

Beyond Survival: Application of a Complex Trauma Treatment Model in the Christian Context

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Disrupted systems of meaning are a core domain in which adults with a complex trauma history are impacted, often leading to adversely affected belief systems. For adult survivors of childhood trauma, experiences related to shame, betrayal, meaning-making, and mourning often complicate their spiritual and/or religious beliefs. This article uses a clinical case example to introduce and illustrate the relevance of a particular complex trauma intervention framework in the context of spiritually-informed treatment with adult Christian clients. Component-Based Psychotherapy (CBP; Hopper, Grossman, Spinazzola, & Zucker, in press) consists of four principal components: (a) relationship, (b) regulation, (c) parts work, and (d) narrative, and is predicated upon the importance of client-therapist parallel process to therapeutic movement and client change. Each treatment component is summarized and practically applied to case material, with particular focus on the ways in which client's faith beliefs and practices can serve as a potential resource and/or barrier in treatment. Particular integrative focus is given to the final treatment component (narrative), where issues of a client's lament, spiritual meaning making, and the therapist's potential vulnerabilities in working with this population are addressed.

There is a growing body of literature that addresses trauma, spirituality, religious coping, and posttraumatic growth, with helpful delineation between adaptive and maladaptive religious coping practices (Ahrens, Abeling, Ahmad, & Hinman, 2010; Chan & Rhodes, 2013; Exline, 2002; Gerber, Boals, & Schuettler, 2011; Harris et al., 2008; ter Kuile & Ehring, 2014; Pargament, Smith, Koenig, & Perez, 1998; Park, 2005). However, there is a more complicated relationship in the literature between *complex trauma*, spirituality, religiosity, and meaning-making (Bryant-Davis & Wong, 2013; Connor, Davidson, & Lee, 2003; Krejci et al., 2004; Pargament, 2008; Walker, Reid, O'Neill, & Brown, 2009). Some studies have found that complex trauma significantly disrupts the spiritual well-being of individuals, in a way that is distinct from acute/situational trauma (Fallot & Heckman, 2005; Harris et al., 2008; Lemoncelli & Carey, 1996; Maltby & Hall, 2012; Weber & Cummings, 2003). Some of the experiences noted in these studies include lower existential well-being, difficulty with trust/belief in a benevolent God or a caring community, projection of a negative parental image onto the image of God, feelings of shame and unworthiness, and religious strain. These findings lend support to the contention that "adversely affected belief systems" are one of the six core areas of functional disturbance occasioned by exposure to complex trauma (Cloitre et al., 2012; Herman, 1992).

Given the complexities of addressing trauma within a religious context, Walker and Aten (2012) have

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encouraged the academic community to participate in collaborative scholarship combining best practice trauma-informed treatment with the psychology of religion in order to enhance clinical care that is culturally relevant for the religious community. Further, Bryant-Davis & Wong (2013) highlight the need for the professional literature to address issues of spirituality in clinical practice with survivors of developmental trauma. The purpose of this article is to introduce and illustrate, through clinical case illustration, the relevance of a particular complex trauma intervention framework (i.e., Component-Based Psychotherapy [CBP]; Hopper, Grossman, Spinazzola & Zucker, in press) in spiritually-informed treatment with adult Christian clients.

Understanding Complex Trauma

The chronic and interpersonal context of the trauma exposure differentiates complex trauma from a more general understanding of traumatic stress. In *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), the criteria for post-traumatic stress disorder (PTSD) includes various stressors associated with the emergence of PTSD symptoms or diagnosis. The set of PTSD stressors identified in the *DSM-5*, however, does not represent an exhaustive inventory of all forms of trauma exposure. In particular, it omits a number of forms of developmental trauma exposure associated with complex psychological and behavioral adaptation over the lifespan (Cook et al., 2005; D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; van der Kolk, 2005; van der Kolk et al., 2005). For example, exposure to childhood emotional abuse and neglect is not included as an eligible stressor for PTSD in the *DSM-5*, despite growing empirical evidence that this form of complex trauma exposure is predictive of many severe and lasting consequences in both children and adults (Norman et al., 2012; Spinazzola et al., 2014).

Defining complex trauma involves an understanding of both the nature of the trauma history and its ongoing impact. Spinazzola and colleagues (2005) provide the following definition:

Complex trauma refers to a dual problem of exposure and adaptation. Complex trauma exposure is the experience of multiple or chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature and early-life onset. These exposures often occur within the child's caregiving system and include physical, emotional and educational neglect and child maltreatment beginning in early childhood. (p. 433)

As such, the construct of complex trauma is more comprehensive than partially overlapping constructs such as polyvictimization and cumulative trauma, which focus upon patterns of trauma exposure, and it is more comprehensive than diagnostic constructs such as complex PTSD and developmental trauma disorder, which delineate specific manifestations of psychopathology associated with exposure to complex trauma (Spinazzola et al., 2013). Recent research has demonstrated that exposure to complex trauma in childhood is predictive of increased symptom complexity in adult survivors (Cloitre et al., 2009).

In order to illustrate the concept of complex trauma in adult psychotherapy clients, with a particular focus on the long-term effects of childhood emotional abuse, consider the story of Tom. Tom is a Caucasian, 52-year-old married male who is living with his wife and three children in a small Midwestern city. Tom identifies as a Christian who is actively involved in volunteer work at his church. He is successful in his work, serving as a senior partner in a respected law firm. Tom initially sought therapy after his wife's discovery of his "secret life." Tom and Darlene had been married 28 years at the time when Darlene discovered, through an envelope of misplaced receipts, that Tom had been secretly spending thousands of dollars. This discovery led to further disclosure; ultimately, Tom confessed that over the past 12 years, he had been viewing internet pornography several times a week and occasionally visiting strip clubs in a larger neighboring city. In addition, Tom admitted to "escaping" to that city at least once a week to purchase marijuana and smoke in isolation. Tom described this as a place where he could "get away when I just need to stop pretending" and where he could "calm down when life gets crazy."

