religious and spiritual beliefs and practice will vary depending on whether the client considers themselves Christian, Jewish, Muslim, Buddhist, or a member of another religion. More importantly, psychotherapists should learn about what kind of Christian, Jewish, Muslim, or Buddhist client they have. In other words, what their faith means to them and how their religious and spiritual faith is practiced and lived out. In the context of treatment of child abuse, child abuse professionals are additionally tasked with trying to understand this information for their clients prior to abuse occurring and then afterward.

Additionally, Walker et al. (2009) rightfully point out that trauma psychotherapists need to carefully consider whether client religiousness and spirituality is a resource for coping and healing, has been damaged by abuse, or is both a resource in some parts of the client's faith and damaged in other parts of their faith system. To accomplish this, psychotherapists need to understand the degree to which clients considered themselves to have a religious affiliation prior to the abuse. Psychotherapists then need to assess whether and how client religiousness and spirituality has changed since the abuse.

As Walker et al. (2010) demonstrated, applying a Level 1 assessment of religion and spirituality involves initially asking several broad, open-ended questions related to religion and spirituality during the initial assessment. Depending on the client's responses, or if the psychotherapist suspects that client religiousness is related to their presenting problems, the initial broad Level 1 assessment is then followed up with additional, more detailed Level 2 assessment questions. Returning to the notion that spiritually informed care following child abuse is also culturally sensitive psychotherapy, asking Level 1 assessment questions about religion and spirituality need not be intrusive or unnatural. Such questions can be asked as part of an initial intake or during an extended assessment prior to beginning psychotherapy. During the Level 1 assessment, I encourage psychotherapists to ask basic questions, starting with the parent or legal guardian, such as "Do you have a religious or spiritual background?", "What is it?". If the parent or guardian answers affirmatively, additional Level 1 assessment questions that are still basic can be added. These include "How often do you and your family attend religious services?" as well as "Are there any religious or spiritual issues that you want to discuss as part of your child's treatment?" When meeting with the child separately, the child abuse professional can ask the child the same questions modified for their age and developmental level (e.g., "Is there anything about religion or God that you think is important for us to talk about in therapy?")

From the above set of basic questions, child abuse professionals can get a basic sense of whether a child, parent, or their family adheres to a specific religious tradition, and how often they participate in it (and by proxy, how committed they are to it). Psychotherapists should be careful to assess both parent and child response about the relevance of religion and spirituality to treatment against information about the index trauma itself that they are collecting during the assessment. In Kristy's case, presented above, she would likely have said that she didn't want to discuss religion in therapy despite the obvious relevance of needing to do so.

At this point, I wish to point out that for clients who are not religiously committed, for whom the nature of the abuse does not involve religion or spirituality, and who do not wish to discuss religious or spiritual issues in trauma treatment, culturally sensitive psychotherapy would involve no further inclusion

of religion and spirituality in treatment. I say this to also emphasize that spiritually informed care does not involve attempts to proselytize or impose one's own religious and spiritual beliefs and values on one's clients. Some assessments will identify non-religiously committed clients and families for whom religious and spiritual issues are not pertinent to treatment. In these cases, therapists demonstrate their cultural sensitivity to religion and spirituality simply by assessing its potential relevance and then providing treatment without further reference to it.

Conversely, some Level 1 assessments of religion and spirituality will undoubtedly identify clients for whom additional Level 2 assessment is warranted. In those instances, in addition to asking broadly about client religious background, therapists should consider obtaining additional information. Such information includes whether clients engage in personal spiritual practices. Then, if clients endorse engaging in spiritual practices, assessing the nature and frequency of those practices. This information should be assessed for both pre-abuse and post-abuse functioning. So, for example, therapists might ask child clients "Do you do anything like pray or read the Bible (or Torah or other sacred writings)?" Then, ask "Did you do anything like pray or read the Bible (or Torah or other sacred writings) before the abuse happened"? Depending on their response, therapists can then ask separately about how often clients prayed and how often they read the Bible before and after the abuse as separate behaviors. Additionally, therapists should assess public, corporate religious behaviors prior to and following the abuse. So, psychotherapists could ask "How often did you attend church (or synagogue, or mosque) before the abuse?" They can also ask "How often do you attend church (or synagogue, or mosque) since the abuse?" Similarly, psychotherapists should assess for the presence of spiritual struggles involving client relationships with God or the Divine. This can be done asking directly "Have you had any problems in your relationship with God (or Yahw-h, or Allah) since the abuse? Tell me about that". All these questions can be modified to allow parent or guardian reporting for themselves as well as for their child.

