

Lancaster Theological Seminary

**Unveiling Religious Trauma: A Feminist Perspective on Personal Narratives,
Assessment Tools, and Psychospiritual Care**

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by

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and Psychospiritual Care
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Abstract

This dissertation presents an inductive research methodology aimed at exploring the understudied phenomenon of religious trauma and its assessment tools through a feminist lens. The research commenced with the collection and analysis of personal narratives from individuals who have experienced religious trauma. These narratives served as the foundation for identifying patterns and themes crucial for developing hypotheses guiding the investigation of published spiritual assessment tools and the formulation of a religious trauma screening tool. By centering the narratives of religious trauma survivors, this study seeks to empower individuals and communities affected by religious trauma while advocating for social change within academic and professional spheres related to chaplaincy, counseling, and social work.

Engaging in qualitative research, this study unveiled insights into the multifaceted nature of religious trauma, emphasizing the significance of incorporating personal experiences into the research process. Furthermore, this dissertation adopts a transdisciplinary approach, bridging academic disciplines and professional fields to address the complexities of religious trauma and to provide a screening resource that is trauma-informed and considers experiences of intersectionality.

This dissertation introduces the Shepley Religious Trauma Screening Tool (SRTST), designed to function within a trauma-informed psychospiritual care system. The SRTST aims to assist chaplains, counselors, and professionals in child welfare in recognizing religious trauma symptoms and adverse religious experiences among children and youth populations, thus facilitating early intervention and support.

To Adam, Dimitri, and Alistair – for all the sacrifices.

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Chapter 1: Introduction

One ultimate quest of my life has been a constant search for a sense of belonging. I began this search as a child who often felt misplaced and misunderstood, and continued seeking a community that would fully embrace me as my genuine, authentic self well into adulthood. I did not know as a young person that I was living with autism and how the disorder was impacting my life or worldview. I was not raised in a religious family, though I did seek out religious people and was curious about spirituality as a child. Other kids at school who were popular, or more importantly to my child self, not poor, talked about Sunday School and youth groups and they made church seem like the place to be. Those other kids appeared to me as well adjusted and happy. I thought if I could figure out this whole church thing, then I might also slip into a life full of friends and away from poverty.

When I was nine years old, I visited my best friend's Southern Baptist congregation for the first time. My father had reservations about me visiting the church, but I was so excited to sleep over at my friend's house and go to church with her family the next morning that he eventually said it was alright. My friend lived next door and the church was a short walk away, so the next morning, dressed in our Sunday best, we skipped from her house to the church. What I remember most about the experience is that the pastor began his sermon by yelling to the congregation, "You are all wretched creatures in need of redemption!" And then, the congregation shouted back at him, "Amen!" I was shocked that this man had just openly insulted everyone, and more so that they all agreed with him.

After the initial wave of shock passed, I sat stewing through three hours of the pastor's berating, humiliating, confusing, and scary shouts and hollers. I had imagined the arts and crafts tables and singing fun songs, but now, suddenly, I was worried about my own wretchedness and

how I might escape an eternity in the pits of hell. I wanted to rewind to yesterday before I had this newfound source of anxiety and fear. When we finally took a break for lunch, I told my friend I felt sick and walked home. When my dad asked how it went, I said, “It was ok, I just got bored and wanted to come home before they finish lunch and go back to the sanctuary.” He laughed and joked about church being an all-day affair. This was my first major adverse religious experience. When I was 17, I was diagnosed with obsessive compulsive disorder and acute anxiety. I spent the next three decades obsessed with my own wretchedness and how to find a sense of belonging in the world as a wretched creature.

By my mid-thirties I had recognized and accepted a call to ordained ministry in the United Church of Christ and was serving as a licensed pastor for a local congregation. I was an experienced trauma-informed professional and had engaged in various personal therapy practices over the years. I no longer saw myself as a wretched creature, my mental health was managed, and I had found a place to belong. At this time in my life, I thought I was better equipped to safely navigate congregational life for myself and my family. My family lived in the parsonage at the church, and we served nearly five years together with the congregation. In the fall of 2018, during my final year of seminary, my oldest child came out to the congregation as transgender. They were overwhelmingly supportive, and things seemed to continue as usual.

The congregation agreed to serve as my ordaining call - a necessary part of the ordination process in the UCC, and I agreed to support them while they initiated the search and call process to find a new pastor. On Saturday, May 4, 2019 I graduated from Lancaster Theological Seminary with my Master of Divinity degree. I was one step closer to ordination. On Sunday, May 5, 2019, after I led the worship service, the congregation held a secret meeting and voted in favor of withdrawing their support for my ordination.

The president of the consistory was tasked with calling to inform me of the change. She said, through her own tears, the congregation decided that I was “too progressive” and they were “concerned about how your family will reflect on the congregation.” Even as I received this surprising news and my own emotions and thoughts were racing, I was still this person’s pastor, and in those moments, she needed pastoral care. She said she did not agree with the decision and she did not want to make the phone call to me, yet here we found ourselves. I provided what care I could, and we expressed mutual love and respect for each other before ending the call.

I received the phone call while enroute to the annual meeting of the local association, a gathering of other clergy and lay leaders. When I arrived, several people were already informed of this news and greeted me with their awareness. I sat through the meeting humiliated and confused. I was angry and wounded. And then I wondered, how could I share the news with my family without inflicting this harm on them? It turned out, I could not protect my family from the trauma they would endure. We all knew what the congregation meant when they summarized the issue as me being too progressive and referenced my family.

We spent another nine months in the parsonage until my time was up and I was released from that congregation. Over the nine months, I endured frequent re-traumatization and experienced severe depression, anxiety, fear, guilt, and nightmares. Since then, with more trauma therapy and tremendous efforts on each of our parts, my family has nearly fully recovered. I can now speak about these experiences without feeling triggered or questioning whether I belong in the Church.

My story and my family’s experiences are illustrations of adverse religious experiences and religious trauma. Adverse Religious Experiences are understood as “an event, series of events, relationships, or circumstances within or connected to religious beliefs, practices, or

structures that are experienced by an individual as overwhelming or disruptive.”¹ Religious Trauma refers to the “lasting adverse effects on a person’s physical, mental, social, emotional, or spiritual well-being after an Adverse Religious Experience has occurred.”² While both of these terms will be explored further in the Key Terms and State of Field sections of this chapter, it is important to know that religion and spirituality can be sources of adversity and trauma.

For clinicians, it is still relatively new to see religion itself as a source of trauma in people’s lives, according to Laura Anderson, a licensed therapist based in Tennessee.³ “Religion has been looked at as a fairly pro-social or communal factor,” she said, adding, “There were very little resources for clinicians and survivors.”⁴ Simply put, religion has widely been viewed as a protective factor in a person’s life rather than a potentially harmful factor and because of this widespread assumption we have not yet developed adequate resources and tools to support survivors of religious trauma.

Yet, I have observed the presence of AREs and RT in congregational life and in the youth I serve in the child welfare system. I have personally experienced adversity within religious communities and witnessed the infliction of religious trauma onto others. At Bethany Children’s Home, my current ministry setting, I complete a spiritual assessment with each youth during our intake process. In addition to informing how I can provide pastoral support and care for the young person, my observations and notes are shared with the youth’s clinical team including their psychiatrist, therapist, and case manager. In my first six months as Bethany’s chaplain, I adapted two existing spiritual assessments to use during my interviews with youth. I adapted the

¹ Slade, Darren M. GCRR. “Adverse Religious Experiences (AREs) vs. Religious Trauma (RT): An Important Distinction.” Accessed November 30, 2022. <https://www.gcurr.org/post/adversereligiousexperiences>.

² Ibid.

³ Russell-Kraft, Stephanie. “Can Religion Give You PTSD?” *The New Republic*, March 23, 2021. <https://newrepublic.com/article/161772/can-religion-give-ptsd>.

⁴ Ibid.

FICA tool and the HOPE spiritual assessment into a conversational assessment format. During my conversations with youth at intake, some of them shared stories inferring the youth had an ARE and could be suffering from the lingering impacts of religious trauma. In these cases, I was able to ask additional questions to gather enough information to develop a treatment plan. However, these conversational assessments did not provide a direct framework to ensure screening of AREs or RT beyond the assessee's inference and voluntary sharing of information or stories. So, after observing AREs and RT and identifying a gap in published screening tools, I decided to create a religious trauma screening tool that could offer the caregiver a broader, deeper insight into the young person's AREs and how those experiences impact the youth's worldview. In other words, a tool that could help us recognize adverse religious experiences, religious traumas, and trauma symptoms; and then respond to that recognition by incorporating this knowledge into the youth's therapeutic treatment plan.

Bethany Children's Home

In 2009, I learned that Bethany Children's Home was sponsored by the Commonwealth of Pennsylvania to pilot the certification process for the Sanctuary Model of Care developed by psychiatrist Dr. Sandra Bloom. I was interested in Dr. Bloom's philosophy of care for children in congregant settings and juvenile detention facilities and followed her work to Bethany where my husband and I took a job as houseparents in order to participate in Bethany's certification process. Over the first eight years I served at Bethany, I began learning about psychological philosophies and began to understand how we can work together to create what Dr. Bloom refers to as "sane societies."⁵

⁵ Bloom, Sandra L. *Creating Sanctuary: Toward the Evolution of Sane Societies*. Revised ed. New York: Routledge/Taylor & Francis Group, 2013.

Bloom says, “The true objective of the Sanctuary Model is to offer practical tools for operationalizing a moral climate at any level of social organization.”⁶ The model incorporates four pillars: trauma theory, the 7 Sanctuary Commitments, S.E.L.F., and the Sanctuary Toolkit into a model of care that is accessible to organizations interested in developing fair and safe organizational cultures.⁷ I will explore the other three pillars later in my Literature Review and focus now on the second pillar, the 7 Sanctuary Commitments, to help readers understand what Bloom means when she references “sane societies.” The Sanctuary Commitments represent the guiding principles of the Sanctuary Model - the framework of the Sanctuary moral operating system.⁸ The 7 Sanctuary Commitments are designed to be “a coherent, anchoring, moral system for decision making and problem solving that represent universal principles typical of all human rights cultures.”⁹ The Sanctuary Model aims to develop communal commitments to: nonviolence, emotional intelligence, social learning, open communication, democracy, social responsibility, and growth and change.¹⁰ As the anchoring moral system of the organized group, these commitments continuously pull participants back to their own moral compass and the shared practices of the community that are dedicated to overall safety - leading groups to function as a “sane society.”

As a member of the Sanctuary core governing committee at Bethany, I had the opportunity to receive this tremendous education in trauma theory and organizational cultures and then teach these theories to the Bethany community. The tools and resources made available to me through the Sanctuary Model of Care changed the way I viewed my own traumatic

⁶ Bloom, Sandra. “The Sanctuary Model: Through the Lens of Moral Safety.” *APA Handbook of Trauma Psychology: Trauma Practice*. Washington, DC: American Psychological Association, 2017. 499–513.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

experiences, motivated my personal therapeutic growth and recovery, and influenced the way I interacted with the world around me - including how I would come to understand my call to ordained ministry. I integrated the 7 Sanctuary Commitments into my parenting style and marriage, and they quickly became personal core values. Each of these commitments is considered when I engage in discernment for my personal and professional life, and especially when I engage in trauma-informed care.

At the same time as we were moving through this certification process, my family and I attended worship services each Sunday at Bausman Memorial Church on Bethany's campus. Bethany's history tells us that we were founded by Rev. Emmanuel Boehringer who was ordained in the German Reformed tradition and the church on our campus was recognized with standing and supported by the Penn Central, Pennsylvania Southeast, and Penn Northeast Conferences of the United Church of Christ. So, we operated like a church that also managed a non-profit for most of our history. I was fortunate to experience Bethany as the Church, and it was the community's radical hospitality and inclusivity, their cultural concern for social justice, and the commitments to creating sane societies that collided to call me to ordained ministry in the United Church of Christ and ultimately back to Bethany in my current role as Senior Director of Spiritual Wellness and Inclusion.

Today, Bethany is a not-for-profit organization that houses youth through partnerships with county, state, and federal agencies including county-based children and youth social services, juvenile justice organizations, and the federal Office of Refugee Resettlement (ORR). In general, our local youth are court-ordered into placement by a judge who has determined through case records that the youth is unable to live with a legal guardian for reasons related to the youth's health and safety. Once the judge orders the youth into placement with a congregant

care agency, the youth's county assigned social worker reaches out to Bethany to see if we have availability and to assess the youth for placement in one of our programs. Youth attend school and participate in educational and therapeutic programming through our emergency shelter, intensive treatment program, our long-term residential and transitional living programs, and our Helping Hands program which collaborates with the ORR.

Our primary purpose at Bethany is to help our youth achieve permanency placement with appropriate legal guardianship or reunification with family and we do this by helping youth achieve the goals in their service plan, which is developed by the youth's case management team. Service plan goals typically include participating in individual and/or family counseling, increasing school attendance, and developing life skills. The Home is recognized as a trauma-informed Specialized Setting serving survivors of human trafficking and youth transitioning into adulthood; and is the only organization of its kind in Pennsylvania to house transgender, non-binary, and gender-fluid or gender-queer youth according to their gender identity. In 2015, we earned recognition as an Open and Affirming (ONA) organizational partner with the Open and Affirming Coalition of the UCC, and our ability to appropriately house LGBTQ+ youth is one way we live into our ONA covenant. The Home is also recognized by the Joint Commission, which sets care standards for healthcare organizations.

Bausman Memorial is now recognized as a chapel, with our church standing removed in 2015. This allows us to incorporate a multifaith environment in our program of spiritual care. Bridging our experiences and knowledge of the Sanctuary Model with a new vision for healing centered engagement, it is essential that we explore the complex realities in which our youth live and how these youth interact with complex religious groups and spiritualities.

My current role as Senior Director of Spiritual Wellness and Inclusion includes a variety of responsibilities. I serve as the sole interfaith chaplain on campus, providing spiritual formation and care for our youth and team members in a diverse and inclusive setting. I accomplish this through providing individual pastoral counseling sessions, facilitating small groups, and hosting workshops and other events on campus. I chair our Diversity, Equity, and Inclusion Committee and serve as a leader on several other committees. I train new hires on our approaches to DEI and Spiritual Wellness and offer professional development opportunities for our team members throughout the year. Primarily, I am responsible for developing a psychospiritual care program with DEI at its core for our youth residents.

To this research project, I brought fifteen years of experience as a trauma-informed professional, a passion for religious trauma recovery, and the theological assumption that pastoral care providers want to understand their role in recognizing and reducing spiritually related traumas, and helping individuals and communities heal from these traumas. I hold a Master of Divinity from Lancaster Theological Seminary and I am ordained clergy in the United Church of Christ. I am certified to offer life coaching through art and storytelling, and I have worked with clergy, lay leaders, and individuals to recreate their own life narratives to reflect their current values and life goals. I am also a Reiki master and teacher, incorporating energy healing into my approach to pastoral counseling.

I hold a certificate in Religious Trauma Studies from the Global Center for Religious Research, and I am trained as an advisor for diversity, equity, and inclusion in corporate and clinical settings. I am also trained to recognize and prevent the Commercial Sexual Exploitation of Children and have served as a small group facilitator for the My Life My Choice prevention curriculum for female-identifying youth. I hold certifications in several suicide prevention

models and maintain annual professional training in the areas of Therapeutic Crisis Intervention through Cornell University. My professional qualifications and experiences positioned me well to develop a religious trauma screening tool for use with youth populations. I also hold a certification in transitional ministry, which has proven essential in the creation of a new multicultural psychospiritual care program at Bethany Children's Home.

Trauma Theory and a Trauma Informed Approach

For at least the last century, practices in psychology and psychiatry have generally regarded spirituality and religion as one part of a whole person and the person's understanding of and relationship with their spirituality or religion as one part of a holistic treatment plan. By the 1980's, spirituality was described as a multicultural issue in counseling and this led to the integration of spirituality into graduate-level counseling courses, holistic wellness models, and assessment instruments.¹¹ By 2005, the American Counseling Association (ACA) was outlining this integration of spirituality into counseling through a variety of areas in its *Code of Ethics*.¹² The 2014 ACA *Code of Ethics* continued to provide for the integration of spirituality in counseling through these aspects: informed consent, developmental and cultural sensitivity, personal values, advocacy, quality of life, counselor competence, multicultural and/or diversity considerations, counselor credentials, non-discrimination, and evaluation, assessment, and interpretation.¹³ Contemporary psychological assessments typically address spirituality and religion as a part of the person's cultural identity.

¹¹ Brown, David, Elise Johnson, and Mark Parrish. "Spirituality Assessments: Limitations and Recommendations." American Counseling Association, August 28, 2007. Accessed September 18, 2023. <https://www.counseling.org/Resources/Library/VISTAS/2007-V-online-MSWord-files/Brown.pdf>.

¹² Ibid.

¹³ "ACA 2014 Code of Ethics." American Counseling Association, 2014. Accessed September 20, 2023. <https://www.counseling.org/resources/aca-code-of-ethics.pdf>.

Although psychotherapeutic professionals were considering spirituality in their evaluations of clients for the last hundred years, it was only in the last fifty years that we saw major developments in the study of traumatic stress. In 1922, Dr. E. E. Southard of Harvard Medical School was teaching his students about “social psychiatry.”¹⁴ He explained social psychiatry to his students as: “an art now in the course of development by which the psychiatrist deals with social problems” and “that part of the knowledge of psychiatry which has a bearing upon social problems.”¹⁵

Fast forward to a nation coping with the aftermath of World War II when military psychiatrists concluded “that neuropsychiatric problems were more serious than had been previously recognized, that environmental stress was a major contributor to mental maladjustment, and that purposeful human interventions would alter psychological outcomes.” These psychiatrists determined that early treatment in non-institutional settings, or treatment in the context of the person’s social relationships, was essential to treating what was then recognized as battle neurosis, shell shock, or combat fatigue.¹⁶ However, despite psychiatrists’ awareness of the communal context of these traumatic experiences the general American population continued to consider combat fatigue to be a result of the individual soldier’s weakness.¹⁷ After they left military service, these same psychiatrists applied the concept of treatment within the familial or social context with their civilian clients.¹⁸ Through praxis and

¹⁴ Bloom, Sandra L. *Creating Sanctuary: Toward the Evolution of Sane Societies*. Revised ed. New York: Routledge/Taylor & Francis Group, 2013. 113.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Ibid. 22.

¹⁸ Ibid.

research, they determined that cultural factors which caused significant stress were significant contributors to mental illness and correlating treatments.¹⁹

Around the same time in the 1940's, psychiatrists were introduced to General Systems Theory which laid much of the foundation for what would later become culturally responsive counseling. General Systems Theory helped psychiatrists recognize that people "could only be understood and helped in the context of their family system, their cultural framework for constructing reality, and the larger systems within which they live and work, as well as the network of connections that comprise each individual's personal and cultural history."²⁰ This consideration of social factors and how they affected a person's psychological state began to alter how psychiatrists approached psychological assessments. Yet, it was not until the 1970's that the "reality of violence and its effects became central to our culture."²¹

During this decade, Vietnam War veterans and their advocates organized themselves outside of official government systems to illustrate and draw awareness to the individual and communal challenges they faced as a result of the war.²² This was a significant shift in American veteran attitudes which resulted in significant shifts in general American attitudes about war and its lasting impacts.²³ These shifts led to greater research and development efforts in psychiatry to understand how to treat war induced trauma.²⁴ In 1980, the psychiatric Diagnostic and Statistical Manual (DSM) included the diagnosis of "post-traumatic stress disorder" (PTSD), which helped progress the field of traumatic stress studies.²⁵ In 1985, the International Society of Traumatic

¹⁹ Ibid.