Over the course of the first several weeks of therapy, Tom revealed a life filled with paradox. Despite his lifelong academic and professional success, Tom's view of himself did not match his life's accomplishments. When talking about himself, Tom vacillated between making self-deprecating jokes and angry, self-loathing comments. In social situations, Tom admitted to being well-liked by peers and colleagues due to his ability to be compliant and charming. However, Tom harbored a persistent fear that others would reject him "if they ever discovered my dark side." Tom reported that he has struggled with chronic depressive affect, anxiety, and feelings of emptiness. Additionally, Tom discussed frustration about ongoing medical issues, which reportedly included migraine headaches and chronic digestive tract irritation.

When asked to discuss his childhood, Tom was vague and struggled to find the words to describe his family relationships. Although he attempted to characterize his family as “fine” and “typical,” a more thorough assessment revealed that Tom experienced his parents as simultaneously strict and emotionally distant. In a hasty attempt to apologize for betraying his parents, however, Tom stated that he was “probably just being dramatic” and that “many other kids have it much worse...like the inner city kids I work with at church.” Although it took several weeks of therapy for Tom to elaborate on his family relationships, further discussions revealed a childhood almost completely devoid of emotional connection. Tom was subject to routine verbal abuse and harsh criticism by his father, who belittled him daily for being “too sensitive” and “not athletic enough.” This maltreatment was echoed and magnified by his older brother, who Tom described as more accepted by, and strongly identified with, his father. Tom disclosed that his mother, also subject to her husband’s physical and verbal abuse, spent much of her time isolated from the family. He tearfully described incidents where he would look to his mother while being berated by his father, only to find her quietly staring at the floor. Additionally, since his older brother was in high school with him, the verbal abuse Tom experienced at home often carried over to school, where his brother’s friends would join in the bullying behavior.

Tom admitted that he had always told himself that the stories of his life were “not bad enough to qualify as abuse,” which resulted in his decision to never share his childhood experiences with his wife. At the age of 52, Tom shared his story for the first time in his life with his therapist, and a few weeks later with his wife. At this point, Tom also admitted the need for more social support, and agreed to reach out to a group of friends at church who he viewed as trustworthy. However, even though he ultimately felt supported by the close friends in his church community, he experienced church as a scary place. When asked further about this, Tom articulated the belief that God must look upon him “with disgust” and “can’t possibly see me as worthy of having a good life.”

In view of the definition of complex trauma provided in this article, Tom’s childhood experiences and the resulting life patterns illustrate various dynamics of trauma exposure and adaptation. During his childhood development, when emotional and social skills would normally be cultivated, Tom’s experiences were defined by chronic verbal abuse, emotional neglect,

domestic violence exposure, and a pervasive lack of a protector or advocate. Tom’s story reveals an adult who is coping the best that he can, but with significant gaps in his ability to identify, manage, and express his feelings in a relationally healthy manner. Additionally, Tom’s symptoms reveal chronic struggles with a negative view of himself, ongoing medical distress, spiritual fears and alienation, and a proclivity toward numbing his emotions through substance use and withdrawal into sexual fantasy. Tom’s story demonstrates several ways in which complex trauma survivors learn to cope with pain; however, these trauma-driven survival skills are often significantly misunderstood by the people surrounding the survivor.

For clinicians in general, understanding complex trauma is of critical importance. It is estimated that the prevalence of childhood trauma histories in the general psychiatric population ranges from 40% to 70% (Saxe et al., 1993; van der Kolk, 2003; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). In addition to these prevalence statistics, a striking body of research has accumulated over the past two decades linking histories of adverse childhood experiences with many chronic health problems and risky health behaviors in adults (Anda et al., 2008; Corso, Edwards, Fang, & Mercy, 2008; Dube et al., 2009; Felitti et al., 1998).

For the psychotherapist working with Christian clients, there is an additional layer of complexity: A history of relational trauma often leads to difficulties with meaning-making and can distort and erode core faith beliefs. According to Herman (1992), “Traumatic events...undermine the belief systems that give meaning to human experience. They violate the victim’s faith in a natural or divine order and cast the victim into a state of existential crisis” (p. 51). Further, some of the core components of the long-term impact of complex trauma overlap significantly with spiritual concerns. For example, a central struggle for complex trauma survivors is negative self-perception, including the experience of chronic guilt, intense shame, and feelings of being evil or unworthy. For the Christian therapist, a fundamental assumption about people is that all are made in the image of God or are *image bearers* of God’s likeness. Therefore, the clinician working with Christian clients has the opportunity to assist trauma survivors in a path of healing that includes adopting new beliefs about the self as a person of worth. Another common experience for those with a complex trauma history is to experience alterations in their “systems of meaning,” which can include hopelessness, despair, and loss of

previously sustaining beliefs, including faith beliefs (Cloitre et al., 2012; Herman, 1992; Luxenberg et al., 2001). Again, this is an opportunity for the therapist to connect deeply and sensitively with the Christian client whose sense of hope and faith has been profoundly wounded.