For example, Walker et al. (2010) applied this process to the case study of Lamar, the 10-year-old African American male, and his mother. Lamar's psychotherapist met with Lamar's mother prior to meeting with Lamar individually. The psychotherapist asked open-ended questions such as "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 indicated that her faith was important to her, and that she was concerned that while she continued to attend church, Lamar had refused to attend church since the rape occurred. This provided Lamar's psychotherapist with valuable information regarding Lamar's psychosocial as well as religious and spiritual functioning.

Later, Lamar's psychotherapist asked Lamar additional Level 2 assessment questions. Specifically, his therapist asked if he had talked to God about the abuse. Additionally, the therapist asked Lamar if he wanted to talk about God or about his faith during psychotherapy. Lamar responded by saying that he wasn't sure that God could help him, and that he didn't want to talk about God or religion in treatment. Given that Lamar's mother had reported that both she and Lamar frequently attended church prior to his rape, Lamar's self-report of his religious and spiritual functioning after the rape represented a significant change. In the next section, I provide examples of addressing religion and spirituality in treatment after the assessment process is completed.

Incorporating religion and spirituality into treatment following childhood trauma

Trauma-focused cognitive behavioral therapy (Cohen, Mannarino, & Deblinger, 2016) is arguably the single gold-standard, evidence-based treatment for children and adolescents who have suffered childhood physical and sexual abuse. Over 50 published studies with over 4,500 participants have found TF-CBT to be effective in treating post-traumatic stress symptoms resulting from childhood abuse (Thielemann et al., 2022). I have previously published an extensive approach to addressing religious and spiritual issues in TF-

CBT (Walker et al., 2010). In the present article, I highlight individual treatment modules from TF-CBT to demonstrate the importance of addressing religious and spiritual issues in TF-CBT. Specifically, I review religious and spiritual considerations in the Cognitive Coping and Processing I, Trauma narrative, and Cognitive coping and processing II modules. My rationale for doing so is that these three modules represent the heart of treatment in TF-CBT. TF-CBT progresses generally from helping clients and their non-offending parents to understand client symptoms, then to cope with them. Afterward, clients are taught to recognize their non-trauma related cognitions in Cognitive Coping and Processing I. Then, they are helped to integrate the experience of trauma into their lives during the Trauma narrative module before challenging trauma-related cognitions in the Cognitive Coping and Processing II module.

Cognitive coping and processing I

In this part of treatment, building on the previous module, psychotherapists help clients to understand the relationship between their thoughts (demonstrated through their own self-talk), feelings, and behaviors (Cohen et al. 2006, 2016). This is also referred to and demonstrated as the Cognitive Triangle (Cohen, et al., 2006, 2016). After learning the Cognitive Triangle, children and adolescents are then taught to replace maladaptive thoughts with alternative thoughts that can generate positive feelings as well as more adaptive behavioral outcomes. Cohen et al. (2006, 2016) encourage focus on non-trauma-related cognitions during this treatment module. Later, psychotherapists identify trauma-related cognitions during the telling of the trauma narrative. Finally, therapists challenge and correct trauma-related cognitions in the Cognitive Coping and Processing II module.

However, as Walker et al. (2010) pointed out, sometimes children and adolescents have cognitive distortions rooted in religion and spirituality that must be addressed during Cognitive Coping and Processing I before they can discuss their trauma or access religious or spiritual resources for coping. As Walker et al. (2010) presented, in Kristy's treatment, her psychotherapist needed to address her father's religious threats before she could even discuss her abuse. Due to her father's threats, Kristy came to believe that God would abandon her and be angry with her if she discussed the abuse with anyone, including her psychotherapist. To challenge these cognitions, her psychotherapist engaged Kristy in a collaborative process whereby the psychotherapist helped identify incongruities between the God her father described and the God she had learned about in church. This process then provided a foundation for challenging other damaging statements that her father had made.

Trauma Narrative

Prior to the actual trauma narrative, Cohen et al. (2006) encourage psychotherapists to first talk with child and adolescent clients about the therapeutic rationale for discussing the abuse and resolve client ambivalence about doing so. Afterward, therapists and clients typically read a psychoeducation book together before creating the trauma narrative itself. Next, children construct the trauma narrative, often by writing a book about the trauma. This frequently begins with non-traumatic events in a child's life, followed by disclosure of the least threatening parts of the abuse before building up to the worst moments of the abuse. Cohen et al. encourage therapists to consider asking clients to include in the book parts of the trauma that they thought they would never tell anyone. Then, clients are taken through a process of identifying what they were thinking and feeling during different parts of the traumatic event(s). Although a book is often made to tell the trauma narrative, the trauma narrative format is flexible. Children can also create a song, a poem, or construct a book as a series of pictures rather than written chapters.