²⁰ Ibid. 117.

²¹ Ibid. 22.

²² Ibid.

²³ Ibid.

²⁴ Ibid.

²⁵ Ibid.

Stress Studies was formed to “provide a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma in the United States and around the world.”²⁶

Bloom posited that the resurgence of interest in recognizing and responding to traumatic experiences was the emergence of trauma theory.²⁷ Trauma theory is a “knowledge base that serves as anchor for the integration of various psychological theories, techniques, and points of view, a possible unified field theory of human behavior.”²⁸ Through a shared knowledge base that explains what trauma, adversity, and interpersonal violence do to the body, mind, and soul of the individual and how that impacts the group, psychiatrists could engage trauma theory to formulate effective strategies to respond to client’s lived experiences of trauma, adversity, and violence.²⁹

In the late 1990’s, a major study of childhood adverse experiences was published and highlighted the importance of screening for trauma in children and adolescents. The Adverse Childhood Experiences (ACEs) study was authored by Dr. Vincent Felitti and Dr. Robert Anda and was funded by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente.³⁰ Drs. Felitti and Anda surveyed over 17,000 people who were all members of the same health maintenance organization (HMO) in San Diego, CA.³¹

The original study helped behavioral health professionals better understand the long-term impacts of certain categories of adverse childhood experiences. The categories included physical,

²⁶ Ibid.

²⁷ Ibid.

²⁸ Ibid.

²⁹ Ibid.

³⁰ “About the CDC-Kaiser Ace Study.” Centers for Disease Control and Prevention, April 6, 2021. <https://www.cdc.gov/violenceprevention/aces/about.html>.

³¹ Ibid.

sexual, or psychological abuse or neglect; living in a household with a member who was mentally ill, imprisoned, or a victim of domestic violence; and exposure to substance abuse.³²

The authors found a strong correlation between the number of adverse childhood experiences a person claimed and a wide range of physical, emotional, and social issues in adulthood.³³

Interestingly, the study did not include any references to adverse religious experiences.

According to Bloom, those adverse childhood experiences lead to disrupted neurodevelopment in early childhood, which then leads to emotional, cognitive, and social impairment in childhood and adolescence.³⁴ She further argues, “these impairments leave children vulnerable to the adoption of many different health-risk behaviors which lead directly or indirectly to a variety of diseases, various forms of disabilities, and social problems - and eventually early death.”³⁵ The CDC has since published updated results from their study to include more states and more diverse populations, however, they have not yet included adverse religious experiences in the study.

Due to the original study’s evidentiary findings that childhood adverse experiences were directly linked to the ten most common causes of death in the United States, I would argue that the original ACEs study prompted the increase of research pertaining to toxic stress and trauma.³⁶ Bloom’s research and development in the field of social psychiatry, especially and uniquely with complexly traumatized children and adolescents, was groundbreaking. Since this time, the body of research based in trauma theory has expanded and evolved to include

³² Bloom, Sandra L. *Creating Sanctuary: Toward the Evolution of Sane Societies*. Revised ed. New York: Routledge/Taylor & Francis Group, 2013. 31.

³³ Ibid.

³⁴ Ibid.

³⁵ Ibid.

³⁶ Ibid.

formulated treatment guidelines for PTSD and dissociative disorders.³⁷ There is extensive research and literature on “Complex Post-traumatic Stress Disorder” and “Developmental Trauma Disorders” as psychiatrists hope to “extend the diagnostic categorization system to encompass the complex and interactive problems associated with exposure to childhood adversity and prolonged exposure to traumatic stress.”³⁸

Today, a trauma informed approach in behavioral healthcare settings is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). Chaplains, counselors, and social workers should pay attention to SAMHSA's recommendations for trauma-informed care because the administration provides a framework for delivering effective, ethical, and client-centered services to individuals who have experienced trauma. SAMHSA currently recommends universal screening for trauma in behavioral health services.³⁹ Today’s body of research indicates that trauma is common, affecting more than half the American population; and behavioral health problems become increasingly difficult to treat if trauma-related symptoms and disorders are not detected early and treated effectively.⁴⁰ SAMHSA promotes screening, early identification, and intervention as a preventative strategy.⁴¹

SAMHSA’s framework for a trauma-informed approach is grounded in four assumptions. It is important to note that these assumptions apply to systems, communities, and organizations more so than service specific tools, such as assessments or screening tools. However, Bethany Children’s Home is a trauma-informed organization that functions from these same four

³⁷ Ibid. 22.

³⁸ Ibid.

³⁹ Substance Abuse and Mental Health Services Administration. “Trauma-Informed Care in Behavioral Health Services”. *Treatment Improvement Protocol (TIP) Series 57*. HHS Publication No. (SMA) 13-4801. Rockville, MD. 2014. 91.

⁴⁰ Ibid.

⁴¹ Ibid.

assumptions, meaning I operate from these assumptions within my professional scope and I recognize the value of basing my resource development, a religious trauma screening tool, on these assumptions. According to SAMHSA, “a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.”⁴²

Assumptions and Central Terms:

My ministry setting positions me within a western context concerning medical treatment and treatment models that include mental health awareness, psychotherapeutic options, and trauma-informed care. In this context, it is assumed that people have access to certain resources, including mental health management options. The implicit privileges include access to therapy, treatment plans, and a variety of therapeutic treatment modalities. I recognize, especially in a post-COVID world that continues to highlight so many of the gaps in access in our society, that many people who seek treatment do not have adequate access to psychiatric and therapeutic treatment options. One of the gaps we have identified is a lack of qualified, trained psychiatrists and therapists in most of our communities - not enough care providers for the scale of people seeking care. I also recognize that many communities face cultural barriers to accessing mental health care. My ministry setting is also recognized as an Open and Affirming organizational partner of the United Church of Christ, and as such adopts an LGBTQ+ affirming theological stance that may be disputed by other churches and faith communities.

⁴² Department of Health and Human Services, and Larke Huang. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, HHS Publication No. (SMA) 14-4884, 2014.

As an ordained minister in the UCC, I identify largely with the concepts of liberation theologies - Latin and Black Liberation Theology and Queer Liberation Theology primarily, and my pastoral care approaches are influenced by feminist and Womanist theologians and scholars. Through my theology of ministry, I assert that cross-cultural awareness is essential to meeting people where they are, especially in their suffering. My embodied theology and praxis of ministry is focused first on healing, second on teaching people how to live a cruciform life, and third on preaching the gospel; and assumes democracy and choice are foundational to a person's sense of safety and belonging, and that creating belonging - not assimilation - is essential to a Christian community. Because healing individuals and communities is at the core of my vocation and ministry, I believe it is important for each of us to have a critical awareness of the institution of religion and its areas for growth, be able to recognize the harm caused through our religious communities and be willing to engage in reconciliation.

Trauma is defined by the American Psychological Association as an emotional response to a terrible event, such as natural disaster or rape.⁴³ I rate that definition as slim, and prefer SAMHSA's concept of trauma, which says trauma "results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."⁴⁴ Trauma is often studied and referred to as traumatic stress. With traumatic stress or trauma, three areas of the brain are implicated in the stress response: the amygdala, hippocampus, and prefrontal cortex. Traumatic stress can be associated with lasting changes in these areas of the brain, especially in children.

⁴³ American Psychological Association. "Trauma." Accessed March 8, 2023. <https://www.apa.org/topics/trauma>.

⁴⁴ Department of Health and Human Services, and Larke Huang. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, HHS Publication No. (SMA) 14-4884 (2014).

The amygdala helps people detect and react to other people, places, and things in the environment that could be dangerous. This is important for safety and survival. According to Nadia Tourinho, “after trauma, the amygdala can become even more attuned to potential threats in their environment, leading a child to closely monitor their surroundings, make sure that their environment is safe, and have strong reactions to new people. This heightened attention to potential threats in their environment can make it hard for children to pay attention in school, go to new places, or interact with people they don't know.”⁴⁵ The prefrontal cortex helps control the activity of the amygdala and is involved in helping people learn that previously threatening people or places are now safe. In children who have experienced trauma, the connection between the prefrontal cortex and the amygdala might not be as strong.⁴⁶ As a result, the prefrontal cortex is less active at reducing the amygdala's response to people, places, and things that are no longer predicted as dangerous.⁴⁷ This can lead to persistent elevation in fear and anxiety from triggers that remind children of the trauma that they have experienced.⁴⁸

The hippocampus is responsible for learning and memory. According to Tourinho, “trauma affects the development of the hippocampus, which can impair learning and memory in children, such as the ability to learn and remember information about the surrounding environment.”⁴⁹ Tourinho says this results in children who have experienced trauma not being able to retain information about how to tell if one situation is safe and another is dangerous, leading them to experience a harmless situation as dangerous.⁵⁰

⁴⁵ Tourinho, Nadine. Collective Trauma and Building a Trauma-Informed Culture. July 2022. Course Handout.

⁴⁶ Ibid.

⁴⁷ Ibid.

⁴⁸ Ibid.

⁴⁹ Ibid.

⁵⁰ Ibid.

Complex Trauma is the result of being exposed to multiple traumatic events.⁵¹

Historical Trauma is the cumulative, multigenerational, collective experience of emotional and psychological injury in communities and its descendants.⁵² I would add to that definition the experience of spiritual or religious injury. **Primary Trauma** is understood as an experience outside the usual range of human experiences that would be significantly distressing to almost anyone while **secondary trauma** results from a person knowing about a traumatic event experienced by someone close to the person - the stress resulting from helping or wanting to help a suffering person.⁵³ **Vicarious Trauma** is the emotional residue of exposure to stories of trauma and witnessing the pain, fear, and terror that trauma survivors endure.⁵⁴ A **trauma response** is how trauma presents itself in a person's life; these responses trigger a person's internal protective mechanism and typically fall into the same four categories: fight, flight, freeze, or fawn.⁵⁵

A Trauma-Informed Approach is understood as a program, organization, or system that is educated on trauma and experienced with survivors of trauma and: realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.⁵⁶ A trauma-informed approach depends on practitioners being culturally responsive, which first requires **cultural competence**, or the ability to understand, communicate with, and effectively interact with people across cultures - grounded in respect and

⁵¹ Lacy, Shawn. "Glossary." Enhancing Trauma Awareness, Lakeside Global Institute. Jan 2023. Course Handout.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Ibid.

⁵⁵ Bloom, Sandra L. *Creating Sanctuary: Toward the Evolution of Sane Societies*. Revised ed. New York: Routledge/Taylor & Francis Group, 2013. 26.

⁵⁶ Department of Health and Human Services, and Larke Huang. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, HHS Publication No. (SMA) 14-4884 (2014).

appreciation of cultural differences.⁵⁷ Practitioners will also need to apply integrative and collaborative approaches in a multicultural counseling practice.

An **integrative approach** offers an individualized, holistic approach to therapy that combines ideas and techniques from different therapeutic schools of thought depending on the unique needs of a given client.⁵⁸ Using a **collaborative approach**, an assessor and client work together to: construct an accurate definition of the problem; formulate hypotheses regarding the cause of the problem; brainstorm ways to confirm or disconfirm the hypotheses; and develop a treatment plan that responds to the problem.⁵⁹ These approaches allow the counselor to establish a **contextual viewpoint**, which incorporates the client's understanding of the presenting concern, includes an extensive exploration of their trauma history and strengths, as well as an explicit exploration of their multiple identities and the contexts in which they live; and employees cultural formulation tools.⁶⁰

Using cultural formulation tools, a counselor is better equipped to resist the use of stereotypes or implicit biases in their evaluation of the client and development of treatment plan goals. **Stereotypes** are exaggerated or distorted beliefs about the characteristics, attributes, and behaviors of individuals and communities that categorize individuals and communities in

⁵⁷ Center for the Study of Social Policy. 2019. "Key Equity Terms and Concepts: A Glossary for Shared Understanding." Washington, DC: CSSP. Accessed April 11, 2022. <https://cssp.org/resources/key-equity-terms-concepts/>.

⁵⁸ "Integrative Therapy." Psychology Today. Accessed August 2, 2023. <https://www.psychologytoday.com/us/therapy-types/integrative-therapy>.

⁵⁹ Sue, Derald Wing. *Counseling the Culturally Diverse: Theory and Practice*. United Kingdom: Wiley, 2022. 213-14.

⁶⁰ Ibid.

singular, pejorative terms.⁶¹ **Implicit biases** are beliefs or attitudes that affect our understanding, decisions, and actions, and that exist without our conscious awareness.⁶²

A culturally responsive, trauma-informed approach relies on an understanding of **intersectionality**, a term coined by Kimberle Crenshaw in 1989. This term describes how aspects of our identity, such as race and gender, intersect and interact with each other, informing how individuals simultaneously experience oppression and privilege interpersonally and systematically.⁶³ Since my experiences in the ministry setting and my research have identified those in the LGBTQ+ community as being especially at risk of having AREs and RT, I am including a few relevant terms.

When referring to those who identify as lesbian, gay, bisexual, transgender, and/or queer I am using the acronym **LGBTQ+**. The (+) is inclusive of all expressions of gender identity and sexual orientation. **Transgender** is an umbrella term that incorporates differences in gender identity wherein one's assigned biological sex does not match their felt identity. This umbrella term includes persons who do not feel they fit into a dichotomous sex structure through which they are identified as male or female. Individuals in this category may feel as if they are in the wrong gender, and this perception may or may not correlate with a desire for surgical or hormonal reassignment.⁶⁴ **Genderqueer** refers to a person whose gender identity falls outside of the gender binary (i.e., identifies with neither or both genders). Genderqueers may also use the term "**gender fluid**" as an identifier but typically reject the term "transgender" because it implies

⁶¹ Center for the Study of Social Policy. 2019. "Key Equity Terms and Concepts: A Glossary for Shared Understanding." Washington, DC: CSSP. Accessed April 11, 2022. <https://cssp.org/resources/key-equity-terms-concepts/>.

⁶² Ibid.

⁶³ Ibid.

⁶⁴ Meier, S. C., and Labuski, C. M. "The Demographics of the Transgender Population." In *International Handbook on the Demography of Sexuality*, edited by A. K. Baumle, 289–327.

a change from one gender category to another. **Queer** is an umbrella term that individuals may use to describe a sexual orientation, gender identity or gender expression that does not conform to dominant societal norms. Historically, it has been considered a derogatory or pejorative term and the term may continue to be used by some individuals with negative intentions. Still, many LGBTQ+ individuals today embrace the label in a neutral or positive manner.⁶⁵ Some youth may adopt 'queer' as an identity term to avoid limiting themselves to the gender binaries of male and female or to the perceived restrictions imposed by lesbian, gay and bisexual sexual orientations.

My major project proposes the development of a resource that will significantly improve the quality of care we provide in my ministry setting at Bethany Children's Home. The spiritual wellness program I am developing at BCH is a psychospiritual program. **Psychospiritual** is a term commonly used to describe a wide range of therapeutic systems that embrace a spiritual dimension of the human being as fundamental to psychic health and full human development and incorporates psychological and spiritual methods (such as meditation, yoga, dream-work, breathwork) in a holistic, integrated approach to healing and inner growth.⁶⁶ I grounded my research of trauma and a trauma informed approach through a study of **Social Psychiatry**, which deals with social factors associated with psychiatric morbidity, social effects of mental illness, psycho-social disorders and social approaches to psychiatric care.⁶⁷

It is important to note that the field of study around Adverse Religious Experiences and Religious Trauma is an emerging field, and the language used to discuss these themes can vary

⁶⁵ Russell, S.T., Horn, S., Kosciw, J., and Saewyc, E. "Safe Schools Policy for LGBTQ Students and Commentaries." *Social Policy Report* 24 (2010): 1-25. <https://doi.org/10.1002/j.2379-3988.2010.tb00065.x>.

⁶⁶ Mijares, Sharon G., and Gurucharan Singh Khalsa. *The Psychospiritual Clinician's Handbook: Alternative Methods for Understanding and Treating Mental Disorders*. 2nd ed. New York, NY: Haworth Reference Press, 2007.

⁶⁷ Bloom, Sandra L. *Creating Sanctuary: Toward the Evolution of Sane Societies*. Revised ed. New York: Routledge/Taylor & Francis Group, 2013.26.

amongst source materials. To define adverse religious experiences and religious trauma, I have selected the following terms because they are comprehensive and align with SAMHSA's concept of trauma. An **Adverse Religious Experience (ARE)** refers to an “event, series of events, relationships, or circumstances within or connected to religious beliefs, practices, or structures that are experienced by an individual as overwhelming or disruptive.”⁶⁸ AREs are generally categorized as resulting from three types of experiences that occur within a religious group or related to a set of religious beliefs: abusive, neglectful, and communal practices.⁶⁹ The categories of abuse and neglect can both include physical, emotional, verbal, and sexual experiences.⁷⁰ Communal practices that can lead to a person having an adverse religious experience include, among others, forced confessions, shunning and/or excommunication, social isolation, behavior control, and forced ritual performance.⁷¹ For some people, these overwhelming or disruptive experiences can potentially result in religious trauma.

Religious Trauma (RT) refers to the “lasting adverse effects on a person’s physical, mental, social, emotional, or spiritual well-being after an Adverse Religious Experience has occurred.”⁷² As with other traumas, the adverse religious experience can alter a person’s worldview and their self-perception to the point that the person’s central nervous system becomes trapped in a loop of trauma responses. These trauma responses can include chronic health conditions, mental health conditions, chronic shame and/or fear, suicidal ideation, and other risky behaviors.⁷³ **Religious Trauma Syndrome (RTS)** is a term coined by Marlene

⁶⁸ Slade, Darren M. “Adverse Religious Experiences (AREs) vs. Religious Trauma (RT): An Important Distinction.” GRCC. Accessed November 30, 2022. <https://www.gccr.org/post/adversereligiosexperiences>.

⁶⁹ Ibid.

⁷⁰ Ibid.

⁷¹ Ibid.

⁷² Ibid.

⁷³ Ibid.

Winell in 2011. Winell defines RTS as a “condition experienced by people who are struggling with leaving an authoritarian, dogmatic religion and coping with the damage of indoctrination.”⁷⁴ She offers further exploration of this through a two pronged narrative commonly identified as stemming from communal practices in their respective religions by those living with RTS; the narratives say that people are inherently not okay and that people are inherently not safe.⁷⁵

While AREs, RT, and RTS might include sexual abuse, **Nonsexual Spiritual Abuse** (NSA) specifically does not. One of my primary sources uses the term and bases her use of NSA on a definition of **spiritual abuse** - the coercion and control of one individual by another in a spiritual context.⁷⁶ Oakley and Kinmond go on to explain, “This abuse may include: manipulation and exploitation, enforced accountability, censorship and decision making, requirements for secrecy and silence, pressure to conform, misuse of scripture or the pulpit to control behavior, requirement of obedience to the abuser, the suggestion that the abuser has a “divine” position and isolation from others, especially those external to the abusive context.”⁷⁷

Research collectively suggests that RT, RTS, and NSA survivors are often diagnosed with **post-traumatic stress disorder (PTSD)**, which develops when a person’s brain is in a constant reactive state unable to shift into a responsive state, and that constant reactive state is one of anxiety caused by past trauma.⁷⁸ Research on military service members experiencing PTSD has been well documented since the Vietnam War, and this body of research includes studies on **moral injury** - a term that came up in the published assessments I surveyed. This term

⁷⁴ Winell, M., Religious Trauma Syndrome (Series of 3 articles), *Cognitive Behavioural Therapy Today*, Vol. 39, Issue 2, May 2011, Vol. 39, Issue 3, September 2011, Vol. 39, Issue 4, November 2011. British Association of Behavioural and Cognitive Therapies, London.

⁷⁵ Ibid.