Complex Trauma: Fundamental Concepts

It is important to first note complex trauma's origins in early attachment relationships to primary caregiver(s). Attachment theory and other interpersonal theories of understanding suggest that a secure and consistent model of nurturing over time imprints upon a child the belief that others can be trusted and relied upon, and that the world is generally a safe place (Bowlby, 1988). However, when children experience relationships as rejecting, unsafe, or tumultuous, this experience often translates into long-term negative beliefs about self and others and impairs patterns of relating.

Complex trauma should also be understood in terms of its long-term biological impact on human development, with the most severe neurobiological consequences correlating with earlier abuse and/or neglect. In early childhood, the size, activity levels, and neural connections in the brain increase dramatically, with subsequent critical periods of development that continue into the early twenties. Although an in-depth discussion of the neurobiological impact of trauma is beyond the scope of this chapter, the literature related to interpersonal neurobiology, affect regulation, and the biological impact of trauma has much to contribute to a well-formulated understanding of the traumatized client (Cohen, Perel, DeBellis, Friedman, & Putnam, 2002; Curtis & Cicchetti, 2007; Perry, 2009; Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Schore, 2003; Schore & Schore, 2008; Shonkoff et al., 2012; Siegel, 2001; Teicher et al., 2003; van der Kolk, 2003; van der Kolk, 2006).

When considering the impact of trauma on child development, it is important to conceptualize development as a cumulative process, with the mastery of each new task or milestone laying the groundwork for success at the next level. Experiences of relational trauma, neglect, and environmental adversity have been found to have a significant, formative impact on development (Pynoos, Steinberg, & Wraith, 1995; Siegel, 1999). Blaustein and Kinniburgh (2010) describe the various negative outcomes and risk factors resulting from complex trauma as "core developmental deficits" in four competency categories: intrapersonal, interpersonal, self-regulatory, and neurocognitive.

One of the most striking and consistent areas of developmental impact is a survivor's difficulty with regulating emotions and behavior. For a child growing up in a relatively healthy and non-traumatic environment, there are opportunities throughout development to learn to manage emotions and behaviors in ways that fit the situational demands. However, for individuals who were unable to master regulation skills in childhood due to the developmental impact of trauma, those deficits may still be functioning as the root causes of an array of functional difficulties in academic, vocational, and interpersonal situations.

Complex trauma case conceptualization and treatment planning are based on the premise that the majority of treatment-seeking adult survivors of complex trauma exhibit disturbances across core areas of functioning: (a) emotional and behavioral regulation difficulties; (b) disturbance in relational capacities, such as altered perceptions of self and others; (c) alterations in attention or consciousness, such as dissociation; (d) somatic distress; and (e) adversely affected belief systems (Cloitre et al., 2012; Pelcovitz et al., 1997). In addition, many of these clients also experience distress in one or more of the PTSD symptom clusters of hyperarousal, avoidance, and re-experiencing (van der Kolk et al., 2005).

Trauma and Spirituality-Informed Assessment

In light of impaired early relationships, alterations in optimal neurobiological and physiological development, and wide-ranging deficits in self-regulatory capacities, it is not difficult to imagine why the diagnostic presentation of complex trauma survivors is so complicated. Clients with complex trauma histories typically present with multiple comorbid diagnoses (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Likewise, most exhibit some combination of distressing behaviors including, but not limited to, self-injury, dissociation, emotional intensity or constriction, social isolation, substance abuse, disordered eating patterns, excessive or constricted sexual behaviors, sensation seeking (behavioral/relational), chronic medical problems, persistent alterations in mood, and reenactment of unhealthy relational patterns (van der Kolk, McFarlane, & Weisaeth, 1996).

There are a number of particular components of assessment that are critical to consider in the effort to adequately understand the client with a complex trauma history. These include obtaining a thorough history of the client's trauma by conducting a comprehensive biopsychosocial assessment; assessing the client's

relational history through a trauma-informed lens; carefully examining the chronology, interrelationship, and plausible misdiagnosis of comorbid conditions; and utilizing specialized assessment tools as applicable (Briere & Spinazzola, 2005; 2009; Luxenberg, Spinazzola, & van der Kolk, 2001). Additionally, it is important to explore clients' religious or spiritual histories, in order to assess their spiritual distress, the impact their specific faith beliefs have on their view of their trauma history, their view of God in terms of their internal working models, and the potential for their religious practices and faith community to serve as either a resource or barrier in treatment. To this end, there are several spiritual assessment resources that, if considered in light of a trauma-informed assessment process, could serve as useful guides in this regard (Moriarty & Davis, 2012; Pargament, 2007; Pargament & Krumrei, 2009).

Spiritually-Informed Treatment With Complex Trauma Survivors

Twenty years of research and clinical experience have substantiated that the most effective approach to treatment with complex trauma survivors is phase-based and involves three stages of therapy. Phase 1 focuses on facilitating physical and psychological safety, reducing symptoms, and increasing emotional and behavioral regulation capacities; Phase 2 focuses on processing and integrating traumatic memories as a part of the client's more cohesive sense of self and history; and Phase 3 focuses on connecting to and preparing for a sense of community engagement and competency beyond therapy (Cloitre et al., 2012; Herman, 1992). Although these phases have distinct features, there is a necessary fluidity to treatment with complex trauma survivors, by which therapeutic work in one phase (e.g., trauma processing) will often necessitate drawing upon previous work from another phase (e.g., emotional regulation strategies). It is for this reason that the Trauma Center¹ has delineated a component-driven model of intervention with adults impacted by complex trauma: Component-Based Psychotherapy (CBP; Hopper et al., in press). This model consists of four principal components: (a) relationship, (b) regulation, (c) parts work, and (d) narrative, and is predicated upon the importance of client-therapist parallel process to therapeutic

movement and client change. The remainder of this article will discuss this model, particularly in the context of working with clients from a Christian faith background.