Walker et al. (2010) suggested that because the primary purpose of the trauma narrative is to help

clients integrate the traumatic experience into their lives, psychotherapists might explore parallels to client narratives in stories from their own religious traditions. This could be done using sacred texts from clients' religious faith traditions as a guide. As Walker et al. pointed out, most religious traditions have stories involving making meaning of suffering and overcoming adversity with faith. Connecting spiritually and emotionally with those stories might help clients of various ages to make meaning out of their own experience of suffering when done in a developmentally appropriate manner. For example, Walker et al. suggested that to help resolve spiritual struggles, the story of Job might be particularly beneficial for Jewish and Christian clients to discuss in psychotherapy. The book of Job is an ongoing discussion of Job's experience of suffering between Job and God. Similarly, Walker et al. (2010) pointed out that therapists treating Buddhist children and teens could consider encouraging them to meditate on the Buddha's Four Noble Truths in relation to their trauma. In a related vein, Islamic clients could reframe their suffering as a temporary condition that will later be rewarded by Allah.

Elsewhere, I have repeatedly suggested that rather than trying to answer for clients why God allowed their suffering, the role of psychotherapists is to bear witness to client struggles related to meaning, purpose of the trauma, and suffering (Walker et al., 2009; Walker et al., 2010). Rather than answering those questions for clients directly, I have suggested psychotherapists help clients process their feelings about God by encouraging clients to ask God directly their questions about the abuse, and by inviting clients to write down their thoughts about how God might respond to their questions. Psychotherapists could also ask clients where Yahw-h, God (or Jesus), or Allah was during the abuse, and how Yahw-h, God, or Allah feels about it. This could be accomplished in several ways. First, psychotherapists can use an empty chair technique, helping clients to alternate between asking God questions before then stating what they think God's responses would be. In addition, this discussion could occur while creating a book during the construction of the trauma narrative. Clients could draw their idea of Heaven and/or God and have an ongoing discussion with God in the trauma book itself. Walker et al. (2010) presented the case of Kristy completing a trauma narrative in this manner. While completing her trauma narrative, the psychotherapist wrote what Kristy described while Kristy drew pictures in her trauma book. While completing the trauma narrative, Kristy's psychotherapist asked her where she believed God was when the abuse occurred. In contrast to her fears about God abandoning her prior to Cognitive Coping and Processing I in TF-CBT, when completing her trauma narrative, Kristy decided that God should be represented as a star in the sky helping her during the abuse.

Cognitive Coping and Processing II

In this TF-CBT module, psychotherapists identify, explore, and correct trauma-related cognitive distortions. Cohen et al. (2006) describe common cognitive distortions, such as children believing that they should have been able to prevent abuse. Additionally, children often believe their world will never be safe again following trauma.

In engaging spiritually informed care following trauma, I encourage psychotherapists to identify and explore trauma-related cognitive distortions with religious and spiritual content. For example, in asking about what God believes about their abuse, some religiously committed clients might discuss cognitive distortions with religious content, such as "God was punishing me" or "I sinned, so I deserved this". I believe that clients are more likely to discuss religious and spiritual issues in the trauma narrative and subsequent cognitive processing if they were subjected to religion-related abuse as part of their traumatic experience. As I have previously noted, some children or teens may experience abuse committed by a parent or clergy member who used sacred writings to justify the abuse itself. In those instances, it is particularly important for psychotherapists to explore and directly challenge such cognitions. For example, children who have experienced physical abuse might be directly told,

"The Bible doesn't say that your dad can hit you – we have laws against that".

Walker et al. (2010) discussed these considerations in the context of the case of Kristy, presented earlier. As indicated earlier, Kristy's psychotherapist had to challenge and correct Kristy's cognitions related to her image of God before she could even disclose the abuse to her psychotherapist. Walker et al. also noted that Kristy had subsequently been placed in foster care. Thus, she also wondered if God knew where she was and if God continued to love her. Kristy's psychotherapist challenged these cognitions by asserting that God was everywhere and knew everything that she did. Kristy's psychotherapist also reflected to her that God was always with her, and that she could talk to God whenever she wanted by praying. Challenging her religion-related cognitive distortions in these ways helped her cope with being in foster care.

Conclusion

Years ago, Dalenberg (2000) reminded child abuse professionals that abuse is simultaneously profoundly difficult for clients to discuss out loud and for psychotherapists to empathically hear. Similarly, religion and spirituality are also deeply personal. As has been demonstrated multiple times before, "spirituality and trauma are often inextricably intertwined" (Walker et al., 2015, p. 3). Spiritually informed care involves acknowledging the complex ways that religion and spirituality can be both harmful parts of traumatic experiences as well as resources for healing. ■

Author Bio

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