⁷⁶ Oakley, L. R., & Kinmond, K. *Breaking the Silence on Spiritual Abuse*. New York: Palgrave Macmillan. 2013. 21-22.

⁷⁷ Ibid.

⁷⁸ Lacy, Shawn. "Glossary." Enhancing Trauma Awareness, Lakeside Global Institute. Jan 2023. Course Handout.

is best defined as the distressing psychological, behavioral, social, and spiritual aftermath of exposure to traumatic or unusually stressful circumstances in which people act as perpetrators of, fail to prevent, or witness events that contradict deeply held moral beliefs and expectations.⁷⁹

According to Norman and Maguen, “In order for moral injury to occur, the individual must feel like a transgression occurred and that they or someone else crossed a line with respect to their moral beliefs,”⁸⁰ This term is more commonly used in reference to military service and in work environments. A few of the hallmark symptoms of moral injury are experiencing guilt, shame, disgust, and anger related to the inciting event.⁸¹ Another hallmark reaction to moral injury is an inability to forgive one’s self, and consequently engaging in self-sabotaging behaviors.⁸² Moral injury typically impacts an individual's spirituality, such as when the person has difficulty understanding how their beliefs and relationship with a Higher Power can be true or real given the horrific event the person experienced, which can lead to uncertainty about deeply held spiritual beliefs.⁸³ Trauma is understood as having lasting impacts on a person’s worldview and their ability to interpret the world around them as safe. While uncertainty or questioning of one’s own spiritual beliefs can be part of a healthy spiritual life, in cases of moral injury this uncertainty can result in alterations to the person’s worldview similar to those experienced by survivors of RT, RTS, and NSA.

While religion and spirituality can be intertwined for many people, it is important to distinguish these terms within the context of my research. **Religion** is understood as a variety of

⁷⁹ Norman, Sonya B, and Shira Maguen. “Moral Injury.” Va.gov: Veterans Affairs. National Center for PTSD, April 20, 2020.

https://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury.asp#:~:text=Moral%20injury%20is%20the%20distressing,individual's%20values%20and%20moral%20beliefs.

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² Ibid.

⁸³ Ibid.

social and cultural frameworks encompassing prescribed behaviors, morals, beliefs, perspectives, texts, sacred sites, prophetic teachings, ethical principles, and institutions, which typically establish connections between humanity and supernatural, transcendental, and spiritual realms. Modern usages of “**spirituality**” tend to refer to a subjective experience of a sacred dimension,⁸⁴ and the “deepest values and meanings by which people live”^{85,86} often in a context separate from organized religious institutions.⁸⁷ This may involve belief in a supernatural realm beyond the ordinarily observable world, personal growth, a quest for an ultimate or sacred meaning, religious experiences, or an encounter with one's own inner dimension.⁸⁸

Also important to distinguish are the separate pieces of a full spiritual assessment. A **spiritual screen** allows healthcare providers to recognize whether spirituality is important to a person and whether additional information should be gathered. The spiritual screen is typically performed upon admission to most healthcare institutions and often includes one or two questions aimed at determining whether the patient has any religious or spiritual needs that the healthcare setting can address during the patient’s stay.⁸⁹ A **spiritual history** elicits more information than a spiritual screen and is used to understand how a person’s spiritual life and history affect their ability to cope with their present crisis.⁹⁰ In the context of my research resource development, the present crisis will be understood as the youth’s current circumstances regarding their out-of-home placement. A **spiritual assessment** is the process of gathering and

⁸⁴ Saucier, Gerard, Skrzypinska, Katarzyna [“Spiritual But Not Religious? Evidence for Two Independent Dispositions”](#) (PDF). *Journal of Personality*. Oct 2006.

⁸⁵ Sheldrake, Philip, *A Brief History of Spirituality*, Wiley-Blackwell, 2007.

⁸⁶ Griffin, David Ray, *Spirituality and Society*, SUNY, 1998.

⁸⁷ Wong, Yuk-Lin Renita; Vinsky, Jana, “Speaking from the Margins: A Critical Reflection on the ‘Spiritual-but-not-Religious’ Discourse in Social Work”, *British Journal of Social Work*, 2009. doi:10.1093/bjsw/bcn032

⁸⁸ Waaijman, Kees, *Spirituality: Forms, Foundations, Methods*, Peeters Publishers, 2002.

⁸⁹ Cadge, Wendy, and Julia Bandini. “The Evolution of Spiritual Assessment Tools in Healthcare.” *Society*, no. 5 (2015): 430–37. <https://doi.org/10.1007/s12115-015-9926-y>.

⁹⁰ Ibid.

organizing spiritually based data into a coherent format that provides the basis for interventions.⁹¹ This refers to the process completed after the spiritual screen and history is taken and includes an interview with the client, or in my context, the youth. I am positing that a culture sketch must also be included in the spiritual assessment and should be considered during the analysis of all collected data to provide the basis for interventions.

Research Question and Methodology

As I considered the steps I would need to take to develop a new religious trauma screening tool, I realized I would need to perform research in a few different areas. My research sits at the intersection of several professional fields, including pastoral care and chaplaincy, psychology and counseling, and social work. Professionals and researchers in each of these fields have contributed significantly to the emerging study of religious trauma and potential treatment options for survivors.

Personal stories of abuse, neglect, and other AREs or religious trauma were the inspiration for this project. My own story coupled with the stories I heard from the youth at Bethany inspired me to specialize my ministry in religious trauma treatment. Since our youth are a highly protected class of people, I did not want to utilize their personal stories in my project. I decided instead to search for personal stories of survivors of religious trauma. These personal stories would help the reader better understand the concept of religious trauma and they would serve as evidence of the necessity for a spiritual assessment that includes screening for religious trauma. Therefore, I engaged in listening to and reading stories from survivors. These stories are integrated into each chapter as examples of RT.

⁹¹ Hodge, D. R. *Spiritual Assessment: A Handbook for Helping Professionals*. Botsford, CT. North American Association of Christians in Social Work. 2003.

I realized that I also needed to better understand the concept of religious trauma and how professionals are recognizing and responding to RT. So, I took a 30-hour certification course on Religious Trauma Studies through the Global Center for Religious Research. This course introduced me to some of the leading voices in religious trauma research and helped me identify many of my major conversation partners for this project. I speak more to AREs and RT, in particular in the State of the Field section of this chapter.

In order to develop a screening tool designed primarily for use in clinical settings, I needed to study the evolution of spirituality as it relates to treatment in psychiatry, psychology, and counseling. Given that this is too wide to explore, I began by researching the roots and evolution of social psychiatry and traced the role of spirituality in counseling from 1922 through today. In order to better understand the use of spiritual assessments in the fields of chaplaincy, psychology and counseling, and social work, I researched the evolution of spiritual assessment development, recommended praxis, and content from the 1970's through today. I also studied the concepts of trauma-informed care, multiculturalism in counseling, and intersectionality. Specifically, I focused on how to conduct a trauma-informed assessment and interview.

Based on what I learned about AREs, RT, the various styles and uses of spiritual assessments, and the trauma-informed approach I developed a checklist of evidence-based assessor competencies and content recommendations by which to check existing spiritual assessments. These were the questions my research aimed to address:

1. How did existing spiritual assessments screen for adverse religious experiences and religious trauma? What was missing?
2. In what ways are existing assessments trauma-informed? What was missing?
3. How did existing assessments address intersectionality? What was missing?

My framing question had two parts. First, based on the *content* of the existing spiritual assessment, how might that content help inform the assessor of the assessee's adverse religious experiences and/or religious trauma? Second, considering the utilization of the existing spiritual assessment in the *praxis* of trauma-informed care, in what ways was the assessment trauma-informed with a lens for intersectionality?

I incorporated a feminist perspective in my research. My research began with gathering personal stories from the community, religious trauma survivors, in order to develop a resource that could serve the same community. My own story is also included as an illustration of adverse religious experiences, religious trauma, and RT symptoms. Focusing on the lived experiences of survivors, I lifted "experience" as a source of knowledge and authority. My research sits at multiple academic and professional intersections and aims for a holistic approach; it is transdisciplinary in nature and aims to create social change. I also offer several critiques of my own chosen ministerial and vocational disciplines, including the Church's roles and responsibilities in recognizing and responding to religious trauma in chapter five.

My research methodology was inductive, beginning with my collection and study of personal stories and continuing through my survey of published spiritual assessment tools and resource development. Engaging in qualitative research, I identified patterns and themes in the personal stories which helped me develop a hypothesis of what to look for in the published assessment tools; as well as what to ask about in the religious trauma screening tool. Through exploratory research, I investigated the understudied issues of religious trauma and relevant screening tools; and will recommend additional opportunities for research regarding these issues in chapter five.

Using my checklist of evidence-based assessor competencies and content recommendations, I completed a formal survey of a sample of published spiritual assessment tools to answer my research questions. These assessments included: the FICA Spiritual History Tool, the HOPE assessment, 4 FACTS assessment, Searle-Vance Spiritual Assessment, Kathryn Hope Keller's Spiritual Abuse Questionnaire, Rebecca Drumstra's Adverse Religious Experiences Questionnaire, and four tools developed by social work researcher and professor David Hodge. Hodge's instruments and methods included spiritual genograms, spiritual lifemaps, spiritual history narratives, and spiritual eco-maps.

Next, I compiled all my research into an analytical essay. I included my checklist and survey of existing spiritual assessment tools at the end of the essay. I then used the same checklist to guide the development of a religious trauma screening tool to ensure that the new tool would be culturally responsive, trauma-informed, and consider intersectionality. During the development process, I organized a group of clinicians and behavioral specialists at Bethany who could review the screening tool questions and methods and provide feedback. Their feedback helped me recognize when the tool met the standards I set forth.

Since I wanted this tool to function as part of our intake process at Bethany, I also needed the workgroup to help me identify team member roles and responsibilities for administering the new screening tool. Together, we discerned these roles and responsibilities, and I developed a new procedure to implement religious trauma screening during youth intakes. My religious trauma screening tool, including instructions for the assessor, are included in chapter four. Bethany's spiritual assessment procedure is also outlined in chapter four as a suggested method of implementation in similar behavioral health settings. A copy of the procedure is included in the Appendix.

My audience for this project is pastoral theologians, chaplains, counselors, and those interested in advancing the field of psychospiritual care. This includes clergy and lay leaders within the United Church of Christ and across Christian denominational lines, including Protestant and Catholic faith traditions. My research and development of a religious trauma screening tool has implications for spiritual caregivers serving in clinical or specialized settings, and for professionals in the fields of psychology, counseling, and social work.

State of the Field

Something stood out to me as I began my research on religious trauma; a common thread emerged and indicated that I was not alone in my experience of recognizing religious trauma as a cause of mental, emotional, physical, and spiritual illness. What surprised me was that while so many physicians, psychiatrists, and counselors were noticing the presence of adverse religious experiences or religious trauma as root causes of their patient's illness, we did not have a shared working definition of religious trauma until 2023. Defining religious trauma was not only a task for my project, developing a definition for this concept has been the focus for many professionals and researchers for the last three decades.

When I began this project in 2021, the literature primarily consisted of qualitative studies and personal stories intended to advance the field in two ways: to make the case that religious trauma is a real phenomenon and to help develop a shared working definition of religious trauma. In a groundbreaking quantitative sociological study led by Darren Slade at the Global Center for Religious Research, the authors dedicated six pages to defining religious trauma.⁹² As Slade, et.al. note in their article, until very recently, most references to religious trauma in the

⁹² Slade, Darren M., Adrianna Smell, Elizabeth Wilson, and Rebekah Drumsta. "Percentage of U.S. Adults Suffering from Religious Trauma: A Sociological Study." *Socio-Historical Examination of Religion and Ministry* 5, no. 1 (2023): 1–28. <https://doi.org/10.33929/sherm.2023.vol5.no1.01>.

available literature have offered no official or clinically justifiable definition and most often appeared in relation to religious fundamentalism, offering little information relating RT to non-fundamentalist communities.⁹³ The authors explored the evolution of the definition as it expanded over the years to align more closely with clinically relevant definitions of trauma or traumatic stress. I infer that the authors dedicated such attention to the evolution of the definition of RT because whether we have working definitions and exactly what is outlined within those definitions impacts how professionals develop their praxis of care. Understanding how the definition has evolved offers insight as to how evidence-based practices have evolved in their response to adverse religious experiences to now include screening for religious trauma.

I also was not alone in my search for tools and resources to help me understand the spectrum of influences that might lead to religious trauma, alongside responses to individuals and communities suffering from the lingering impacts of such trauma. During the course I completed on Religious Trauma Studies, I heard from nearly thirty researchers, clergy, clinicians, and other professionals who were each asking for a shared definition of religious trauma while also attempting to develop tools and resources to support the caregivers' ability to respond to religious trauma. The definition was a critical missing piece of the puzzle. But why was the idea of religious trauma so hard to pin down and define?

Our diverse and varying relationships with religion, religious culture, and spirituality are also deeply personal and subjective; making it difficult for psychologists and other specialists to zero in on what constitutes the “religious” part of religious trauma. Additionally, clinicians were working backwards from their observations of clients to discern the lasting effects of religiously associated trauma and correlating trauma responses. Because psychologists and physicians first

⁹³ Ibid.

noticed religious trauma in patients connected to strict, authoritarian faith traditions, the concept languished in the land of religious fundamentalism until the early 2000s. Professionals and researchers were rather narrow in their focus on what they considered oppressive religious ideologies that could pose enough threat to a person's sense of safety to result in religious trauma. Contributions to this definition have evolved since the early 1990s, so in order to help the reader understand the current state of the field of religious trauma research, I will share a few highlights here.

By the early 2000s, psychologists were not only certain that religious trauma was a real phenomenon, they were also certain that it needed to be explored with clients as a potential mental health factor.⁹⁴ In 2003, Deana Morrow connected oppressive religious doctrines with the psychological damage experienced by lesbian women, including lifelong feelings of guilt, shame, low self-esteem, internalized homophobia, depression, and suicidal ideation.⁹⁵ As I mentioned earlier, in 2011, Marlene Winell coined the expression "religious trauma syndrome," which led to more psychologists linking abusive religious environments to a mental health disorder.

Winell's definition of religious trauma syndrome is specific to people who have experienced authoritarian, dogmatic religions and struggle to leave those faith traditions and cope with the damage of indoctrination.⁹⁶ She posits that RTS happens in a twofold manner: first, prolonged exposure to the teachings and practices of a restrictive religion can be adverse or toxic and result in lasting negative impacts; second, leaving the religious community can be

⁹⁴ Ibid. 5.

⁹⁵ Ibid.

⁹⁶ Winell, M., Religious Trauma Syndrome (Series of 3 articles), *Cognitive Behavioural Therapy Today*, Vol. 39, Issue 2, May 2011, Vol. 39, Issue 3, September 2011, Vol. 39, Issue 4, November 2011. British Association of Behavioural and Cognitive Therapies, London.

experienced as highly stressful and often involves sudden and significant loss of connection to family and social supports.⁹⁷ Winell shares a list of common trauma responses and symptoms identified by survivors of RT and those living with RTS, along with comments from those experiencing intense symptoms of RTS. According to her, key symptoms of RTS are:

- Confusion, difficulty making decisions, trouble thinking for self, lack of meaning or direction, undeveloped sense of self
- Anxiety being in “The World”⁹⁸
- Sleep and eating disorders, substance abuse, nightmares, perfectionism, discomfort with sexuality, negative body image, impulse control problems, difficulty enjoying pleasure or being present here and now
- Rupture of family and social network, loneliness, problems relating to society, personal relationship issues.”⁹⁹

Winell identifies a two-pronged narrative that commonly impacts RTS survivors. First, ‘you are not okay/there is something wrong with you,’ and second, ‘you are not safe.’ She aligns these narratives with the Christian doctrines of Original Sin (not okay) and Hell (not safe).¹⁰⁰ Winell also posits that those in highly restrictive, authoritarian, fundamentalist faith communities are more likely to be exposed to adverse religious experiences and develop RTS. Further, Winell makes the connection between RTS and PTSD, citing the impact of RTS and PTSD as the same: “long-lasting, with intrusive thoughts, negative emotional states, impaired social functioning, and other problems.”¹⁰¹ Finally, Winell recognizes that without providing a definition for these

⁹⁷ Ibid.

⁹⁸ Ibid, see for more on experiencing anxiety in “the world.”

⁹⁹ Ibid.

¹⁰⁰ Ibid.

¹⁰¹ Ibid.

adverse religious experiences, therapists and other counselors have little to work with from a diagnostic perspective, and have limited resources available to respond to clients presenting with RTS. She calls for additional research and development of assessment and treatment resources, which my research aims to provide.¹⁰²

Winell's contributions have been significant to developing international awareness of the study of RT, however, categorizing religious trauma as a syndrome is problematic considering recent advances in the mental health sciences.¹⁰³ Slade, et.al. note two primary reasons clinicians and researchers are moving away from the term "syndrome" in regard to religious trauma. First, the term applies arbitrary parameters to people's lived experiences, "thereby excluding them from treatment options or alienating them with feelings of being diseased or abnormal."¹⁰⁴ Second, the term is simply inaccurate. Consistent presentation of a cluster of symptoms makes a "syndrome," however, religious trauma occurs on an individual spectrum without consistent presentation of a specific set of symptoms. The use of the term "syndrome" wrongly implies the person is suffering from the same cluster of symptoms as anyone else suffering from religious trauma.¹⁰⁵ When we understand that trauma is something that happens *to* a person, and that trauma causes disruption and changes to the person's central nervous system, we can differentiate between healing trauma wounds and treating genetic abnormalities or diseases categorized as syndromes.¹⁰⁶

¹⁰² Ibid.

¹⁰³ Slade, Darren M., Adrianna Smell, Elizabeth Wilson, and Rebekah Drumsta. "Percentage of U.S. Adults Suffering from Religious Trauma: A Sociological Study." *Socio-Historical Examination of Religion and Ministry*, no. 1 (2023): 1–28. <https://doi.org/10.33929/sherm.2023.vol5.no1.01>.

¹⁰⁴ Ibid.

¹⁰⁵ Ibid.

¹⁰⁶ Ibid.

Alyson Stone recognized that RT is basically a standard clinical understanding of trauma that derives from within a religious context, and expanded on Winell's work to acknowledge that RT often occurs outside of the restrictive, authoritative, dogmatic fundamentalist groups identified by Winell.¹⁰⁷ Stone's preliminary definition of religious trauma in 2013 characterized the mental health problem as, "pervasive psychological damage resulting from religious messages, beliefs, and experiences."¹⁰⁸ In 2020, Michelle Panchuk considered RT as "putative experiences of the divine being...that transform an individual in a way that diminishes their capacity for participation in religious life."¹⁰⁹ This definition assumes an individual has a worldview that includes a "divine being," excluding groups who do not affirm the role of a divine being in their spirituality. Cheryl Johnston would build on Panchuk's work to define RT as "a spectrum of conditions resulting from a traumatic experience perceived by the survivor to be caused by religious practices, communities, teachings, symbols, and/or the divine being to the extent that the survivor's ability to participate in religious life is disrupted."¹¹⁰

Each of these contributions has enhanced the clinical understanding of religious trauma. The problem with these definitions is that they focus on the person's inability to participate in their chosen faith community or develop a sense of spirituality at all.¹¹¹ Not all people who experience RT want to leave their faith tradition, and many continue to find therapeutic healing within faith communities.¹¹² Because of the commonly positive benefits of religiosity or spirituality on mental health, researchers and practitioners need to remain as neutral as possible

¹⁰⁷ Ibid. 6.

¹⁰⁸ Ibid.

¹⁰⁹ Ibid.

¹¹⁰ Ibid.

¹¹¹ Ibid.