Primary Conduit of Treatment Change: Client-Therapist Parallel Process

In CBP, treatment is rooted in the recognition that the client will be impacted by the relationship with the therapist and likewise, the therapist will be impacted by the relationship with the client. When considering client and therapist faith beliefs as a dimension of the therapeutic relationship, there is added complexity in the parallel process. For example, the client and therapist may or may not share similar spiritual beliefs or religious backgrounds. Certain religious beliefs may hold positive valence for the client and not for the therapist. Given the critical importance of therapist attunement and the sensitive role that spirituality can hold in client experience, such factors are helpful to bear in mind as a part of the overall therapist-client relationship.

Therapist, know thyself. In order to function in a healthy and effective manner as a therapist, the importance of self-reflection and self-awareness is vital. Therapists must strive to recognize and understand their own defensive coping strategies, and they must learn how to stay attuned to the types of interactions that activate those defensive strategies (either toward being overly reactive toward a client or overly protective of a client). When considering the potential impact of working with trauma on the spiritual life of the therapist, there is an added consideration in knowing oneself. Do therapists have religious beliefs or traditions that leave them vulnerable to not fully hearing or witnessing a client's pain? How do therapists manage the potential cognitive dissonance between their religious beliefs and their clients' experiences and the resulting existential questions that may arise? Given the importance of therapist self-awareness when working with vulnerable clients, it is highly recommended that therapists consider either ongoing personal therapy for themselves and/or ongoing supervision with someone who can help navigate the psychological and spiritual reactions that may arise. Wiggins (2009) recommends a variety of spiritual self-awareness questions and exercises that may facilitate therapists' process of self-reflection, including a spiritual genogram or a spiritual autobiography in which therapists examine their previous positive and/or negative experiences with particular faith beliefs and practices.

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Therapist as a healing “tool.” Fear of relational connection and intimacy is one of the painful legacies of exposure and adaptation to complex trauma. Clients’ historical experiences commonly impact the therapeutic relationship, and therapists find themselves engaged in enactments that mirror clients’ past relational struggles. Although there are countless specific ways in which a therapist can get “pulled into” enacting old and familiar unhealthy patterns with clients, they have the daunting task of interacting with each client in a way that embodies a new and corrective relationship. This requires therapists to be deeply mindful of their own state of attunement and self-regulation with each client.

Relational rupture and repair. The attachment theory literature describes processes by which infants and caregivers experience *ruptures* in the relationship, where infants feel momentarily abandoned or not well cared for by caregivers (Bowlby, 1988). In normative parental relationships, the primary caregiver *repairs* this temporary rupture in the relationship by tending to the child’s needs. As long as the caregiving is consistently attuned, and repairs are made when needed, the child learns to internalize the dynamics of a healthy relationship with another flawed human being. This dynamic is also experienced between client and therapist in a relational treatment model (Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 2000), whereby therapists might intervene in a manner that is misattuned or dysregulated. Therapeutic ruptures and the process of acknowledgement and repair can serve as tremendous healing experiences for clients with complex trauma histories, who may have rarely had the opportunity to experience relational disruption in a safe context. It is in the context of this therapeutic relationship that we will consider the four components of the CBP model.

Treatment Component 1: Relationship

A client with a complex trauma history typically comes to therapy with many painful relational experiences and unhealthy definitions of relationship. One of the primary goals of this model is to assist clients in examining past relationships, drawing connections between their past and present relational patterns, and altering unhealthy relational dynamics in their present life. Returning to the example of Tom and Darlene, Tom entered therapy due to marital distress related to his wife’s recent discovery of his secretive financial and sexual behaviors and drug use. During the early

stages of therapy, Tom and his wife Darlene presented as a couple for treatment, and Darlene continually requested that the therapist focus on the “enforcement” of behavioral techniques to manage Tom’s behavior. Although Darlene was understandably hurt and angry at the discovery of several secrets after 28 years of marriage, the ongoing intensity of her expressed emotions contributed to a cyclical communication pattern in therapy, in which Tom expressed deep shame and self-contempt related to his past behaviors and Darlene expressed ongoing anger and doubt of his sincerity and ability to change.

After a more thorough assessment of both Tom’s and Darlene’s histories, the therapist discovered that both individuals came from a context of childhood trauma. Both experienced varying degrees of neglect and abuse in their families of origin, and neither had disclosed this history to the other. For Tom, his behaviors and subsequent shame after being discovered by his wife paralleled the deep sense of shame and social/emotional isolation he experienced as a child. For Darlene, the relational betrayal and her experience of her husband’s strip club visits as “just another example of men viewing women as sexual objects” mirrored her own childhood experience of betrayal and sexual exploitation in her family of origin. Further, her sense of loneliness in light of Tom’s withdrawal into pornography was reminiscent of her childhood memories of feeling alone in her suffering. Both partners were continuing to live out the unique relational survival patterns originally cultivated in the context of developmental trauma. When feeling overwhelmed or defeated, Tom reverted inward—into fantasy—which led to subsequent shame and self-loathing. When Darlene’s sense of relational safety felt threatened, this fear triggered her to react angrily and aggressively in self-protection.