¹¹² Ibid.

and not classify religion as overtly negative or positive.¹¹³ Additionally, the definitions offered by Winell, Panchuk, and Johnston seem to exclude the possibility that someone can suffer from RT without having a direct relationship with a religious institution.¹¹⁴ Not only can non-religious individuals suffer from secondary and vicarious trauma simply by witnessing injuries caused by some religionists, unchurched people are still impacted by the messages of religious groups and can be negatively impacted by these messages.¹¹⁵

In 2020, considering the shortcomings of these contributions to the definition of religious trauma, the North American Committee on Religious Trauma Research (NACRTR) issued the definition presented in the key terms section of this chapter. The group intended the definition to be more clinically justifiable and inclusive of the spectrum of people's lived experiences with religion and spirituality. They also wanted to distinguish between the incidents that can *cause* RT, the adverse religious experiences, and the trauma itself. As defined in my Key Terms, AREs are understood as experiences of religiosity that undermine a person's sense of safety or autonomy and impact their overall wellbeing. These incidents can lead to the lasting impacts of trauma in the person's nervous system and need to be recognized as contributing factors to RT.

In the sociological study published by Slade, et.al., the authors include six major lasting adverse effects, or RT symptoms, that are generally a direct result of AREs. The six manifestations of religious trauma are: anxiety, stress, fear, depression, shame, and nightmares.¹¹⁶ The authors note that this list is not exhaustive, while also recognizing that the six manifestations do encompass the majority of what clinicians and patients have identified as

¹¹³ Ibid.

¹¹⁴ Ibid.

¹¹⁵ Ibid. 7.

¹¹⁶ Ibid. 9.

chronic problems associated with RT; most likely because they are the easiest for patients to self-identify.¹¹⁷ Identifying interpersonal, emotional, and cognitive difficulties alongside symptoms associated with Post Traumatic Stress Disorder (PTSD) and Complex-PTSD, clinicians are increasingly recognizing symptoms like hyper-vigilance, dissociation, and decreased self-worth in survivors of religious trauma.¹¹⁸

What are the experiences that cause religious trauma and in which contexts are these experiences occurring? In 2021, GCRR launched a survey to explore if and how religious trauma is happening among American adults.¹¹⁹ The survey received 1,581 qualified responses making the results generalizable for the U.S. adult population; however, screening criteria was minimal which makes findings discussing the nuances of specific groups directional as opposed to representational since the study cannot guarantee representation of nuanced co-culture groups.¹²⁰ Demographics collected included age, race, gender identity, and sexual orientation.

The study found that 1,029 respondents (65.1%) believe people suffer from religious trauma, while 37.3% reported knowing someone who likely suffers from RT.¹²¹ Of those who stated they knew someone living with religious trauma, two-thirds claimed to know between one and four people and one-third claimed to know five or more people who potentially suffer from RT.¹²² 438 respondents (27.7%) self-identified as having religious trauma at some point in their life.¹²³

¹¹⁷ Ibid.

¹¹⁸ Ibid. 9.

¹¹⁹ Ibid.

¹²⁰ Ibid. For detailed research methodology see 9-10.

¹²¹ Ibid. 12.

¹²² Ibid.

¹²³ Ibid.

The survey also included the six manifestations of religious trauma and asked those who self-identified as having RT to rate the extent to which the six symptoms negatively impacted their life. Out of 1,581 respondents, 17% suffer from anxiety while 16% suffer from stress specifically because of religion.¹²⁴ Fear and depression due to religion negatively impact 15%, while 13% suffer from religion-induced shame and more than 11% suffer from religion-induced nightmares.¹²⁵ The authors posit that “these six symptoms are reasonable when considering that nearly 22% (341) of respondents do not think they live up to the expectations of their religion and almost 13% (202) have been accused of this very thing by others. Additionally, 11% and 12% of participants feel at least one of the six symptoms because religious leaders or religious family members (respectively) do not accept them for who they are. Almost one-in-ten (9.2%) experience trauma symptoms because they have to hide their true selves in religious settings.”¹²⁶

Other highlights of the study include the following rounded data points:

1. Of those who say they do not suffer from RT, 5.2% currently suffer from four of the six major RT symptoms.
2. Of the total sample, 15% say they currently suffer from at least three of the six RT symptoms.
3. Of those who personally know someone who likely suffers from RT, 90% claimed to know between 1-10 people.
4. Of those who disclosed having an ARE, 66% self-identified as experiencing RT.¹²⁷

¹²⁴ Ibid.

¹²⁵ Ibid.

¹²⁶ Ibid. 15.

¹²⁷ Ibid. 18.

The authors concluded that it is likely that one-third (27-33%) of the adult population in the U.S. have experienced RT at some point.¹²⁸ The number increases to 37% when we include those suffering from any *three* of the six major religious trauma symptoms.¹²⁹ What is interesting, is that about 11% of respondents did not identify as having experienced RT; however, over five percent of those respondents stated that they are currently suffering from four of the six major RT symptoms. The authors of the study contribute the discrepancy to two major influences. First, the inherent stigma associated with suffering from religious trauma can contribute to the person's sense of pressure to protect their faith community to avoid being seen as dissident or apostate.¹³⁰ Second, the word "trauma" is most often associated with maximally acute and somewhat rare adverse occurrences, such as wartime combat and sexual assault. When the word "trauma" is commonly misassociated with such acute experiences, some people might assume they do not meet the requirements to qualify as "traumatized."¹³¹ Additionally, since many religious communities express criticism or skepticism regarding mental health, some individuals within those communities may have learned to dissociate from their emotions in favor of following religious expectations.¹³² Therefore, it is reasonable for the authors to conclude that some survey respondents may be suffering from RT without realizing it.¹³³

This study is one of the only published quantitative studies on religious trauma available as of this writing. As clinicians, chaplains, and other professionals continue to explore options for fully integrating religion and spirituality into their clinical practices, I imagine this study to

¹²⁸ Ibid. 19.

¹²⁹ Ibid.

¹³⁰ Ibid. 20.

¹³¹ Ibid.

¹³² Ibid.

¹³³ Ibid.

be foundational to their progress. This study shows that religious trauma is a society-wide phenomenon and a chronic problem within the adult population of the U.S. At this time, I am not aware of quantitative research on the youth population and their experiences of RT, though I believe the U.S. youth population would at least mirror, if not exceed the statistical data collected in this study. I base this presumption on my professional experiences with youth in congregant care and youth who identify as LGBTQ+ who present with adverse religious experiences and religious trauma. Although fewer young people are being raised in explicitly religious families or communities, youth in placement frequently present with symptoms of religious trauma, including hell trauma and/or deeply rooted anxiety around their own forgiveness. These youth also represent diverse religious and spiritual traditions or communities, though most frequently they represent an un-churched youth population. Therefore, I infer that non-religious, un-churched young people can and do experience religious adversity and religious trauma. The study also supports the call for additional research and resource development to help professionals recognize and respond to religious trauma. This is the gap my project sought to fill: to help professionals in clinical settings gain a deeper awareness of religious trauma as a real and chronic mental health concern and to provide them with a tool that helps to recognize RT in clients and know how to respond to those trauma wounds.

Chapter 2: Significance and Literature Review

My research sits at the intersection of several professional fields, including pastoral care and chaplaincy, psychology and counseling, and social work. These are the same professional intersections that make up my ministry setting at Bethany Children's Home. As part of an interprofessional care team that is responsible for our youth's wellbeing and success, I provide pastoral care that functions in tandem with the counseling and social services they receive. As previously mentioned, I am a trauma-informed clergy person and BCH is a trauma-informed agency, and as such it is critical that we do everything possible to align our services with evidence-based trauma-informed practices.

This includes screening our youth residents for a variety of traumas. SAMHSA recommends completing a full trauma history that includes screening for: trauma-related symptoms, depressive or dissociative symptoms, past and present mental disorders, severity or characteristics of a specific type of trauma, substance abuse, and risks for self-harm, suicide, and violence.¹³⁴ In our setting at BCH and similar settings, much of the youth's trauma history might be shared with us through referral paperwork or the youth's case records to which we have access. What is most often missing in referral paperwork is an in-depth analysis of the severity or characteristics of specific types of trauma, such as interpersonal violence and other adverse childhood events. While we might glean awareness of such an event through referral documents, these files most often lack pertinent information regarding how the adverse experiences have impacted the youth's health and wellbeing. Further, it is this category in which a religious trauma screen would be justified.

Another component to this project was considering the various governing and regulatory agencies which oversee our work in behavioral healthcare settings. In Pennsylvania, child residential

¹³⁴ Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. *Treatment Improvement Protocol (TIP) Series 57*. HHS Publication No. (SMA) 13-4801. Rockville, MD. 2014

and day treatment facilities are required to adhere to what is commonly called the “3800 regulations.” The Governor’s office, Attorney General, and other legislative committees are responsible for maintaining this massive document that regulates health and safety of sites and individuals at service provider locations that receive state funding. Since BCH is one of those sites, we must adhere to the rules and regulations within this large document that pertains to child residential facilities - chapter 3800. This chapter mandates that we assess our youth’s health and safety at intake and throughout the course of their care.

Through the health and safety assessment at intake, our team members might gather additional information related to trauma symptoms, past and present mental disorders, issues with substance abuse, risks for harm to self or others, and physical health. What chapter 3800 does not mandate is a spiritual assessment or screening for religious trauma, inferring most service providers are not paying attention to their service population’s spiritual or religious needs. As my research indicates, this is a problem. We now recognize religious trauma as a chronic mental health problem. And, in the U.S. we are currently experiencing a mental health crisis. Behavioral healthcare providers, such as Bethany Children’s Home, have a responsibility to address spirituality and religion in their response to this mental health crisis.

The Joint Commission does set a standard of care that includes spiritual screens, histories, and assessments. Since BCH is accredited and recognized with a gold star from the Joint Commission, we continuously strive to achieve the standards of care set forth by the JC. The Joint Commission expects us to perform a spiritual assessment with every youth we serve.¹³⁵ In my role as chaplain, I needed to be able to complete a spiritual assessment with each youth during the intake process. In addition to informing how I could provide pastoral support and care for the young person, my observations and notes would be shared with the youth’s clinical team including their psychiatrist, therapist, and case

¹³⁵ Cadge, Wendy, and Julia Bandini. “The Evolution of Spiritual Assessment Tools in Healthcare.” *Society* 52, no. 5 (2015): 430–37. <https://doi.org/10.1007/s12115-015-9926-y>.

manager. Based on the Joint Commission's standards and my analysis of the research, I have developed a religious trauma screening tool and a spiritual assessment procedure that works to triage youth at intake, ensuring each youth has been seen and their spirituality has been assessed. The model we are implementing at Bethany could easily be implemented in similar trauma-informed clinical settings and those with Joint Commission accreditation.

In this project, I wanted to study spiritual assessments because in my work as a chaplain for youth, I recognized the presence of Adverse Religious Experiences (AREs) and Religious Trauma (RT), and I saw a gap in screening tools. When I could not find a screening tool that would obviously and intentionally screen for religious trauma, I originally thought I needed to develop a more robust spiritual assessment tool. Perhaps I could create a spiritual assessment that would not only collect a spiritual history in relation to a person's current illness or situation but could also indicate whether the person is living with adverse religious experiences or religious trauma. However, as I will discuss in chapter 3, the field has a plethora of spiritual assessment options. The problem is not the available published spiritual assessments, it is that they do not intentionally screen for AREs or religious trauma.

Indeed, in 2012, chaplain and researcher George Fitchett called on healthcare professionals to stop creating new spiritual assessment tools and argued that "we need to focus attention on a critical review of existing models and the dissemination of best practices in spiritual assessment."¹³⁶ Fitchett's call to stop developing new spiritual assessments and instead continue research resonated with me. First, little information was available on the validity or effectiveness of the published spiritual assessments I surveyed. Second, while I thought I needed to develop a more robust spiritual assessment, I discovered that I actually needed a religious trauma screening tool that could function as part of a larger spiritual assessment or trauma assessment framework. Through my survey of published spiritual assessment

¹³⁶ Hodge, D. R. *Spiritual Assessment: A Handbook for Helping Professionals*. Botsford, CT. North American Association of Christians in Social Work. 2003.

tools, I was able to determine the existence of several options for professionals to engage in a trauma-informed, culturally responsive spiritual assessment. However, none of these options assessed for AREs or RT. These options will be explored in chapter four. My religious trauma screening tool, including instructions for the assessor, are also included in chapter four.

The purpose of the religious trauma screen is to provide chaplains and counselors in trauma-informed clinical environments with a spiritual screening tool that is trauma-informed, considers intersectionality, and intentionally screens for AREs and RT. Professionals in these various settings will be able to use the assessee's responses and their own observations to develop a therapeutic recovery plan that addresses key areas of religious adverse experiences to provide clients with the greatest chance for full recovery. In counseling intake procedures, spirituality is typically explored as a cultural or communal factor in a full psychological assessment. I suggest adding the religious trauma screen for any clients presenting with trauma histories.

Literature Review

Adverse Religious Experiences and Religious Trauma

To recognize and respond to religious trauma, caregivers need to have a basic awareness of trauma theory in psychology and counseling. My introduction to trauma theory and the concept of trauma-informed care happened in 2009 when I began to study Dr. Sandra Bloom's Sanctuary Model of Care. Bloom is co-founder of the Sanctuary Institute, co-director of the Center for Nonviolence and Social Justice, and Associate Professor of Health Policy and Management in the school of Public Health at Drexel University in Philadelphia, PA. In *Creating Sanctuary: Toward the Evolution of Sane Societies* Bloom offers an extensive overview of the history of trauma studies and the development of trauma theory. *Creating Sanctuary* highlights the biological, psychological, and social aspects of trauma

through a description of a hospital-based program that Bloom led for adults who experienced abuse as children.

Bloom offers anecdotes and case studies from her career blended with historical and current events to map out the history of traumatic stress studies and provides definitions of common trauma related diagnosis in mental health. She discusses the human stress responses and abnormal brain development in children exposed to toxic stress and describes the Adverse Childhood Experiences Study which is foundational to my research on Adverse Religious Experiences. The original ACE Study was authored by Doctors Vincent Felitti and Robert Anda and sponsored by Kaiser Permanente and the Centers for Disease Control and Prevention.¹³⁷ The study made a direct correlation between adverse childhood experiences and disrupted and unhealthy lives as adults.

“...adverse childhood experiences lead to disrupted neurodevelopment in early childhood, which then leads to emotional, cognitive, and social impairment in childhood and adolescence...and leave children vulnerable to the adoption of many different health-risk behaviors which lead directly or indirectly to a variety of diseases, various forms of disabilities, and social problems - and eventually early death.”¹³⁸

In my discussion in chapter three, I am positing that AREs and RT have the same potential outcomes when the religious trauma is left unidentified and untreated.

Later, Bloom also discusses the idea of social deviance and moral treatment. Bloom provides the reader with an overview of the history of social psychiatry and the field's key social philosophers. She introduces and describes the therapeutic milieu, including General Systems Theory and feminist critiques and what it takes to create a living-learning environment. This added to my research on the evolution of spirituality in psychological assessments and the evolution of spiritual assessments, while maintaining that morality and spirituality are core components of the whole self and must be considered

¹³⁷ Bloom Sandra L. *Creating Sanctuary: Toward the Evolution of Sane Societies* Revised ed. New York: Routledge/Taylor & Francis Group. 2013. 30.

¹³⁸ Ibid.

in any exploration of adverse experiences or trauma. This section was particularly important to my research on the evolution of the trauma-informed approach and how social psychiatry developed into multicultural counseling.

Bloom outlines some of the components of the Sanctuary Model of Care in the chapter entitled “Creating Sanctuary: Reconstructing the Social.” It is here that Bloom discusses how the model is rooted in creating a sense of overall safety for everyone in the group and how shared assumptions, goals, and practices contribute to that sense of safety. Throughout the book and again in the conclusion to this chapter, Bloom reminds the reader that the Sanctuary Model sought to help clinical professionals change their lines of questioning from “What’s wrong with you?” to “What has happened to you?”¹³⁹ The first question implies that the person is inherently perverse in judgment and behavior and is often the first question we ask people who diverge from what we perceive as normal.¹⁴⁰ This line of questioning allows us to place those people “outside the realm of human discourse, allowing us to avoid sharing in their experience of separation and suffering.”¹⁴¹ This question is also related to the two pronged narrative identified by Marlene Winell in her work with survivors of Religious Trauma Syndrome.

In “The Sanctuary Model: Through the Lens of Moral Safety,” published in the *APA Handbook of Trauma Psychology: Trauma Practice*, Bloom offers a clear and concise outline of the Sanctuary Model of Care that is similar to the outline I used as a member of Bethany’s steering committee and Core Team. I chose this source because it makes the information more immediately accessible than the way it is presented in *Creating Sanctuary*. According to Bloom, “The purpose of this chapter is to describe the Sanctuary Model as a trauma-informed, evidence-supported, relationship-based, high-commitment, high performance organizational development approach that enables a program, a system,

¹³⁹ Ibid. 195

¹⁴⁰ Ibid.

¹⁴¹ Ibid. 196.

or a community to consciously and deliberately design or redesign their own workplaces so that establishing and maintaining safe moral climates becomes possible.”¹⁴² Bloom also provides historical background and evolutions of the Sanctuary Model since its inception. She articulates the model’s four pillars: trauma theory, the 7 Sanctuary Commitments, S.E.L.F., and the Sanctuary Toolkit. She shares outcomes and how the Sanctuary Model is implemented. This article speaks to my research on the history of trauma theory and spirituality in psychological assessments.

In a three-article series published in *Cognitive Behavioural Therapy Today*, Marlene Winell defines Religious Trauma Syndrome (RTS) and explores the symptoms, or trauma responses, related to RTS. This series offers significant insight into RTS and the lived experiences of people suffering from these symptoms and the religious communities in which these adverse religious experiences occurred. She explains that those in highly restrictive, authoritarian, fundamentalist faith communities are more likely to be exposed to adverse religious experiences and develop RTS.¹⁴³ Further, Winell makes the connection between RTS and Post-Traumatic Stress Disorder (PTSD), citing the impact of RTS and PTSD as the same.¹⁴⁴ Finally, Winell recognizes that without providing a name and definitions for these adverse religious experiences, therapists and other counselors have little to work with from a diagnostic perspective, and have limited resources available to respond to clients presenting with RTS. She calls for additional research and development of assessment and treatment resources, which my research aims to provide.¹⁴⁵

¹⁴² Bloom, Sandra. “The Sanctuary Model: Through the Lens of Moral Safety.” Essay. In *APA Handbook of Trauma Psychology: Trauma Practice*, edited by Steven N. Gold, 499–513. Washington, DC: American Psychological Association, 2017.

¹⁴³ Winell, M., “Religious Trauma Syndrome (Series of 3 articles),” *Cognitive Behavioural Therapy Today* 39, no. 2 (May 2011), 39, no. 3 (September 2011), 39, no. 4 (November 2011). British Association of Behavioural and Cognitive Therapies, London.

¹⁴⁴ Ibid.

¹⁴⁵ Ibid.