Furthermore, this pattern overlapped with elements of spiritual struggle for both Tom and Darlene. For Tom, marital conflict elicited a further sense of shame in the eyes of God (“How can God forgive me if my wife cannot?”), while it incited a heightened sense of anger at God in Darlene’s experience (“How could God allow this to happen after all I’ve been through?”). In summary, Tom and Darlene’s individual patterns of relating and coping made logical sense in the context of their life histories; however, their shame and secrecy had prevented them from ever disclosing, discussing, or even realizing how their histories, beliefs about themselves and others, and coping patterns had been impacting their relationship throughout their marriage.

In this example, it is clear that there are many levels of therapeutic work to be done within the couple relationship. However, this example highlights the need for both trauma survivors to understand their relational beliefs and patterns, in order to develop new and healthier relational skills and responses. The relational component of trauma therapy is well served by the use of treatment models that can empathically lead clients toward a greater range of emotional experience and safety in sitting with those emotions. Additionally, the therapist can assist in giving language and validation to experiences, in a way that helps the client understand the connection between past and present relational difficulties and patterns (Fosha, 2003; Fosha & Slowiaczek, 1997).

When working with a client from a Judeo-Christian religious background, an understanding of the literature both on attachment to God (Beck & McDonald, 2004; Granqvist & Kirkpatrick, 2008; Hall, Fujikawa, Halcrow, Hill, & Delaney, 2009; Kirkpatrick, 2005; Maltby & Hall, 2012) and on God-image (Moriarty & Davis, 2012) can help inform the relational treatment component of CBP. Given the relevance of attachment theory to a thorough understanding of complex trauma treatment, the attachment to God and God-image literature significantly contributes to an understanding of how one's implicit experience of God might interact with internal working models of self and others. With some religiously-oriented clients, therapeutic interventions exploring their views of God (and assumptions about God's view of self) could be beneficial in reducing a sense of spiritual shame and negative view of self. Further, given that there is evidence to suggest that individuals' implicit experience of God is based on past relational experiences (Hall et al., 2009; Maltby & Hall, 2012), the therapeutic relationship can potentially serve as a healing agent in a client's gradual process of experiencing care and acceptance on a spiritual level.

Treatment Component 2: Regulation

For individuals who have grown up in a chronically traumatic and/or rejecting environment, the issue of self-regulation is a key component of treatment (Cloitre et al., 2012). Emotional and physiological arousal often serve as triggers for the fight, flight, or freeze response in the autonomic nervous system (McEwen, 1998; van der Kolk, 2006). Although this pattern of automatic response may have been adaptive and necessary for survival at one time for the client, it often becomes habitual over time and no longer meaningfully connected to present events. For many adult clients

with complex trauma histories, overwhelming emotions or high levels of arousal will automatically lead to whatever coping strategy they have learned to be most effective at emotional suppression or arousal reduction, such as self-harm, substance abuse, dissociation, or aggressive interpersonal responses to others (Ford & Courtois, 2009).

The goal of addressing regulation in CBP is to enhance the client's capacity to modulate affect and arousal in a more agentic, deliberate, and adaptive manner in order to restore healthy equilibrium following dysregulation of emotions, behaviors, physiology, and thoughts. Therefore, treatment includes helping clients develop or improve awareness of arousal states and teaching clients to use tools for regulating arousal states. It is important to acknowledge, however, that the clinical presentation of emotional and behavioral dysregulation is diverse and unique to the survivor.

Consider distinct examples of dysregulation in what we might consider two ends of an emotional continuum for Tom and Darlene. As described above, Tom is emotionally constricted and tends to cope with his chronic shame and internalized symptoms through numbing coping patterns. Darlene, on the other hand, is emotionally reactive and tends toward over-arousal and aggressive relational interactions. Tom's and Darlene's patterns, although logically connected to their past lives, are no longer functional. In the midst of their successful efforts to survive their childhoods, Tom and Darlene never learned the requisite life skills of recognizing, naming, and managing their emotions in the moment. In the example of Darlene, she would benefit from the opportunity to take a step back from her reactivity and identify her emotional, cognitive, and physiological "in the moment" responses when she gets activated. In Tom's case, learning to gradually acknowledge and tolerate an emotion without numbing will be an important treatment challenge. For clients with these and other emotional and behavioral regulation difficulties, there are several skills that the client can learn that will lead to building competence in self-regulation.

Building awareness of triggers. This involves helping the client identify and understand both the internal and external sensory, emotional, and relational cues that lead to emotional/physiological arousal and distress.

Identifying, labeling, and expressing emotions. Survivors of complex trauma often have not had the developmental opportunity to learn how to accurately

understand and label emotions, particularly in the moment of stressful interactions. Further, clients from a Christian faith background can be prone to experiencing guilt about expressing emotions or believing that particular emotions (e.g., anger, fear) are sinful. This is particularly true for clients who have experienced spiritual abuse or who grew up in a family that professed a Christian faith and was simultaneously abusive. For these clients, permission to feel a range of emotions, gentle assistance toward an emotional vocabulary, and empowerment to express emotions can lead to important growth and healing.

Building mindfulness skills. Survivors of complex trauma are often prone to self-criticism and shame, which can make the process of identifying and embracing emotions very complicated. Through mindfulness skills training, therapists encourage clients to “sit with” feelings with the goal of increasing their self-compassion and acceptance for a range of emotional expression. Hathaway and Tan (2009) describe a religiously oriented variation of Mindfulness-Based Cognitive Therapy (MBCT) that can assist therapists in integrating aspects of prayer and meditation on God into treatment when helpful to the client. In their adaptation of MBCT, Hathaway and Tan provide a case example in which a Christian client’s ability to engage with painful affect with less self-criticism and greater self-acceptance was enhanced by her faith beliefs. As the therapist encouraged the client to connect to her stated belief in God’s unconditional love and acceptance in the midst of her painful inner experience, gradually she was able to grow in her ability to internalize self-compassion. Practically, the client was simply reminded to meditate on God’s presence while engaging in mindfulness practice and “invite God into dialogue” (Hathaway & Tan, 2009, p. 166) related to her distressing thoughts and emotions. This example illustrates how assisting a client in integrating Christian faith beliefs into mindfulness strategies can act as a powerful enrichment for building regulation skills.

Explicit use of spiritual resources in regulation. There are various forms of prayer and meditation that could be useful for some clients in the service of regulation. Contemplative prayer (Merton, 1969) and centering prayer (Keating, 1994) originate from monastic traditions and encourage quieting the mind and body while meditating on a single sacred word or phrase. Breath prayer (Barton, 2006) is a similar form of prayer that guides the individual to focus on her breath as the life-giving essence, while gently and rhythmically

repeating a brief phrase that elicits comfort or connection to God. Additionally, religious imagery can serve as a means of self-soothing, as the individual focuses on a sacred image that might evoke a sense of safety, connection, or empowerment. Clients can engage in prayer and meditation in either calm or more active states, depending on the physiological regulation needs of the individual.

One of the challenges that can arise in a Christian context is confusing dysregulated behavior with willful sin. While the concept of sin is an important component of the Christian faith, clients with emotional and behavioral regulation difficulties may be prone to coping adaptations that would traditionally be viewed as sinful (e.g., substance abuse, various sexual behaviors). For the therapist working with Christian clients, this is important to understand for various reasons. First, it is important to assist clients in viewing their own coping behaviors and relational patterns in light of trauma history. For clients who are prone to shame, it can be healing to learn how to honor their past coping behaviors. Additionally, understanding this overlap can assist the therapist in educating faith communities and clergy on the challenges of behavioral change for the trauma survivor.

Treatment Component 3: Parts Work

When working with complex trauma, it is always important to assess for dissociative symptoms and coping styles, given the prevalence of dissociative experience for survivors. Although it will be experienced and manifested at varying levels of severity, dissociation is a normative part of the survival experience in complexly traumatized clients (Steele & van der Hart, 2009; van der Kolk et al., 1996). Less severe dissociation might be experienced by trauma survivors as cognition without emotional connection or as somatic symptoms experienced without cognitive awareness (Putnam, 1997); whereas more severe dissociation might be experienced as distinct alterations in their state of consciousness.

When working within the CBP model, it is assumed that trauma survivors have “parts” of themselves, which are understood to represent split off or un-integrated aspects of their larger identity. It is also assumed that these parts often originally helped the person survive and endure painful experiences by containing traumatic and overwhelming memories and the associated somatic, affective, and cognitive symptoms. Trauma survivors often carry a profound burden of shame and stigma about their dissociative experiences, thus putting these experiences into words can assist survivors in the process of feeling less alone. Parts

work involves psychoeducation about the normalcy of experiencing aspects of self in various “parts,” making connections between present-day experiences of self with past trauma experience, and integrating the diverse self-experiences into a more cohesive sense of self.

In the case of Tom, therapy uncovered various ways in which he experienced different parts of himself in different settings and relational circumstances. For example, although Tom typically felt nervous prior to his visits to the strip clubs and profoundly guilty afterwards, he reported that in that setting he felt like a “different person”—strong, attractive, and sexually confident. When spending time talking to the other tenants in his secret apartment, Tom described himself as feeling relaxed and self-assured in a way that was not consistent with his affective experience at home. In those moments, Tom also abhorred his compliant, mild-mannered, depressive self as a “big sissy” who defers to his wife and volunteers at church. As Tom explored these various self-experiences, he realized that even his mannerisms, tone of voice, and posture were quite different in these multiple contexts.

Tom was initially tentative in therapy when discussing parts of himself, disclosing the fear that his therapist would “think I am crazy.” However, through the process of reflecting on his present day experiences of himself in light of his past abusive context, Tom began to make connections. He was able to explore his present-day experiences in light of a childhood in which his father belittled emotional expression and his mother was emotionally disempowered. Over time, Tom developed compassion for the parts of himself that he had previously disavowed, while also beginning to integrate his affective experiences in a way that was increasingly coherent. He reported a significant level of relief in being able to acknowledge these previously confusing and disconnected states of being. Tom’s treatment illustrates the manner in which parts work is essential to a comprehensive complex trauma treatment approach, given the importance of addressing dissociative symptoms. Further treatment resources address the range of common dissociative experiences and treatment approaches (Boon, Steele, & van der Hart, 2011; Schwartz, 1995; Steele & van der Hart, 2009), including specific ways to incorporate Christian spirituality into work with internal parts of self (Steele & Schwartz, 2010).

Treatment Component 4: Narrative

Much of the traditional trauma treatment literature discusses the importance of memory processing for the

purpose of decreasing anxiety and other psychological and physiological symptoms of PTSD (Foa et al., 2005; Foa, Keane, Friedman, & Cohen, 2009; Goodson, Lefkowitz, Helstrom, & Gawrysiak, 2013; Resick et al., 2008). In CBP, the core treatment component of narrative involves understanding, accepting, transcending, and integrating traumatic experiences into one’s broader life narrative. With this understanding in mind, trauma experience integration includes narrative processing, mourning losses, making meaning of the traumatic experiences, and moving beyond the identity of survivor to an identity of one who is engaged in a meaningful life. It is this treatment component that lends itself most naturally to the discussion of integration of faith and psychological treatment, as the larger existential questions of understanding theodicy (e.g. Who is God in the midst of my suffering?) and one’s personal faith journey (e.g. How do I relate to God in light of my trauma story?) are common in trauma processing for the Christian client.