In the summer of 2023, a sociological study was published by Darren Slade, Adrianna Smell, Elizabeth Wilson, and Rebekah Drumsta. The study sought to determine the percentage of adults in the United States who have experienced religious trauma and what percentage currently suffer from religious trauma symptoms. This study is important because until then, the literature consisted of qualitative research that focused on individual experiences through case-studies and personal stories shared in interviews. With little to no empirical data to support the hypothesis that religious trauma was a real phenomenon, these case-studies and interviews were the only “proof” that religious trauma existed. This study begins to fill in the gap of missing empirical data, and helps readers understand the state of the field in religious trauma research, including the number of people impacted by RT and the six most common symptoms they experience. The study confirmed what many chaplains, counselors, and other professionals have observed for decades: religious trauma is “a society-wide phenomenon and spiritual abuse is a chronic problem within religious communities.”¹⁴⁶

In an article by Valerie Tarico and Marlene Winell titled “The Sad, Twisted Truth about Conservative Christianity's Effect on the Mind,” the pair explores how religion derives much of its power from influencing unconscious processes that determine how we go through life, what causes us distress, which goals we pursue and which we abandon, how we respond to failure, and how we respond when other people hurt us.¹⁴⁷ They posit that some religious beliefs and practices are more harmful than others. Tarico and Winell cite Janet Heimlich, an investigative journalist, who identified three characteristics of religious groups that are particularly prone to harming children. The characteristics are

¹⁴⁶ Slade, Darren M., Adrianna Smell, Elizabeth Wilson, and Rebekah Drumsta. “Percentage of U.S. Adults Suffering from Religious Trauma: A Sociological Study.” *Socio-Historical Examination of Religion and Ministry* 5, no. 1 (2023): 1–28. <https://doi.org/10.33929/sherm.2023.vol5.no1.01>.

¹⁴⁷ Tarico, Valerie, and Marlene Winell. “The Sad, Twisted Truth about Conservative Christianity's Effect on the Mind.” *Salon*, November 6, 2014. https://www.salon.com/2014/11/01/the_sad_twisted_truth_about_conservative_christianitys_effect_on_the_mind_partner/.

authoritarianism in major theistic religions, any rigid power hierarchy; when isolation or separatism is promoted as a means of maintaining spiritual purity; and fear of sin, hell, or a looming apocalypse.¹⁴⁸

This article highlights how some religious groups promote threat-based models of reality that can cause AREs and RT, especially in children. This article is important in its exploration of how religious communal practices can be experienced as adverse or traumatic; and faith doctrines and belief systems that cause trauma and re-traumatization.

In 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services released a publication called “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach.” This publication provides definitions for some of my key terms, elaborates on the principles of a trauma-informed approach, and most importantly provides guidance for implementing a trauma-informed approach - all essential elements of my research and major project design. I considered the key principles of SAMHSA’s trauma-informed approach in my discussion on assessor competencies and developing the content of the religious trauma screening tool. The work group offers a table of sample questions to consider when implementing a trauma-informed approach including several ‘implementation domains.’ These domains include governance and leadership; policy; physical environment; engagement and involvement; cross sector collaboration; screening, assessment, treatment services; and training and workforce development.¹⁴⁹ I reflected on these implementation domains as I developed the procedure for conducting a religious trauma screen as part of a spiritual assessment at Bethany.

The Psychospiritual Clinician's Handbook: Alternative Methods for Understanding and Treating Mental Disorders contributes to my conversation on psychospiritual care models and highlights how the

¹⁴⁸ Ibid.

¹⁴⁹ Department of Health and Human Services, and Larke Huang. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, HHS Publication No. (SMA) 14-4884, 2014.

care provider's worldview effectives trauma-informed outcomes. The book consists of contributions from multiple authors who share new perspectives on alternative treatments for depression, anxiety, eating disorders, and PTSD which all incorporate spirituality into their treatment models. Collectively, the authors explore how spiritual practices like yoga and mindfulness meditation can be used in psychotherapy. Each contributor provides case studies as illustrations of effective treatment. The book also explores the historical movements towards a model of psychospirituality.

It is through personal stories that my readers will gain further awareness of the spectrum of AREs and insight into the injurious impacts of these experiences. These stories will help the reader better understand how AREs present as trauma and will highlight patterns in trauma responses. My next major conversation partner uses the terminology of Nonsexual Spiritual Abuse (NSA) to discuss what I am otherwise referring to as AREs or RT. This source supports the prevailing idea that adverse or traumatic experiences in the religious or spiritual context can and do result in post-traumatic stress disorder and/or complex trauma. This major source is an essay authored by Jennifer Yates and Jill L. Snodgrass entitled "The Religious Locations of LGBTQ+ Survivors: Survivors of Christian Nonsexual Spiritual Abuse" published in the book *Navigating Religious Difference in Spiritual Care and Counseling* in 2019.

In this essay, Yates' personal experiences of NSA are interwoven with stories from her doctoral dissertation on the topic of NSA. In her dissertation, Yates used qualitative and quantitative research methods to examine whether posttraumatic stress disorder (PTSD) could result from NSA.¹⁵⁰ Yates recognizes America's heteronormative, Christian-dominant culture and how the effects of NSA are

¹⁵⁰ Yates, Jennifer, and Jill L. Snodgrass. "The Religious Locations of LGBTQ+ Survivors: Survivors of Christian Nonsexual Spiritual Abuse." In *Navigating Religious Difference in Spiritual Care and Counseling*, edited by Jill L. Snodgrass, 251–280. Essays in Honor of Kathleen J. Greider. Claremont Press, 2019. <https://doi.org/10.2307/j.ctvwrn4c3.18>.

compounded by a person's intersecting identities.¹⁵¹ In addition to offering the author's personal experiences of NSA and complex trauma, this essay defines these terms. Yates also suggests three competencies for relational-ethical counseling with LGBTQ+ survivors of NSA, which is relevant to my research on how to develop a trauma-informed spiritual assessment tool that considers intersectionality.

She writes from the perspective of someone who experienced NSA and chose to live into her Christian identity as an act of resistance.¹⁵² This perspective, especially within the LGBTQ+ community, could not be overlooked in my research. Faith as a protective factor is essential to understanding faith as a source of abuse, adversity, and conflict, as will be explored further in my research. Yates also assumes that members of the LGBTQ+ community are impacted in various ways by Christianity whether or not they identify as Christian, due to the Christian-dominant views in the US.¹⁵³ Therefore, these stories of NSA survivors provide an important perspective to my research by positing that anyone who identifies as LGBTQ+ can experience NSA, thus bolstering the need for a comprehensive assessment across caregiving disciplines. Further, Yates highlights that NSA survivors are too often unidentified, misdiagnosed, or mistreated in therapy. This insight is the ministerial and vocational motivation for my research project.¹⁵⁴

One of the most significant resources that speaks to those who leave their religion after AREs is an article by Stephanie Russell-Kraft titled "Can Religion Give You PTSD?" Russell-Kraft interviewed Laura Anderson and Brian Peck who in 2019 co-founded the Religious Trauma Institute and who both identify as survivors of RT that resulted from the strict evangelical religious communities of their childhoods. Anderson and Peck educate the reader on the themes of trauma and religious trauma,

¹⁵¹ Ibid. 252.

¹⁵² Ibid. 254.

¹⁵³ Ibid. 251.

¹⁵⁴ Ibid. 266.

offering insight into the emerging context in which AREs and RT are likely to occur. Anderson explains the uptick in people leaving evangelical faith traditions and seeking support or treatment for RT by sharing that many of her clients reported divergences in the trajectory of their church, primarily their understanding of God, during and after the 2016 presidential election.¹⁵⁵

Russell-Kraft also interviewed more than a dozen former evangelicals for their stories, so this article offers several relevant story sources for my project. Each of the people interviewed shared unique stories of abuse and disillusionment with their church.¹⁵⁶ Some asked to remain anonymous sources, specifically because they feared retaliation from family members - some of whom were involved in pro-Trump militia movements.¹⁵⁷ “Their stories shared one factor: despite no longer believing in hell, purity culture, or the imminent rapture, they all struggled to overcome the toll those ideologies had taken on their minds and bodies.”¹⁵⁸

The article also stresses for therapists and other care providers to be culturally competent and to recognize how different identities intersect with religious trauma, pointing out that gender, ethnicity, race, and sexual or affectional orientation overlap with religious belief systems resulting in experiences of intersectionality.¹⁵⁹ LGBTQ+ individuals, for example, might struggle with internalized homophobia or transphobia, and may have been subjected to conversion therapy.¹⁶⁰ Stephanie Pizzo reports in the article that she sought therapy to process childhood trauma related to her abusive father and conservative Pentecostal community, and her therapist skirted the discussion of AREs while telling her to focus on the good parts of her religion instead.¹⁶¹ The insights gleaned from the personal narratives in this article

¹⁵⁵ Russell-Kraft, Stephanie. “Can Religion Give You PTSD?” *The New Republic*, March 23, 2021. <https://newrepublic.com/article/161772/can-religion-give-ptsd>.

¹⁵⁶ Ibid.

¹⁵⁷ Ibid.

¹⁵⁸ Ibid.

¹⁵⁹ Ibid.

¹⁶⁰ Ibid.

¹⁶¹ Ibid.

supports my interest in developing a religious trauma screening tool that is culturally responsive and considers intersectionality.

Another source which discusses the AREs and RT related to leaving a religion is Amy Fallon's piece, "Losing My Religion: Facing the Trauma of Leaving a Faith," published in *The Sydney Morning Herald* in 2021. Fallon interviewed Sherrie D'Souza who spent four decades as a Jehovah's Witness and started the first Australian Recovering from Religion (RfR) support group when she left the religion four years ago.¹⁶² D'Souza identifies as a survivor of Religious Trauma Syndrome and her story highlights some of the common traumas and trauma responses experienced by those who leave a strict authoritarian religious community, as previously outlined in the 'Religious Trauma Syndrome' section of my key terms.

In this article, Fallon also interviewed Caroline Winzenried, a psychotherapist based in Boronia, Victoria, who is one of a handful of counselors in Australia treating clients who are "struggling with the effects of indoctrination by high-control religions, whether they've quit their faith or still embrace it."¹⁶³ Winzenried says, "People with religious trauma sometimes present with anxiety, depression or post-traumatic stress disorder (PTSD), so they might get diagnosed with one of those."¹⁶⁴ This speaks to the diagnoses often attributed to the symptoms associated with religious trauma, and can inform the treatment modalities utilized with such clients. For me, an awareness of common mental health diagnosis given to those suffering from AREs and RT leads to greater awareness of the symptoms and trauma responses experienced by RT survivors.

¹⁶² Fallon, Amy. "Losing My Religion: Facing the Trauma of Leaving a Faith." *The Sydney Morning Herald*, September 11, 2021. <https://www.smh.com.au/lifestyle/life-and-relationships/losing-my-religion-facing-the-trauma-of-leaving-a-faith-20210817-p58jht.html>.

¹⁶³ Ibid.

¹⁶⁴ Ibid.

In “The Health Effects of Leaving Religion” Jon Fortenbury discusses people to whom he refers as “deconverts” (someone who leaves their religion) and shares two stories of deconverts that offer insight into the positive and negative health effects of leaving a religion. One is the story of Curtis Penfold who was raised in the Church of Jesus Christ of Latter-Day Saints (Mormons) and got fired from his job, kicked out of his apartment, and left Brigham Young University all in the same week after he struggled to reconcile his beliefs with the lived realities of his LGBTQ+ peers.¹⁶⁵ Fortenbury uses Penfold’s narrative to highlight the AREs and RT experienced by deconverts. He also argues that some people who leave religion become healthier than they were before, as was the case for Annie Erlandson, who’s story is shared in chapter three.

Intersectionality:

In *Addressing Cultural Complexities in Counseling and Clinical Practice: An Intersectional Approach*, Pamela Hays contributes significantly to multiple aspects of my research project. She provides some background information on the historical development and use of psychological assessments and how they were/are used in the praxis of pastoral theology. Through her ADDRESSING framework and discussions of intersectionality, Hays offers resources and insight into becoming a culturally responsive therapist. She discusses the need for culturally responsive therapists to be highly self-aware and suggests using the ADDRESSING framework as one tool to develop self-awareness and positive therapeutic alliances with clients. The ADDRESSING framework can also help therapists “formulate hypotheses and well-informed questions that are closer to the client’s reality and increase the

¹⁶⁵ Fortenbury, Jon. “The Health Effects of Leaving Religion.” *The Atlantic*, September 28, 2014. <https://www.theatlantic.com/health/archive/2014/09/the-health-effects-of-leaving-religion/379651/>.

therapist's credibility.”¹⁶⁶ I discuss how to incorporate the ADDRESSING framework into spiritual assessments and interviews in chapter 4.

In her discussion of cultural responsiveness as it relates to assessments, Hays recognizes that standardized assessments have been influenced and developed primarily by the dominant European American culture with views that are so prevalent they almost seem universal. Therefore, cultural influences and considerations in screening tools and procedures must be made explicit to the client to increase their sense of safety with the therapist and produce more authentic responses.¹⁶⁷ She suggests a strengths-oriented approach which allows the therapist to see three things: a fuller picture of the client to include positive aspects, difference as strength rather than deficiency, and that culture can be a healing resource that builds on what is working well in the client's life.

Significant to my research project is a foundational awareness of intersectionality, how trauma happens, and the lasting physical, psychological, emotional, and spiritual impacts of trauma. In order to understand the nature of AREs and RT, it is important for the reader to first understand how trauma affects neurological development and ongoing brain functions. In a chapter entitled “Understanding Trauma,” Hays provides a historical snapshot of trauma awareness and science. She reflects on the psychological and developmental effects of trauma. She specifically discusses the relationship between race and trauma, trauma and people with disabilities and older adults, trauma and sexual or gender minorities, and trauma in immigrant populations. Hays offers ten trauma-informed strategies that are culturally responsive to be used in assessing for trauma; all of which are relevant to assessing for AREs and RT.

¹⁶⁶ Hays, Pamela A. *Addressing Cultural Complexities in Counseling and Clinical Practice: An Intersectional Approach*. 4th ed. Washington, DC: American Psychological Association. 2022. 108.

¹⁶⁷ Ibid. 136.

Hays also provides historical and current trends in various testing tools used in the field of trauma work. She begins by discussing the assessment of intellectual abilities and moves through mental status evaluations, neuropsychological assessments, and personality assessments. She concludes that a thorough assessment of any type should include a thorough clinical interview conducted by culturally competent professionals in culturally responsive spaces.¹⁶⁸ Hays also focuses on an integrative approach to therapy, which looks at developing treatment plans and various interventions. Throughout the book, Hays uses case studies and vignettes to illustrate examples of culturally responsive methodologies at play. Each chapter includes key terms, practice exercises, reflection questions, and key ideas to make these concepts accessible and easier to incorporate into praxis.

Counseling the Culturally Diverse: Theory and Practice by Derald Wing Sue is a leading textbook on multicultural counseling that provides a comprehensive guide for scholars and practitioners who work in the mental health field, social workers and psychiatrists, and others working with culturally diverse populations. Sue is a professor of psychology at Columbia University and writes extensively on topics such as intersectionality and microaggressions. This book examines the concept of "cultural humility" as one of the major characteristics of cultural competency and provides some of the definitions in my Key Terms. I relied on this textbook in my chapter 3 discussion on conducting culturally responsive, trauma-informed assessments and interviews. Sue's work contributed to my checklist of assessor competencies and informed how I formulated questions in my screening tool.

Joan Coaston interviewed Kimberle Crenshaw, who coined the term "intersectionality" in a piece called "The Intersectionality Wars" in which they discuss how the concept of intersectionality has become a dividing line between the right and left political parties of the United States. They discuss how intersectionality was originally a law concept that experienced tremendous growth in awareness in 2017

¹⁶⁸ Ibid. 206.

when organizers of the Women's March cited women's intersecting identities as sources of complex oppression.¹⁶⁹ Explained simply, American society is currently engaged in three debates around intersectionality: "one based on what academics like Crenshaw actually mean by the term, one based on how activists seeking to eliminate disparities between groups have interpreted the term, and a third on how some conservatives are responding to its use by those activists."¹⁷⁰ This source contributed to my understanding of intersectionality and how the concept has evolved beyond the field of law and become relevant in the field of trauma-informed care.

Assessments:

The published spiritual assessments that I researched included: the FICA Spiritual History Tool, the HOPE assessment, 4 FACTS assessment, Searle-Vance Spiritual Assessment, Kathryn Hope Keller's Spiritual Abuse Questionnaire, Rebecca Drumstra's Adverse Religious Experiences Questionnaire, and four tools developed by social work researcher and professor David Hodge. Hodge's instruments and methods included spiritual genograms, spiritual lifemaps, spiritual history narratives, and spiritual eco-maps. With exception to the Searle-Vance Spiritual Assessment, I have used each of these in my professional practices as a chaplain. My survey of these tools is included in chapter 4. In this section, I have included literature relevant to these tools. These articles provided awareness of the author's rationale for developing a spiritual assessment tool and the contexts, or settings, in which these tools were intended for use. They also provided some insight into the roles and responsibilities of various professionals who might be involved in the assessment process.

In an article called "The Evolution of Spiritual Assessment Tools in Healthcare" Cadge and Bandini explore the history of spiritual assessment tools as a way to illustrate the place of spirituality

¹⁶⁹ Coaston, Jane. "The Intersectionality Wars." *Vox*, May 20, 2019. <https://www.vox.com/the-highlight/2019/5/20/18542843/intersectionality-conservatism-law-race-gender-discrimination>.

¹⁷⁰ Ibid.

and religion in American healthcare. The authors trace the diffusion of spiritual assessment tools from their origins in chaplaincy and pastoral counseling in the 1970s into the fields of nursing, medicine, and social work throughout the following decades. This article highlights the shifts in where spiritual assessments are conducted and by whom, including the types of professionals developing these tools and their rationales.

To better understand this same evolution in psychology and counseling, I turned to an article by K. Elizabeth Oakes and Mary M. Raphael called “Spiritual Assessment in Counseling: Methods and Practice.” This article discusses the rationale for counselors to conduct a spiritual assessment, which informed the development of our procedure at Bethany. The information in this article also contributed to my understanding of counselor competencies, the significance of the timing of the assessment, and how to formulate questions appropriately for a culturally responsive assessment and interview.

Another source that helped me identify assessor competencies and better understand the rationale for conducting trauma screens was a treatment improvement protocol (TIP) published by the Substance Abuse and Mental Health Services Administration (SAMHSA) and was entitled Trauma-Informed Care in Behavioral Health Services, series 57.¹⁷¹ The TIP is essentially a reference book of recommended evidence-based practices for behavioral health service providers. I relied heavily on this document throughout my research since it is included in our reference resources at Bethany. SAMHSA currently recommends universal screening for trauma in behavioral health services.¹⁷² Their recommendations regarding timing, content, environment, and choosing screening instruments heavily informed how I developed our spiritual assessment procedure at Bethany. I delve further into this in my discussion of

¹⁷¹ Substance Abuse and Mental Health Services Administration. “Trauma-Informed Care in Behavioral Health Services.” *Treatment Improvement Protocol (TIP) Series 57*. HHS Publication No. (SMA) 13-4801. Rockville, MD. 2014.

¹⁷² Ibid. 91.

trauma screens in chapter three and my rationale for the development of a religious trauma screen in chapter four.

Considering social workers are involved in many behavioral healthcare settings, mine included, I wanted to explore this same evolution in social work practice. Unsurprisingly, like other authors in the literature, Hodge and Holtrop are careful in defining “spiritual assessment” and specifically note why assessing spirituality is important in the field of social work. David Hodge is a researcher and professor of social work. In this article, four spiritual assessment tools are reviewed, including a case study for each tool. This article provided much of my understanding of how to incorporate these tools into my praxis of pastoral theology, and why a professional might choose to use one over the others or use the tools at different times while providing counseling and social services.