Narrative processing. Initially, there are several important treatment considerations when transitioning into the therapeutic phase of narrative processing. In order to safely move into this phase of treatment, it is important that clients have established adequate self-regulation capacities and have access to environmental support, in order to tolerate the anticipated distress that will likely accompany trauma processing (Cloitre et al., 2012). Additionally, it is important that therapists help their clients understand the purpose of narrative processing: to face the pain, fear, and shame of the traumatic past while being grounded in the present in order to integrate the traumatic memories into a more cohesive life story. When clients can tell their story to an empathically engaged and trusted ally, the anxiety and shame begins to decrease, and the stories become less powerful and controlling over their everyday lives. Additionally, when clients can engage in the process of narrative processing with the aid of healthier self-regulation tools, they will begin to experience themselves as empowered and in greater control of previously chaotic arousal states.

Mourning the losses resulting from a trauma history. In the process of telling their stories, trauma survivors often come to recognize—either for the first time or at a deeper level—the many losses that resulted from the chaotic, abusive, or neglectful nature of their pasts. For some, the absence of the desired nurturing relationship with a caregiver may emerge as a profound

loss to be grieved. For others, the loss of a “normal” childhood or the sense of self as damaged in ways that others do not understand may stand out as a significant injustice. There are countless losses that may emerge in the unique life of each client, and the emotionally significant process of realizing, naming, and mourning those losses can be deeply meaningful to the healing process. Mourning in the therapeutic process often involves sober reflection and profound sadness. At the same time, mourning can provide the opportunity for deeper self-understanding and self-compassion, due to realizing the significance of their personal pain. Mourning may also prompt some to move forward in their lives to advocate for healing and justice in the lives of others.

Contemporary culture often does not make space for the process of grief and mourning. This can be especially true in the Christian subculture, where some individuals and families feel the pressure to “look good.” Additionally, clients who identify as Christian will often report feeling guilty for a perceived lack of faith, hope, or forgiveness when they are walking through times of suffering. However, the ancient scriptures do not condemn or lecture those who are mourning; rather, the scriptures provide a method by which people can learn to process their pain in a spiritual context. In his book entitled *Raging With Compassion*, John Swinton (2007) discusses the psalms of lament as a means of expressing pain to God and others:

A lament is a repeated cry of pain, rage, sorrow, and grief that emerges in the midst of suffering and alienation.... Lament, and in particular psalm-like lament, is the cry of the innocent, the one who feels treated unfairly, who feels that God has somehow not lived up to the sufferer's covenant-inspired expectations. Most importantly, lament is prayer. It is, however, a very particular form of prayer that is not content with soothing platitudes or images of a God who will listen only to voices that appease and compliment. Lament takes the brokenness of human experience into the heart of God and demands that God answer. (p. 104)

Using the language of lament, trauma survivors can begin to give voice to some of the ambivalence in their view of God and faith. The psalmists express intense emotions including anger, hopelessness, powerlessness, betrayal, and a sense of injustice. Psalm 13:1 (English Standard Version) states, “How long, O Lord? Will you forget me forever? How long will you hide your face from me? How long must I take counsel in my

soul and have sorrow in my heart all the day? How long shall my enemy be exalted over me?” In this psalm, David expresses the sense of isolation and betrayal that many trauma survivors often express.

However, there is also a sense of grounding in these lamentations in that they are often written in the context of remaining anchored to one's faith beliefs, in spite of the uncertainty and unanswered questions. This grounding can be important to many Christian clients, who may experience guilt when admitting anger at God, and can find echoes of their own ambivalence toward God in these biblical texts. As Swinton (2007) further states, “lament provides us with a language of outrage that speaks against the way that things are, but always in the hope that the way things are just now is not the way they will always be” (p. 105). Lament is engaging honestly with God in the process of meaning-making, with the option of reconciliation with God despite unanswered questions about the existence of evil and suffering in the world. Additionally, the practice of lament is grounded in a framework of hope, empowerment, and future orientation.

Swinton (2007) recommends the creation of a personal lament from a pastoral perspective, but this practical treatment strategy could be adapted for use with particular Christian clients engaged in mourning and meaning-making processes in therapy. Following the sequence often reflected in sacred lament texts, clients might consider writing a lament, which could contain naming the offense (e.g., “I am confused and angry that you [God] did not protect me from the suffering of my abusive and chaotic family”) along with an appeal for future justice and peace. The practice of lament can be incorporated into trauma processing with the Christian client, where clients are given permission to express complex and mixed emotions to God through journaling, poetry, music, visual art, or other expressive means.

Moving through processing to meaning-making.

It is relatively well-established that striving to make meaning of our experiences is a natural human endeavor (Frankl, 1984). Additionally, there is a growing body of literature discussing the importance of meaning-making in the lives of those who have experienced trauma and adversity (Grossman, Cook, Kepkep, & Koenen, 1999; Grossman, Sorsoli, & Kia-Keating, 2006; Harvey, Mishler, Koenen, & Harney, 2000; Herman, 1992; Park & Ai, 2006; Solomon, 2004). As mentioned earlier in this paper, there is a complicated relationship in the literature between trauma, religion,

and spirituality, where many of the reported outcomes of stress-related growth (Park, 2005) are focused on situational or community-based traumatic exposure, whereas complex trauma often leads to more severe disruptions in the ability to reconcile questions of suffering and faith. However, these findings make sense when considering that complex trauma most often occurs during childhood or adolescence and influences developmental outcomes.

Gabarino and Bedard (1996) use the term *spiritual dissonance* to describe the significant impact of complex trauma on the spiritual development of children, stating: “by ‘spiritual’ we refer to the inner life of children and adolescents as the cradle for the construction of meaning” (p. 467). They suggest that those who experience trauma at the youngest ages are most vulnerable to lifelong struggles with meaning-making. In contrast, they posit that those who experience trauma in later stages of life have greater “metaphysical momentum in the sense of the longest period of building up behaviors and beliefs to substantiate and support core belief systems” (p. 471).

With this knowledge in mind, it is of the utmost importance that Christian therapists are able to “sit with” the deep sense of ambivalence with which many complex trauma survivors experience their faith. Sitting with this ambivalence in therapy also requires therapeutic restraint from the attempt to answer the painful “why” and “where was God” questions. Instead, the therapist should recognize that these questions “actually contain a hidden request for support in bearing the nearly intolerable feelings associated with having no answers to life’s most profound questions” (Day, Vermilyea, Wilkerson, & Giller, 2006, p. 50). For the Christian therapist working with complex trauma survivors who are grappling to make sense of their faith in light of a painful history, it is of critical importance to approach the work with great humility. Making meaning of past trauma while trying to grapple with the big questions related to God’s existence, God’s goodness, or the benefits versus harms of religion can be a deeply confusing task for the client and the therapist.

The impact of complex trauma bears the risk of damaging or distorting one’s faith system and view of self in relation to God. However, there are tenets of the Christian faith that both psychology and faith traditions believe to be optimal in recovery from suffering: connection (to God and community), sense of meaning, belief in something larger than oneself, observance of ritual, forgiveness, and hope. Hope, in this context, is beyond mere optimism. Rather, hope

“sees [dangers and heartaches] and then sees past them to possibility” (Day et al., 2006, p. 58). Although the therapeutic process can be slow and tedious, therapists should maintain the goal of helping clients move beyond the identity dichotomy of *victim* versus *survivor* to a life of meaningful engagement and fulfillment. In order for this therapeutic aspiration to become reality, however, therapists need to be able to assist their client in embedding the trauma narrative within the client’s greater life narrative.

In the latter stages of Tom’s therapeutic journey, he discovered the hope that can be found in a more integrated life narrative. Although mourning the many losses in his life was deeply painful (e.g., loss of a connection to his deceased parents, loss of years of authentic connection to his wife and children), Tom was surprised at the freedom that he experienced on the other side of processing his narrative with a safe and accepting therapist. Additionally, Tom allowed himself for the first time to acknowledge and verbalize the anger and confusion toward God that had previously led to further guilt and denial. The experience of sharing his ambivalent thoughts and feelings about God with someone who neither denied his faith nor his doubt led Tom to a place where he could live in the mystery and the ongoing questions of his deeply held Christian beliefs. Finally, Tom and Darlene both learned that there was restorative hope in the process of sharing their stories with each other. Although the task of rebuilding trust was slow, Tom and Darlene learned to understand one another’s vulnerabilities in the context of past abuse and neglect. It was only when Tom began to experience himself as a person of worth, through authentic relationship, that he could articulate that his life has purpose and meaning. At the end of treatment, Tom described his transformation through therapy as “waking up for the first time.”

Therapist meaning-making. The mere fact that one of the core areas of trauma impact is related to disrupted systems of meaning (including faith beliefs) calls for clinicians who are well-trained academically and clinically, and who are also spiritually sensitive and competent in the integration of faith and professional practice. Bearing witness to a client’s story may be one of the most profound experiences therapists encounter. If therapists have the honor of accompanying a client through the process of lament and grieving, it is truly a sacred privilege. At the same time, therapists who work in treatment of complex trauma often experience vicarious traumatization, which may also include altered

systems of meaning-making that threaten the therapist's belief systems and faith practices. Pearlman and Caringi (2009) state, "disrupted spirituality is a hallmark of both direct and indirect trauma, and rampant cynicism or despair in clients with complex trauma can challenge the helper's sense of meaning and hope" (p. 209). Perhaps the therapist working with complex trauma can benefit from heeding the words from Langberg (1997): "to sit with suffering is to be a companion to those things that will wage war on the core of your faith." (p. 241). Therefore, it is critical that therapists working with complex trauma consistently attend to their own personal, relational, and spiritual identity, and nurture relationships and practices that maintain a solid sense of emotional, physical, and spiritual health.

Future Directions

Treating individuals impacted by complex trauma is intricate, arduous work. Integrating a faith perspective into this process—while helping Christian clients contend with the challenges to their faith that inevitably arise as they grapple with the meaning and impact of the adversities they have suffered, the losses they have endured, the love and protection they were denied, and the solace that never came—is more exacting still. There remains a critical need for ongoing research focused on treatment outcomes with adults affected by childhood trauma, and as highlighted by this paper, there are additional complexities to be addressed in evaluating optimal interventions with clients from a Christian faith. Broadly, future research with the use of CBP should explore the manner in which intervention components can be tailored to the religious and/or spiritual needs of clients from diverse faith backgrounds, exploring various adaptations that might be useful to increase efficacy and cultural relevance. In the specific context of working with Christian clients, pursuing empirical evaluation of CBP in the treatment of complex trauma from a Christian perspective would be invaluable to future clients and clinicians alike.

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