According to Borneman, et.al. in an article called “Evaluation of the FICA Tool for Spiritual Assessment,” the FICA Spiritual History Tool was developed in 1996 by a team of primary care physicians, led by Dr. Christina Puchalski in collaboration with Drs. Daniel Sulmasy, Joan Teno, and Dale Matthews.¹⁷³ This article provided insight into the rationale for the development of this tool and other details that were important in my survey of assessment tools and interview methods. The FICA tool was intended for use by non-chaplain health care providers who could easily incorporate the spiritual history questions into the patient’s standard medical history. The tool focuses on the main factors that could be relevant to the medical provider in a medical or clinical setting. An article called “Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment” indicates the HOPE questions were also developed with medical professionals in mind. The HOPE tool was intended to serve as a teaching tool to help medical students, residents and

¹⁷³ Borneman, Tami, Betty Ferrell, and Christina M. Puchalski. “Evaluation of the FICA Tool for Spiritual Assessment.” *Journal of Pain and Symptom Management* 40, no. 2 (August 1, 2010): 163–73. <https://doi.org/10.1016/j.jpainsymman.2009.12.019>.

practicing physicians begin to use spiritual assessments in the medical history interview process.¹⁷⁴ The HOPE questions are open-ended and work well in a conversational approach, allowing a person to naturally include whatever information or stories they deem relevant.¹⁷⁵

According to chaplain and researcher Mark LaRocca-Pitts in an article called “Four FACTs Spiritual Assessment Tool,” the Four FACTs assessment combines two screening tools for use by professional chaplains and pastoral care providers. The Four FACTs Spiritual Assessment Tool combines the Four Fs and the FACT spiritual assessment tool, both developed by LaRocca-Pitts.¹⁷⁶ LaRocca-Pitts claims the FACT Tool provides an algorithm for evaluating information and a mechanism for developing a plan of care.¹⁷⁷ LaRocca-Pitts’ claims are explored more fully in my survey of assessments in chapter 4.

The Searle-Vance Spiritual Assessment was the first screening tool I found that intentionally sought to screen for and respond to spiritually or morally related injuries. The assessment was developed by Robert F. Searle and C. Garland Vance while Searle served as Division Chaplain of the US Army Reserves 98th Training Division. The authors of the assessment use the language of moral injury to describe experiences in which one’s human spirit is so bruised and broken that they cease to find meaning and hope in life and no longer seek either meaning or hope.¹⁷⁸ The authors assert that a military chaplain must be able to assess for active military service people’s spirituality and spiritual/moral injuries that could impact the service person’s overall sense of well-being, and further, prove detrimental

¹⁷⁴ Anandarajah, Gowri, and Ellen Hight. “Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment.” *American Family Physician* 63, no. 1, 2001. 81–89.

¹⁷⁵ Ibid.

¹⁷⁶ LaRocca-Pitts, Mark. “Four FACTs Spiritual Assessment Tool.” *Journal of Health Care Chaplaincy*. Taylor & Francis Group. April, 2015.

¹⁷⁷ Ibid.

¹⁷⁸ Searle, Robert F, and C Garland Vance. “A Chaplain’s Comprehensive Spiritual Assessment And Military Mission.” *The Journal of Pastoral Care & Counseling* 75, no. 1 (March 2021): 40–50.
<https://doi.org/10.1177/1542305020968051>. 44.

to the military mission if not identified and treated.¹⁷⁹ This speaks to the authors' awareness of the benefits of holistic care and the potential community impacts of individual spiritual/moral injury; and aligns with my search for an assessment that proves effective in a holistic care setting that assumes trauma happens in community and must be healed within the communal context. Additionally, the authors note that the assessment was reviewed and authorized for use by an Executive Officer, the Judge Advocate General, the Equal Employment Opportunity Officer, Command Sergeant Major, and other leaders within the 98th Division; inferring that the assessment was reviewed for ethical concerns including cross-cultural awareness and themes of inclusivity and accessibility.¹⁸⁰

The authors of the assessment structured their study of existing assessments similarly to how I structured my research project. They surveyed spiritual assessments approved for use by chaplains in the 98th Division and used their findings to develop a more comprehensive assessment.¹⁸¹ The efficacy of the assessment at identifying spiritual/moral injuries is illustrated through a vignette in an article by the same authors, "A Chaplain's Comprehensive Spiritual Assessment and Military Mission" published in *The Journal of Pastoral Care & Counseling* in 2021.

In the article "Measuring Symptoms of Moral Injury in Veterans and Active-Duty Military with PTSD," Harold Koenig reviews the properties of the Moral Injury Symptom Scale-Military Version (MISS-M) which was designed for use with veterans and active-duty military members presenting with PTSD. The MISS-M is referenced in research of the Searle-Vance Spiritual Assessment that I surveyed for my project. Koenig explains that the scales and assessments previously used in military settings did not assess religious or spiritual adversity or changes in religious beliefs, which led to the development of

¹⁷⁹ Ibid. 40.

¹⁸⁰ Ibid. 41.

¹⁸¹ Ibid. 40.

the MISS-M.¹⁸² He also discusses the rationale for the dimensions included in the development of the MISS-M. An interdisciplinary team of mental health and religious professionals came up with ten dimensions that characterize moral injury, based on the literature and research of trauma experts, and recognized eight psychological elements of moral injury.¹⁸³ The team then used this information to develop the MISS-M. Their methodology is similar to how I structured my research project, in that the team first identified common symptoms and presentations of PTSD and worked backwards to determine the types of questions to ask and how to ask those questions. The article also includes the long form version of the MISS-M for reference.

One source that offers insight into the types of questions currently being asked to assess AREs and RT is the Spiritual Abuse Questionnaire developed by Kathryn Hope Keller. Keller makes two claims that align with the claims I am making: one, she claims that clinical assessors need to be culturally competent and understand that religion and spirituality can be an element of a person's cultural identity; two, she claims that trauma competency is essential to assessing and responding to AREs and RT.¹⁸⁴ Through her own research of spiritual abuse, Keller developed a scale to measure experiences of spiritual abuse including abuse of power, suppression of self-expression, and moral injury.¹⁸⁵ The scale includes seventeen statements in a self-reporting format that uses a Likert scale to note the degree to which the person agrees or disagrees with the statements.¹⁸⁶ These statements were derived from emerging patterns in the psychiatric or therapeutic treatment of survivors of AREs and RT, meaning these are statements that might commonly apply to those suffering from AREs and RT.¹⁸⁷

¹⁸² Koenig, Harold. "Measuring Symptoms of Moral Injury in Veterans and Active Duty Military with PTSD." *Religions* 9, no. 3 (March 17, 2018): 86. <https://doi.org/10.3390/rel9030086>

¹⁸³ Ibid.

¹⁸⁴ Keller, Kathryn Hope. "Spiritual and/or Religious Abuse: Emerging Understanding and Clinical Implications." *GCRR: Religious Trauma Studies*. Lecture, 2022.

¹⁸⁵ Ibid.

¹⁸⁶ Ibid.

¹⁸⁷ Ibid.

Another questionnaire that offers insight into the themes explored in screening tools for AREs and RT is the Adverse Religious Experiences Questionnaire developed by Rebeka Drumsta. Her questionnaire is adapted from questions asked during a congregational study on RT at Sanctuary Community Church in Iowa City, IA that began in 2017.¹⁸⁸ The congregation's questions are accessible on the church's website.¹⁸⁹ Drumsta's questionnaire consists of eighteen "yes/no" questions and explains that if a person answers "yes" to one or more questions they may have AREs or RT. She includes a disclaimer that this questionnaire is not intended as a diagnostic tool and is best used as a personal reflection tool that could increase the chances of a person struggling with AREs or RT to seek support.

¹⁸⁸ Drumsta, Rebekah. "How Religious Trauma Hits Home." *GCRR: Religious Trauma Studies*. Lecture, 2022.

¹⁸⁹ For more on Sanctuary Community Church and their congregational study, see: <https://www.sanctuaryic.org/blog/adverse-religious-experiences>

Chapter 3: Research: Praxis and Content of Spiritual Assessments

In Ana Sharp Williamson's childhood, religion was everything. She attended a conservative evangelical church in Belton, Missouri with her family, and her "only social life was church, youth group, and another youth group at a different church."¹⁹⁰ She was homeschooled with a conservative Christian curriculum, which taught a white Christian nationalist narrative of history.¹⁹¹ "I had a textbook that framed the defeat of the Spanish Armada by England as God setting the stage for America, because if England hadn't defeated the Spanish Armada then North America would have been colonized by Catholics and God wanted America to be Protestant," she said.¹⁹² Williamson grew up believing that complementarianism (the belief men and women complement each other through distinct and separate roles) and purity culture (which demands that women remain sexless virgins until marriage) were divine ordinances.¹⁹³ "You're taught that your body belongs to God, then your dad, then your husband," she said.¹⁹⁴ "Your dad protects your virginity, then you get married and your dad gives you to your husband, and your body belongs to him."¹⁹⁵

Williamson believes this worldview caused her to stay for several years in an abusive relationship in which she was pressured to engage in a variety of nonvaginal sex acts.¹⁹⁶ Williamson did not want to engage in these sex acts, and she did not have the language to express herself or know how to refuse sex with her partner. She recalls hearing one verse from

¹⁹⁰ Russell-Kraft, Stephanie. "Can Religion Give You PTSD?" *The New Republic*, March 23, 2021. <https://newrepublic.com/article/161772/can-religion-give-ptsd>.

¹⁹¹ Ibid.

¹⁹² Ibid.

¹⁹³ Ibid.

¹⁹⁴ Ibid.

¹⁹⁵ Ibid.

¹⁹⁶ Ibid.

Jeremiah over and over: ‘The heart is deceitful above all things and beyond cure. Who can understand it?’¹⁹⁷ “The message was: Don’t listen to your feelings,” she said.¹⁹⁸ After sexual encounters with her partner, Williamson would sit in her car and cry.¹⁹⁹ She did not know it was not “normal” to feel this way after sex.²⁰⁰ Williamson was not only traumatized by an abusive relationship. Her trauma began with the ideology of purity culture and became more complex when her sense of identity was fractured. “I didn’t know what it meant to be a woman,” she said, adding, “I had no concept of gender identity beyond evangelicalism.”²⁰¹

Even though she regularly participates in therapy, Williamson is still burdened by the weight of purity culture.²⁰² She now believes women can and should enjoy sex, though she struggled to put her belief into practice in her marriage. “I was very sex-positive,” she said, “I was all like, ‘Hey, close the orgasm gap!’ I would preach that to my friends, but it took a long time for my body and brain to actually believe that for myself.”²⁰³

This represents one of the complicating factors in the treatment of religious trauma - that many evangelicals are taught not to listen to or trust their bodies.²⁰⁴ Since we understand trauma lives in the body, we can recognize that treating religious trauma is more difficult when a person must first develop or regain a sense of their own bodily self.²⁰⁵ Williamson’s story stresses the importance for therapists and other care providers to be culturally competent and to recognize how different identities intersect with religious trauma, pointing out that gender, ethnicity, race,

¹⁹⁷ Ibid.

¹⁹⁸ Ibid.

¹⁹⁹ Ibid.

²⁰⁰ Ibid.

²⁰¹ Ibid.

²⁰² Ibid.

²⁰³ Ibid.

²⁰⁴ Ibid.

²⁰⁵ Ibid.

and sexual or affectional orientation overlap with religious belief systems resulting in experiences of intersectionality.²⁰⁶

In my introduction in chapter one, I offered a brief overview of trauma theory and what it means for a behavioral healthcare setting to practice a trauma-informed approach. In this chapter, I will further identify competencies of a trauma-informed assessor and spiritual assessment model. Considering the many intersections at which my research sits, I will present my findings in two major sections to correlate with my research questions. The first section includes my reflection and interpretation of research findings around areas of *praxis*. This section will address two themes in the research question, the concepts of ‘trauma-informed’ and ‘intersectionality.’ These themes will be explored as competencies of the assessor in their praxis of spiritual assessment. My exploration of praxis includes the assessor’s conceptual reasons to conduct a spiritual assessment, jurisdictional considerations of interprofessional care teams, and the timing of a spiritual assessment.

The second section analyzes research findings regarding the *content* of a spiritual assessment. This section focuses on what makes up the separate components of a full spiritual assessment and the types of questions asked in each separate component. Since my project is rooted in trauma theory, and my resource development is a screening tool to help professionals in child welfare and behavioral healthcare recognize and respond to religious trauma, this section also includes recommendations for conducting trauma screens.

Praxis

Screening and assessment are common practices in a trauma-informed behavioral healthcare setting and the professionals responsible for conducting trauma screens and spiritual

²⁰⁶ Ibid.

assessments must be able to apply certain competencies in their screening and assessment practices. Sue and Hays claim that the ideal assessor must first be a trauma competent counselor and must continuously engage in self-reflection and cross-cultural awareness building by learning from and with other cultures and diverse groups of people. I assert that chaplains and other professionals responsible for conducting spiritual assessments should also have trauma informed counseling skills and must also commit to a life-long learning process from and with other cultures.

Chaplain-researcher George Fitchett traces the origins of modern spiritual assessments to Paul Pruyser's 1976 publication of *The Minister as Diagnostician*, in which Pruyser encouraged clergy to diagnose individuals by integrating their psychological and theological skills.²⁰⁷ Around this same time, Presbyterian pastor and pioneer in chaplaincy education Anton T. Boisen influenced early developments of narrative spiritual assessments.²⁰⁸ A few tools from this time traced their history to psychiatrist Edgar Draper, who hypothesized that a psychiatrist could accurately diagnose a person based only on knowing the person's religious beliefs."²⁰⁹ One such nurse, Ruth Stoll, created what she called a spiritual history guide in 1979.²¹⁰ The tool grouped questions into four areas including the concept of God or deity, sources of hope and strength, religious practices, and the relationship between spiritual beliefs and health.²¹¹ Stoll was clear that not all patients would express their values and beliefs through conventional religious language or rituals and recommended that nurses recognize and respect all values and beliefs.²¹²

²⁰⁷ Cadge, Wendy, and Julia Bandini. "The Evolution of Spiritual Assessment Tools in Healthcare." *Society*, no. 5 (2015): 430–437. <https://doi.org/10.1007/s12115-015-9926-y>.

²⁰⁸ Ibid.

²⁰⁹ Ibid.

²¹⁰ Ibid.

²¹¹ Ibid.

²¹² Ibid.

These early roots in the praxis of spiritual assessment contributed to both an integrative approach and a collaborative approach to counseling and the concept of using a contextual viewpoint - all competencies of a multicultural counselor or assessor.

In the early 2000's, the competencies required to conduct a spiritual assessment were being developed within the counseling field. Therapist and researcher Dr. Len Sperry defined spiritual assessment simply as the process of “eliciting a client’s spiritual and religious history” within the overall psychological appraisal process.²¹³ At this time, researchers recognized clinical evidence that suggested spiritual assessments should be holistic and interdisciplinary, and conceptualization should draw from the fields of medicine, social work, counseling, and psychology.²¹⁴ Additionally, they understood that counselors should only conduct spiritual assessments within the intersecting contexts of spirituality/religion, culture, and psychopathology.²¹⁵ Similar to the healthcare professionals’ interest in understanding the patient’s spirituality in relationship to their medical condition, counselors were encouraged to try to understand the patient’s spirituality in relationship to their clinical issues.

Sperry elaborated on his simple definition of the assessment to include what happens after the initial spiritual history is taken and suggested spiritual assessments should evaluate core values and beliefs of clients. According to Sperry, the full spiritual assessment includes gathering the spiritual history; an exploration of the client’s spiritual community involvement; exploration of the client’s God image; evaluation of the client’s use of spiritual practices; and clarification of the client’s core values and beliefs.²¹⁶ In the praxis of counseling, the counselor is advised to

²¹³ Sperry, Len. *Spirituality in Clinical Practice: Incorporating the Spiritual Dimension in Psychotherapy and Counseling*. 2nd ed. New York: Brunner-Routledge, 2012.

²¹⁴ Ibid.

²¹⁵ Ibid.

²¹⁶ Ibid.

“develop a spiritual assessment case formulation, which evaluates the assessment within the context of the clinical problem and its related diagnosis.”²¹⁷

In the process of clarifying a client’s core values and beliefs, the counselor should not focus on determining whether the client’s beliefs are right or wrong, but instead should focus on how those beliefs and relevant spiritual practices might be used by the client to cope with challenges.²¹⁸ If a counselor has questions about the appropriateness of beliefs, they must be prepared to consult and collaborate with clergy.²¹⁹ Further, if it seems necessary and the client agrees, counselors might refer the client to work directly with an appropriate religious leader.²²⁰ These recommendations from Sperry speak to the importance of the counselor’s self-awareness and ability to recognize the limitations of their professional scope and responsibility of care.

It is important to remember that assessors are not “objective” observers of people, since they each bring their own beliefs, values, and theories into relationships and the therapeutic environment.²²¹ Further, personal characteristics, attitudes, and beliefs influence how an assessment is conducted, what is actually assessed, and the interpretation of clinical data.²²² Therefore, facilitators of a spiritual assessment need to be aware of potential biases that can impact their clinical (or spiritual) judgment, including influences of stereotypes and implicit biases.²²³ Sue asserts that “culturally competent assessment” occurs when evidence-based practices are coupled with a cultural competency framework.²²⁴ This task is achieved when the

²¹⁷ Ibid.

²¹⁸ Oakes, K. Elizabeth, and Mary M Raphael. “Spiritual Assessment in Counseling: Methods and Practice.” *Counseling and Values*, no. 4, April 2008.

²¹⁹ Ibid.

²²⁰ Ibid.

²²¹ Sue, Derald Wing. *Counseling the Culturally Diverse: Theory and Practice*. United Kingdom: Wiley, 2022. 207.

²²² Ibid. 208.

²²³ Ibid. 207-208.

²²⁴ Ibid. 208.

facilitator, or assessor, develops a deeper understanding of each client through an exploration of their unique personal background and worldview.²²⁵

In the scope of a full psychological assessment, clients are typically informed that family, environment, and sociocultural factors will be explored during the assessment and interview.²²⁶ However, due to various reasons, including the assessor's personal comfort level with certain topics or themes, most clinical assessments and interviews do not adequately consider these factors.²²⁷ To help facilitators work around some of the common variables affecting diagnosis and avoid pitfalls, Sue stresses the importance of using both a collaborative approach and a contextual viewpoint to develop openness, increase transparency, and establish a sense of safety in the therapy process.²²⁸ Guided by the principles of collaborative conceptualization, the assessor and client work together to: construct an accurate definition of the problem; formulate hypotheses regarding the cause of the problem; brainstorm ways to confirm or disconfirm the hypotheses; and develop a treatment plan that responds to the problem.²²⁹

A trauma-informed assessment and interview must “incorporate the client’s understanding of the presenting concern, include an extensive exploration of their trauma history and strengths, as well as an explicit exploration of their multiple identities and the contexts in which they live.”²³⁰ Discerning the cultural context of the presenting concern is essential.²³¹ Sue suggests using the Cultural Formulation Interview (CFI), developed by the American Psychiatric

²²⁵ Ibid.

²²⁶ Ibid. 212.

²²⁷ Ibid.

²²⁸ Ibid.

²²⁹ Ibid. 213-214.

²³⁰ Ibid. 214.

²³¹ Ibid. 215.

Association, as part of the collaborative process.²³² The CFI is an overall cultural assessment that uses open-ended questions to elicit personal narratives from the client.²³³ Additionally, Sue urges counselors to adopt multicultural counseling competencies as part of the larger cultural competency framework of the assessment and interview. In this context, cultural humility appears as a way of being that lifts up the “attitudinal components of respect for others, an egalitarian stance, and diminished superiority over clients” and leads to an “other-orientation,” rather than the inclination towards self-focus.²³⁴

Hays aligns with Sue in her suggestions for laying a foundation for culturally responsive assessments and interviews. Hays describes several processes with which the assessor should consistently engage, including: ongoing involvement in our own cultural self-assessment, learning about diverse cultures, specifically differences in the views of minority and dominant culture groups and language use, understanding each person’s unique background and worldview, reflecting on the interactions between the assessor’s and clients’ identities, and establishing a positive alliance between the assessor and client.²³⁵ Hays also recommends using ten strategies, which apply similar ideologies as Sue, maintaining that the assessor’s cultural competency and a collaborative approach are essential to the success of the trauma-informed interview. The strategies are as follows:

1. Be aware of your own cultural identity and how it might trigger a person’s symptoms or make it more challenging for them to share trauma-related information.
2. Don’t limit your assessment to the individual; instead, consider trauma in the context of the person’s culture and community.

²³² Ibid.

²³³ Ibid, for CFI sample questions

²³⁴ Ibid.

²³⁵ Hays, Pamela A., *Addressing Cultural Complexities in Counseling and Clinical Practice: An Intersectional Approach*. 4th ed. Washington DC: American Psychological Association. 2022.136.

3. Be cautious about making judgements regarding what constitutes a traumatic experience until you fully understand the person's family and cultural histories.
4. Remember that the person's perspectives regarding traumatic events, particularly armed conflict, might differ from that of the dominant culture.
5. When asking about trauma, do not assume the person will disclose.
6. Recognize that how the person understands their experiences might be different from how you understand them, including what the person finds reassuring.
7. Remember that language used to describe traumatic experiences can be interpreted differently. To lessen ambiguity in communication, use behavior specific language in questions.
8. Deliberately look for the person's strengths and resources.
9. With children who lack psychological and verbal abilities to express their experiences, be more aware of their behaviors, presenting symptoms, and trauma responses.
10. Pay careful attention to your own vulnerabilities and the potential for secondary trauma.²³⁶

These ten strategies are excellent companions to Hays' ADDRESSING acronym, which is a tool for developing hypotheses and questions about cultural influences that counselors could be inclined to overlook.²³⁷ The strategies accompany the acronym to form a larger ADDRESSING framework for multicultural counseling, similar to the CFI. The ADDRESSING framework makes use of the acronym in two categories of work for the assessor: "(a) the personal work of introspection, self-exploration, and lifelong learning about the cultural influences on oneself and (b) the ongoing interpersonal work of learning from, about, and with diverse people."²³⁸

According to Hays, the ADDRESSING acronym stands for Age and generational influences, Developmental or other Disability, Religion and spirituality, Ethnic and racial

²³⁶ Ibid. 173-177.

²³⁷ Ibid. 19.

²³⁸ Ibid. 20.

identity, Socioeconomic status/social class, Sexual orientation, Indigenous heritage, National origin, and Gender identity.²³⁹ The idea is that the assessor uses the ADDRESSING acronym to create a culture sketch of each client, with much of the information used in the sketch coming through communication with the client. Some of the sections might include pre-populated information based on what was gathered from other intake forms and conversations with the client. It is not expected that the client would complete their own culture sketch using the acronym, rather, the assessor should use the tool to help fill in gaps in the information provided by the client to better understand their personal background and worldview. Additionally, it is expected that the assessor would complete their own culture sketch prior to engaging in treatment sessions with clients. For practice using the ADDRESSING culture sketch, see Hays' many examples throughout the book.²⁴⁰

Much of what I learned from Sue and Hays focused on conducting a full psychological assessment and interview and provided insights into the competencies required for the assessor to function as a “trauma-informed” counseling professional. For other professional competencies in behavioral healthcare settings, I return to SAMHSA’s guide to a trauma-informed approach. SAMHSA recommends behavioral healthcare settings adhere to six principles: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical, and gender issues.²⁴¹

This means that spiritual assessment interviews require physically and psychologically *safe* environments, as defined by the assessee.²⁴² The assessor must communicate openly and

²³⁹ Ibid. 19.

²⁴⁰ Ibid. 136.

²⁴¹ Ibid.

²⁴² Ibid.

honestly to develop trustworthiness, including being *transparent* about the purpose of the assessment and how it will be used in the assessee's treatment plan. SAMHSA explains that "peers" refers to others with lived experiences of trauma, or other trauma survivors.²⁴³ The value of *peer support* in trauma recovery should not be overlooked; however, in the context of a trauma-informed interview, the assessor and assessee are not peers. While an assessor with lived experiences of trauma might be able to recognize indicators of trauma and trauma responses and be well equipped to respond to these traumas in the therapeutic milieu, bonding over similar traumatic experiences in this scenario would be a boundary violation. Therefore, the concept of peer support is less useful in the interview model and more applicable to how a community or system responds to trauma.

The next three principles work together to lift up themes of intersectionality. These principles are supported by Sue and Hays in their assertions that multicultural counseling competency and a collaborative approach are essential to understanding the client's background, worldview, and expectations of the therapeutic process. The fourth principle, *collaboration and mutuality*, is about leveling power differences in the therapeutic relationship.²⁴⁴ *Empowerment, voice, and choice* is the fifth principle and drives us to recognize and build upon each individual's strengths and experiences.²⁴⁵

The assessor's ability to observe and listen for strengths is essential to conducting a culturally responsive assessment and interview. Hays urges assessors to intentionally search for a person's strengths beginning with the first interaction between the assessor and client, because many people are unable to name their own strengths and communal support systems. Hays

²⁴³ Ibid.

²⁴⁴ Ibid.

²⁴⁵ Ibid.

encourages actively listening and looking for strengths to achieve three things: add to the assessor's understanding of the person's background and worldview by gaining a fuller picture of the person and their lived experiences that includes positives (not only the negatives on which the person might be inclined to focus); recognize the positive aspects of culture and diversity to subtly empower clients of minority identities; identify protective or healing factors within the person's cultural context to build on what is already working in the person's life.²⁴⁶

Social workers, like other professionals discussed here, need to take a strengths-based approach to assessing their clients. In this field, researchers have consistently found a generally positive correlation between a person's spirituality and their other beneficial characteristics.²⁴⁷ Various dimensions of spirituality have been associated with a range of positive outcomes in social work, including recovery from addiction, depression, divorce, serious mental illness, homelessness, and sexual assault.²⁴⁸ It is imperative that social workers attempt to understand a client's faith-based or spiritual strengths in order to recognize potential assets to move the client forward. Hodge suggests spirituality might become more salient for clients who are dealing with challenging situations - when people are most likely dealing with social workers; though he highlights the importance of the client's autonomy and recommends the social worker explore and respect the client's desire to integrate their spiritual beliefs into the helping relationship.²⁴⁹

Principles four and five of SAMHSA's model consider "the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice

²⁴⁶ Ibid. 137.

²⁴⁷ Hodge, D. R. *Spiritual Assessment: A Handbook for Helping Professionals*. Botsford, CT. North American Association of Christians in Social Work. 2003.

²⁴⁸ Ibid.

²⁴⁹ Ibid.

and are often recipients of coercive treatment.”²⁵⁰ Coercive treatment occurs too often when assessors presume their own knowledge, culture, and lived experiences to be superior to the client’s. Adhering to principles four and five, the trauma-informed interview must support shared decision making, take seriously the client’s choice, and include the client’s voice in any goal setting for healing and recovery.²⁵¹ Adherence to principle six means the trauma-informed spiritual assessment interview will move past cultural stereotypes and biases while “offering access to gender responsive services; leveraging the healing value of traditional cultural connections; incorporating processes that are responsive to the racial, ethnic, and cultural needs of individuals served; and recognizing and responding to historical trauma.”²⁵²

Throughout my research, several authors have suggested certain competencies for relational-ethical counseling with specific populations. After reviewing them, I realized that they were all in alignment with Sue, Hays, and the framework provided by the SAMHSA working group. For example, Yates suggested three competencies for counseling with and for the LGBTQ+ community: self-reflectivity, adeptness at assessing for complex trauma, and facilitating relational safety and avoiding re-traumatization.²⁵³ These competencies are clearly identified as evidence-based practices which are supported by Sue, Hays, and others. However, Yates offers one additional suggestion specific to the scope of my project. She suggests that the assessor not only be aware of their own social/cultural locations, but also pay special attention to recognizing their own religious location in relation to the client’s to better understand the

²⁵⁰ Department of Health and Human Services, and Larke Huang. *SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*, HHS Publication No. (SMA) 14-4884, 2014.

²⁵¹ Ibid.

²⁵² Ibid.

²⁵³ Yates, Jennifer, and Jill L. Snodgrass. "The Religious Locations of LGBTQ+ Survivors: Survivors of Christian Nonsexual Spiritual Abuse." In *Navigating Religious Difference in Spiritual Care and Counseling*, edited by Jill L. Snodgrass, 253–280. Claremont Press, 2019. <https://doi.org/10.2307/j.ctvwrn4c3.18>.

spectrum of power and oppression at play in the client's life and in the therapeutic relationship.²⁵⁴ This will be especially helpful to the assessor when screening or assessing a diverse youth population in the child welfare system or in youth behavioral healthcare settings.

Considering Intersectionality

When I envisioned a spiritual assessment tool that could seriously consider the concept of intersectionality, I brought with me the awareness that my ministry setting requires its chaplain to be adept in multicultural settings, including actively engaging in three major social justice efforts. These efforts, largely inspired by the works of Black and Queer Liberation Theologians and communities, are as follows: engage with and contribute to anti-racism work within the scope of your field and on larger social platforms through personal and professional development and praxis; live into our communal identity as an Open and Affirming organizational partner with the UCC and as individuals committed to the safety, health, and mental and spiritual wellbeing of LGBTQ+ people and communities; and stay committed to serving those living with poverty to provide equitable access to services and opportunities.

Our youth's identities most often intersect at ethnicity/race with sexuality/gender, ethnicity/race with poverty, sexuality/gender with poverty, or ethnicity/race with sexuality/gender with poverty. Not coincidentally, most of our team members represent similar populations living with similar intersecting identities. This is why addressing these three areas is of utmost importance to Bethany's DEI Committee and why these efforts are so prominent in our strategic DEI Blueprint for the organization. But are these three categories of cultural identifiers especially important to recognize in a spiritual assessment and interview?

²⁵⁴ Ibid.

In short, yes and no. Yes, these three categories are of particular importance in our setting at Bethany because we know, for example, we serve a large population of LGBTQ+ youth; therefore, in preparation for conducting a spiritual assessment and interview, the assessor needs to become culturally competent with LGBTQ+ concerns and be able to openly, comfortably communicate about those concerns with youth. At Bethany, this is always a baseline expectation of all team members, especially while facilitating any therapeutic services. In other settings this might not be the case, and the assessor would need to self-initiate their endeavors to become culturally competent in areas relevant to their clients. And this leads to the “no.” While in my current ministry setting, I am most engaged in social justice issues related to race, sexuality and gender, and poverty responses, these are only a few categories of cultural identification. Because the assessor will not only need to be competent in the cultural identities of their most frequently served populations but will also need to be competent in other cultural identifiers, I see no reason to specifically narrow the focus of intersectionality in my project to these three categories.

Instead, I applied the ADDRESSING framework as an interview and post-assessment tool for use by the assessor who would complete a culture sketch of the client for collaborative use with the client. A person’s intersecting identities influence the person’s lived experiences, therefore, is it vital that the assessor have awareness of these intersections and how they influence the person’s relationship with power and oppression.²⁵⁵ How intersectionality is impacting the client might become clearer using the culture sketch. As previously mentioned, the culture sketch will help both parties identify strengths and protective factors, power dynamics at play, and possible underlying cultural concerns relevant to the presenting problem.

²⁵⁵ Sue, Derald Wing. *Counseling the Culturally Diverse: Theory and Practice*. United Kingdom: Wiley, 2022. 211.

Hays cautions practitioners to avoid rigidity and not get stuck within the confines of the framework. “Within minority and dominant cultures, there are subgroups related to the ADDRESSING influences. And there are other influences and identities that are clearly important for some people.”²⁵⁶ She encourages the assessor to go beyond the acronym to consider whatever identities are important to the person being served.²⁵⁷ To resist rigidity in cultural competence, the assessor will need to recognize that cultures change over time and vary from person to person, understand that people have intersecting multiple identities and the importance or value of these identities varies from person to person, and remember that cultural competence is a life-long learning experience.²⁵⁸ Cultures are not monolithic or completely unified across all practices, attitudes, or beliefs. Further, identifying with a culture does not mean that someone embraces every characteristic of that culture.

Conceptual Reasons to Conduct a Spiritual Assessment

In the late 1990’s, the Joint Commission, which sets standards for healthcare organizations, began to use the term “spiritual assessment.”²⁵⁹ This recognition of spiritual assessments by the Joint Commission likely encouraged the development of additional assessment tools. I was interested to learn about the Joint Commission’s stance on spiritual assessments because Bethany Children’s Home, like many other behavioral healthcare settings, is recognized by the Joint Commission. Bethany’s spiritual assessment procedure would need to support our performance improvement goals to achieve Joint Commission standards of care.

²⁵⁶ Hays, Pamela A., *Addressing Cultural Complexities in Counseling and Clinical Practice: An Intersectional Approach*. 4th ed. Washington DC: American Psychological Association. 2022. 100.

²⁵⁷ Ibid.

²⁵⁸ Sue, Derald Wing. *Counseling the Culturally Diverse: Theory and Practice*. United Kingdom: Wiley, 2022. 211.

²⁵⁹ Cadge, Wendy, and Julia Bandini. “The Evolution of Spiritual Assessment Tools in Healthcare.” *Society*, no. 5 (2015): 430–37. <https://doi.org/10.1007/s12115-015-9926-y>.

In 2003, Pat Staten, the then associate director for standards interpretation of the Joint Commission, participated in a question-and-answer column published in *Hospital Peer Review*.²⁶⁰ Two stand-out questions were asked and answered. The first question was, “Does the Joint Commission standard on spiritual assessment apply only to behavioral health or to all health care settings?” to which Staten replied, “While the behavioral health standards specify a more thorough assessment of a patient’s spiritual outlook, the Joint Commission expects you to conduct a spiritual assessment of every patient in every healthcare setting.”²⁶¹ The second question was “What are we expected to do in making this spiritual assessment?” and asked what healthcare professionals were supposed to consider and determine in a spiritual assessment.²⁶² Staten responded that at a minimum, they should determine “the patient’s religious denomination, beliefs, and what spiritual practices are important to the patient with the specifics varying by setting and circumstance.”²⁶³ While the Joint Commission sets an expectation that behavioral healthcare settings include spiritual assessment in their standards of care, they offer little additional guidance regarding the praxis or content of a spiritual assessment.

In 1997, Richards and Bergin identified five conceptual reasons for a counselor to conduct a spiritual assessment, which I have summarized below:

1. To illuminate the counselor’s understanding of the client’s worldview to enhance the counselor's empathy and sensitivity to the person’s lived experiences.
2. To support the counselor’s diagnosis of healthy or unhealthy spirituality and its relevance to the clinical issue.

²⁶⁰ Ibid.

²⁶¹ Ibid.

²⁶² Ibid.

²⁶³ Ibid.

3. To help the counselor identify spiritual and religious resources that can contribute to successful treatment outcomes.
4. To help the counselor recognize spiritual or religious interventions that can be adapted to the client's needs and the treatment model in which the counselor practices.
5. To Uncover spiritual and religious issues that are presenting as clinical problems.²⁶⁴

Reasons 2 and 5 stand out to me as unique to the field of counseling. Reason 2 suggests counselors perform a spiritual assessment to “support the counselor’s diagnoses of healthy or unhealthy spirituality and its relevance to the clinical issue” while reason 5 suggests their use to recognize spiritual and religious issues that present as clinical issues; both reasons suggest the use of spiritual assessment tools to assist the counselor with diagnosing issues. As a treatment domain, the counselor needs to understand whether the client’s beliefs and practices are beneficial or potentially harmful.²⁶⁵ However, this is problematic considering extrinsic measures are handicapped by the subjective nature of a client’s spirituality and are generally not useful at helping the counselor determine whether the client’s spirituality is beneficial or harmful.²⁶⁶

In the scope of my work at Bethany, I am interested in recognizing the presence of adverse religious experiences and identifying any lasting impacts the AREs might have on a youth resulting in religious trauma. This is the extent to which I am interested in diagnosing a youth’s spirituality as healthy or unhealthy. I am not interested in judging the youth’s beliefs or spiritual practices. I am primarily interested in learning how those beliefs or practices help the

²⁶⁴ Richards, P. S., & Bergin, A. E. *A Spiritual Strategy for Counseling and Psychotherapy*. Washington, D.C. American Psychological Association. 1997.

²⁶⁵ Ibid.

²⁶⁶ Ibid.

youth cope with their current crisis - out of home placement, or how they contribute to the youth's challenges while in placement.

In 2003, David Hodge provided four conceptual reasons for social workers to conduct a spiritual assessment: to gain an understanding of worldview, to enhance client self-determination or autonomy, to identify client's spiritual strengths and resources, and to comply with professional ethics.²⁶⁷ I adapted a combination of Hodge's and Richards and Bergin's conceptual reasons to help me develop a spiritual assessment protocol for direct application to clinical practices in my context at Bethany and in similar settings, which will be presented in chapter 4.

Hodge identifies four issues to highlight the importance of spiritual assessment in social work: ontology, ethics, strengths, and autonomy.²⁶⁸ These issues are not unique to social work, however, the social worker's reasons for exploring these areas are unique to their field. Considering spirituality as central to the client's personal ontology means it is central to their personhood, and this might inform the client's attitudes and practices around child rearing, diet, marriage, medical care, schooling, social interactions, and other dimensions of life that are of particular interest to social work practitioners.²⁶⁹ Hodge posits that social workers must view spirituality as ontological to understand the client's worldview and provide effective services, and I agree.²⁷⁰ I see this as especially important in child welfare and clinical behavioral healthcare settings in which social workers play an integral role in the youth's healing and recovery process.

²⁶⁷ Hodge, D. R. *Spiritual Assessment: A Handbook for Helping Professionals*. Botsford, CT. North American Association of Christians in Social Work. 2003.

²⁶⁸ Ibid.

²⁶⁹ Ibid.

²⁷⁰ Ibid.

Hodge argues that social workers must conduct spiritual assessments to gain awareness of the client's spiritual reality and to provide services that are sensitive to the client's worldview.²⁷¹ Additionally, he urges social workers to use spiritual assessments to identify a client's strengths to help them overcome setbacks commonly recognized in the field of social work.²⁷² He claims that a single assessment approach is unlikely to yield helpful results with all clients, and therefore suggests using a variety of assessment tools to identify worldviews and strengths.²⁷³ For this purpose, Hodge developed four unique spiritual assessment tools which I will explore further in my survey of published spiritual assessments.

Jurisdiction

In the early 1980's, chaplains and nurses were the primary developers of new spiritual assessment tools. In 1983, changes to Medicare reimbursement meant that hospitals were paid fixed amounts per Medicare patient and the amount depended on the patient's diagnosis.²⁷⁴ These changes increased pressure on chaplains to document their contributions to patient care, which led to changes in how spiritual assessments were conducted and by whom. By the mid 1980's physicians were designing their own spiritual assessment tools for use within hospital service and reimbursement structures. Physician Elisabeth McSherry worked with chaplains to develop a specialized body of knowledge, which she called a "clinical science," that might inform their work on spiritual assessment design and practice.²⁷⁵ Using that shared body of knowledge, McSherry designed a Spiritual Profile Assessment (SPA) which she hoped would

²⁷¹ Ibid.

²⁷² Ibid.

²⁷³ Ibid.

²⁷⁴ Cadge, Wendy, and Julia Bandini. "The Evolution of Spiritual Assessment Tools in Healthcare." *Society*, no. 5 (2015): 430–37. <https://doi.org/10.1007/s12115-015-9926-y>.

²⁷⁵ Ibid.

help chaplains make better treatment plans and be able to better document patient changes that resulted from the chaplain's efforts.²⁷⁶

The HOPE tool was published in 2001 by physicians Gowri Anandarajah and Ellen Hight as a teaching tool. I will explore this tool in more detail in my survey of existing assessments. For this part of the conversation, it is important to note that the HOPE tool led to conversation and debate amongst healthcare providers, pastoral theologians, and counselors regarding the professional jurisdiction of the spiritual assessment.²⁷⁷ The authors of the HOPE tool responded to questions and critiques around jurisdiction by saying, "Clinical pastoral education (CPE) trained interfaith chaplains must undergo extensive training, self-reflection and supervision to ensure that they can provide spiritual care without imposing their own beliefs" and encouraged physicians to reflect on their own beliefs before discussing religious or spiritual issues with patients.²⁷⁸

Regarding the diffusion of spiritual assessments from chaplaincy into other professional fields, Cadge and Bandini argue that "while engaging with patients around religion and spirituality began as the professional jurisdiction of chaplains, spiritual assessment tools were designed - in part - to enable professionals in other fields to talk with patients about these topics."²⁷⁹ Cadge and Bandini make the case that spiritual screens and histories might be taken by other healthcare professionals, while spiritual assessments should only be conducted by trained chaplains who have the knowledge and skill set necessary to work with patients around the findings of the spiritual assessment.²⁸⁰ This information helped me define the praxis of

²⁷⁶ Ibid.

²⁷⁷ Ibid.

²⁷⁸ Ibid.

²⁷⁹ Ibid.

²⁸⁰ Ibid.

facilitating spiritual screens, histories, and assessments at Bethany, including roles and responsibilities of other team members who might perform certain aspects of this procedure with youth during the intake process.

Timing

Assessors must also consider the timing of a spiritual assessment. The nature of spirituality and spiritual experiences is extremely personal, private, and sensitive; therefore the counselor must allow time to develop trust and rapport with a client before initiating an assessment and might benefit from facilitating the assessment gradually over time.²⁸¹ This is distinctive from medical healthcare settings in which professionals are typically with patients for a limited period of time and must complete the assessment within a given timeframe. Further, it is suggested that counselors follow their client's lead and recognize opportunities to discuss the client's spirituality.²⁸² Counselors are urged to avoid direct interrogation regarding spirituality or religion and are encouraged to take a verbal spiritual history in similar fashion to a typical family history as a start to the spiritual assessment.²⁸³ These best practices are especially relevant to how our interprofessional team will approach spiritual assessments at Bethany. More about how I navigated timing concerns is explored in chapter 4.

Content of a Spiritual Assessment

In the early 2000's, proponents and practitioners of spiritual assessments began to distinguish assessments from spiritual screens or spiritual histories.²⁸⁴ This movement attempted to make distinctions which were not agreed upon by all proponents, and also created

²⁸¹ Ibid.

²⁸² Ibid.

²⁸³ Ibid.

²⁸⁴ Ibid.

jurisdictional disputes about who could or should gather information about religion or spirituality from patients, as previously mentioned.²⁸⁵ I posit that these jurisdictional distinctions are more important in interdisciplinary settings, such as child welfare and clinical behavioral healthcare settings. Therefore, I want to return to my definitions of a spiritual screen, spiritual history, and spiritual assessment interview to elaborate on how these separate components and their content have evolved for use in these settings. Further, I will explore whether these evolutions in spiritual assessment content addressed religious trauma.

A spiritual screen typically allows healthcare providers to recognize whether spirituality is important to a person and whether additional information should be gathered.²⁸⁶ Chaplain Mark LaRocca Pitts explains, “A spiritual screen is performed upon admission to most healthcare institutions. This often includes one or two questions aimed at determining whether the patient has any religious or spiritual needs that the hospital can address during the patient’s stay,” adding, the information gathered rarely changes during hospitalization.²⁸⁷ A spiritual history elicits more information than a spiritual screen, is used to “understand how a person’s spiritual life and history affect their ability to cope with their present health crisis,” and the information gathered can change during the course of treatment/hospitalization.²⁸⁸ LaRocca Pitts and Fitchett argue that a spiritual assessment is a follow-up tool to be used as needed after a spiritual screen and spiritual history is taken.²⁸⁹

²⁸⁵ Ibid.

²⁸⁶ Ibid.

²⁸⁷ Ibid.

²⁸⁸ Ibid.

²⁸⁹ Ibid.

According to Cadge and Bandini, the number of spiritual assessment tools in circulation grew in the 1990's, largely by physicians, nurses, and chaplains in healthcare settings.²⁹⁰ In 1991 a professor of counseling and psychology, Jared Kass, developed the INSPIRIT tool in collaboration with colleagues in psychology and psychiatry.²⁹¹ The tool was designed as an Index of Core Spiritual Experiences and was introduced to chaplains at a 1992 national convention, though Kass and the other developers intended to use the tool primarily in research.²⁹² This tool was unique from other spiritual assessments because it went beyond exploring a person's beliefs and practices to exploring their lived experiences, including mystical experiences.²⁹³ Exploring a person's lived experiences is a step closer to a trauma-informed spiritual assessment model, however, the tool did not explicitly screen for adverse religious experiences.

Also published in the early 1990's was the 7x7 tool. The 7x7 model was developed by an interdisciplinary group at Rush Medical Center in Chicago, including George Fitchett, and was designed to help the assessor make as few assumptions as possible regarding spirituality.²⁹⁴ Fitchett explained that the tool was called the 7x7 model because it focused on seven holistic dimensions of assessment: the medical, psychological, psychosocial, family systems, ethnic and cultural, societal issues, and spiritual dimensions were each explored.²⁹⁵ The model also included seven aspects of spirituality, which were: beliefs and meaning, vocation and consequences,

²⁹⁰ Ibid.

²⁹¹ Ibid.

²⁹² Ibid.

²⁹³ Ibid.

²⁹⁴ Ibid.

²⁹⁵ Ibid.

experience and emotion, courage and growth, ritual and practice, community, and authority and guidance.²⁹⁶

What was especially important to me about the content in this assessment was that Fitchett and his team understood the pluralistic contexts in which they all worked and recognized the inherent value of cultural humility, which led them to attempt to create a model that could be used to describe the assessee's spirituality while the assessor, through an increased awareness of implicit biases, would bring fewer assumptions about what spirituality had to include.²⁹⁷ I also highlight the 7x7 model because it presents the assessor with an assessment tool that is culturally responsive and considers experiences of intersectionality. Based on the content of the 7x7 model, I believe it could be an effective tool for a practitioner adept at recognizing and responding to religious trauma. However, this evolution in spiritual assessment content did not explicitly address AREs or religious trauma.

In the mid 1990's, medical doctor Todd Maugans published his SPIRITual History tool and in 1996 physician Christina Puchalski published the FICA tool to encourage doctors to engage spirituality as a relevant medical topic.²⁹⁸ Maugans noted that other spiritual assessment tools developed by physicians might not be distinctive enough for all doctors, who each have particular types of relationships with their patients.²⁹⁹ His tool focused on spiritual belief systems and specifically included areas of discussion related to 'ritualized practices and restrictions' and 'implications for medical care and terminal events planning.'³⁰⁰

²⁹⁶ Ibid.

²⁹⁷ Ibid.

²⁹⁸ Ibid.

²⁹⁹ Ibid.

³⁰⁰ Ibid.

Just as hospice care kickstarted a proliferation of spiritual assessment tools in the 1970's, hospice and palliative care continued to influence the creation of spiritual assessment tools in the 1990's. So, in 1996 alongside publications from Pulchaski and Maugans, Chaplain Jerry Muncy published Muncy's comprehensive spiritual assessment tool in the *American Journal of Hospice and Palliative Care*.³⁰¹ His tool offered chaplains an interview fashioned assessment that focused on people's understanding of themselves and others, their religious/spiritual histories, and the care plan moving forward.³⁰² This spoke to the importance of having an assessment tool that was relevant to the population served, the context in which they were served, and the purpose of those services; which tended to be a theme in my research. Most spiritual assessment developers were creating tools for use in their particular professional setting and with a particular population in mind.

In the early 2000's, more spiritual assessment tools emerged within nursing, healthcare, and chaplaincy and at least fifteen new assessments were published during this time. Amongst those assessments were several I had chosen to survey for my research, including HOPE and FACT. Cadge and Bandini take special notice that some of the tools developed during the early 2000's assumed belief in God or a theistic approach, though "many others were as concerned about sources of hope, coping, support and community inside or outside of traditional religious contexts."³⁰³ And, some of the tools developed during this time tended to privilege belief while others elevated experience or practice.³⁰⁴ Almost all of the tools developed during this time were called "spiritual" rather than "religious" assessment tools, which indicates the developers took a

³⁰¹ Ibid.

³⁰² Ibid.

³⁰³ Ibid.

³⁰⁴ Ibid.

broader approach to questions of meaning making, attempted to be as inclusive as possible, and wanted the tools to be applicable to as wide a range of people as possible.³⁰⁵ What the tools continued to lack was any explicit questioning related to adverse religious experiences.

A decade ago, professionals had access to more than forty published spiritual assessment tools. Cadge and Bandini note that proponents of the still loosely organized spirituality and healthcare movement advocate the teaching of how to use spiritual assessments with nursing and medical students. In light of more calls for increased teaching of the tools and procedures, more continues to be written about how to teach the tools than is written about how these tools are used in clinical practice or how people in different fields use them and learn from them.³⁰⁶ In 2012, Fitchett called on healthcare professionals to stop creating new spiritual assessment tools and argued that “we need to focus attention on a critical review of existing models and the dissemination of best practices in spiritual assessment.”³⁰⁷ I reflected heavily on Fitchett’s call to stop creating new spiritual assessments as I was knee deep in research with the intention of developing a new spiritual assessment tool. In the end, based on a greater awareness of assessor competencies, rationales, and jurisdictional concerns surrounding the praxis of spiritual assessments, I understood that what I actually wanted to develop was a religious trauma screen that could function as a separate component of a full spiritual assessment.

Screening for Religious Trauma

According to SAMHSA, the first two steps in screening for trauma are intended to determine whether the client has a history of trauma and whether they have trauma related

³⁰⁵ Ibid.

³⁰⁶ Ibid.

³⁰⁷ Ibid.

symptoms.³⁰⁸ Screening for a client’s trauma history mostly includes “yes” or “no” questions.³⁰⁹

If a client acknowledges a history of trauma, then the second step of additional screening is needed to recognize any presenting trauma symptoms.³¹⁰

SAMHSA recommends screening specifically for the following: depressive or dissociative symptoms, past and present mental disorders, characteristics of a specific type of trauma, substance abuse, social support and coping styles, availability of resources, and risks for self-harm, suicide, and violence.³¹¹ I argue that any youth behavioral healthcare setting should include religious trauma screening to identify characteristics of this specific type of trauma and to explore depressive or dissociative symptoms in the context of adverse religious experiences. When a client screens positive for trauma-related symptoms, then further assessment is needed to define the presenting problem and develop treatment options.³¹²

Trauma screening procedures should define the steps to take after a positive or negative screen, including how to score responses to questions and what constitutes a positive score.³¹³ While some screening procedures have been developed for use by professionals without advanced degrees or training, assessments for trauma-related disorders require administration by a mental health professional who is trained in assessment and evaluation processes.³¹⁴ A trauma assessment should determine the nature and extent of the client’s presenting problems and include self-reported written responses and verbal interviews.³¹⁵ A clinical trauma assessment

³⁰⁸ Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. *Treatment Improvement Protocol (TIP) Series 57*. HHS Publication No. (SMA) 13-4801. Rockville, MD. 2014.

³⁰⁹ Ibid.

³¹⁰ Ibid.

³¹¹ Ibid. 93.

³¹² Ibid.

³¹³ Ibid.

³¹⁴ Ibid.

³¹⁵ Ibid.

should “gather all the information necessary to understand the role of the trauma in their lives; appropriate treatment objectives, goals, planning, and placement; and any ongoing diagnostic and treatment considerations, including reevaluation.”³¹⁶

SAMHSA urges service providers to offer psychoeducation and support during screening and assessment procedures; beginning with explaining screening processes, why specific questions are important, and that the client may choose to delay their response or not respond to any of the questions asked.³¹⁷ This approach offers the client a greater sense of control and safety during the assessment process.³¹⁸ Additionally, SAMHSA makes specific recommendations regarding the therapeutic milieu and how to create an effective screening and assessment environment, as part of the overall assessment process. They include recommendations regarding: the administrator’s proximity to the client during the screening process, helpful communication tips and reminders about cultural variables, the inclusion of culturally appropriate symbols of safety in the physical space, and the use of self-reporting tools.³¹⁹

SAMHSA elaborates on the use of self-administered, written checklists claiming, “traumas can evoke shame, guilt, anger, or other intense feelings that can make it difficult for the client to report them aloud to an interviewer...clients are more likely to report trauma when they use self-administered screening tools.”³²⁰ Interviews should accompany any self-reporting tools to create a sense of safety for the client and to verbally follow up to collect additional data after the self-reporting screen is completed.³²¹ Oftentimes, the information shared by clients in trauma

³¹⁶ Ibid.

³¹⁷ Ibid. 94.

³¹⁸ Ibid. 95.

³¹⁹ Ibid.

³²⁰ Ibid. 97.

³²¹ Ibid.

screens and assessments can have legal implications for professionals in behavioral healthcare settings. SAMHSA reminds service providers to be mindful of mandated reporting and other pertinent laws in their state, have an expert legal consultant available, and access clinical supervision when administering trauma screens and assessments.³²²

Conclusion

What I learned researching the evolution of care models in the fields of healthcare and chaplaincy, psychology and counseling, and social work, plus current evidence-based practices for conducting spiritual assessments and trauma screens helped me define the parameters of my new screening tool, including defining the administration procedures. Much of what I learned here helped me better understand what would be required in the praxis of administering a religious trauma screen and spiritual assessment, and how to select appropriate questions and formats for my new screening tool. The next chapter will further synthesize what I have learned about conducting trauma-informed assessments and interviews through my survey of published spiritual assessments and the introduction of my religious trauma screening tool.

³²² Ibid. 99.

Chapter 4: The Shepley Religious Trauma Screening Tool

Conceptual Reasons to Conduct a Religious Trauma Screen

Pulling from the fields of counseling and social work, I adapted a combination of Hodge's and Richards and Bergin's conceptual reasons for conducting a spiritual assessment to help me develop a spiritual assessment procedure, including a religious trauma screen, for direct application to clinical practices in my context at Bethany and in similar settings. To do this, I reflected on the youth population I serve, the context in which I serve (interprofessional with various codes of ethics), and the various standardizing agencies to which we are accountable, i.e. PA 3800 Regulations and the Joint Commission. I also reflected on Bethany as a trauma-informed organization that follows SAMHSA guidelines and recommendations.

Remember SAMHSA's four R's of a trauma-informed approach: an organization that is trauma-informed *realizes* the widespread impact of trauma and understands potential paths for recovery; *recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively *resist re-traumatization*.³²³ SAMHSA currently recommends universal screening for trauma in behavioral health services and promotes screening, early identification, and intervention as a preventative strategy.³²⁴ I adapted the recommendation to include universal screening for religious trauma in behavioral healthcare services. Additionally, The Joint Commission expects behavioral healthcare providers to conduct a spiritual assessment with every person they serve; therefore, Bethany should be offering the

³²³ Department of Health and Human Services, and Larke Huang. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, HHS Publication No. (SMA) 14-4884 (2014).

³²⁴ Ibid.

religious trauma screen as part of the spiritual assessment procedure with every youth we receive into our care.

My other conceptual reasons for conducting a religious trauma screen, as adapted from Hodge and Richards and Bergin are as follows:

1. **Ontology:** Illuminate the assessor's understanding of the youth's worldview to enhance the assessor's empathy and sensitivity to the youth's lived experiences.
2. **Diagnosis:** Support the assessor's recognition of spiritual and religious issues that are presenting as clinical problems.
3. **Strengths:** Help the assessor identify spiritual, religious, and cultural resources that can contribute to successful treatment outcomes.
4. **Interventions:** Help the assessor determine the role of RT in youth's life and recognize spiritual, religious, or other interventions that can be adapted to the youth's needs and current situation (out-of-home placement); inform therapeutic treatment objectives; inform appropriate ISP goals, planning, and youth placement.
5. **Ethics:** Help the interprofessional care team comply with respective codes of ethics and ethical guidelines including evidence-based practices in psychology, the ACA Code of Ethics, the NASW Code of Ethics, the Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students, and various ordained clergy covenants.
6. **Autonomy & Other Considerations:** Help the interprofessional care team explore and respect the youth's desire to integrate their spiritual beliefs into the helping relationships; respect Children in Foster Care Act (aka Foster Care Bill of Rights) in regards to youths' right to practice, or not practice, a religion of their choice; provide psychoeducation and support to receive youth's informed consent and provide explicit option for youth to

decline to participate; be mindful of mandated reporting requirements as they relate to the information shared during a religious trauma screen and remind youth of agency's mandated reporting policies.

Jurisdiction: Roles & Responsibilities of Interprofessional Care Team Members

It was necessary for me to distinguish the separate parts of the full spiritual assessment and determine which of our team members were best suited to conduct which parts. The term “jurisdiction” is frequently used in the literature regarding which professionals have the appropriate spiritual formation and ministerial authorization to perform a spiritual assessment, so I have adapted the term to outline these roles and responsibilities for an interprofessional care team. The Shepley Religious Trauma Screening Tool (SRTST) is intended to function as part of a larger assessment procedure within a trauma-informed psychotherapeutic, psychospiritual care system. The screening tool is designed to help chaplains, counselors, and professionals in child welfare recognize the presence of religious trauma symptoms and lived adverse religious experiences in children and youth populations. The concept of “measurement” as a feature of the trauma screening tool is important to note here as it influences the roles and responsibilities of team members involved in the youth's spiritual assessment.

Slade, et. al., claim 37% of the American population is suffering from RT; including people who did not self-identify as suffering from RT, though they reported suffering from at least three of the six major manifestations of religious trauma. Using this knowledge, I determined the RT screening tool could utilize a simple tabulation formula to measure AREs and RT. Some trauma screening tools will use a tabulation formula based on frequency or severity of symptoms or group questions into sub-categories to determine if additional assessment is necessary. Since I am not asking about frequency or severity of symptoms, and the questions

address various experiential themes, I decided that answering “yes” to any one question would result in a positive screen and warrant additional assessment. Answering “yes” to one question does not indicate the person is suffering from AREs or RT; however, one “yes” is indicative of a need to further explore their lived experiences to recognize the role of adversity or presence of trauma. My approach here is like Drumsta’s Adverse Religious Experiences Questionnaire, which recommends additional exploration of a person’s experiences if they answer “yes” to one or more questions.

The spiritual screen consists of three questions and can be completed by any member of our intake team, which includes clinicians and case managers. Based on the youth’s responses to those questions, the same team member determines whether to conduct a spiritual history. The same team member also conducts the Shepley Religious Trauma Screen. These team members have professional training to perform trauma screens and histories as well as spiritual screens and histories, and they are trained to analyze clinical assessment results. As part of our rollout of the SRTST in the psychospiritual program at Bethany, I designed a series of professional training sessions for the team members involved, specifically on how to use this tool with our population and within our agencies’ standards of care.

Our agency will use the results of the spiritual screen, spiritual history, and SRTST to triage youth’s spiritual assessment needs. It is presumed that a small percentage of our youth will decline to participate in the spiritual screen, and that additional youth will screen out of the assessment procedure by indicating that religion or spirituality is not an important part of their life or that religion and spirituality have not impacted them in adverse ways. Youth who require a complete spiritual assessment will be invited to meet with me for an interview and discussion of their screening results and any additional questions or concerns from the youth or myself

raised through the youth's participation in the screening process and to collaborate on a course of treatment.

More on my next steps is included in "A Spiritual Assessment Procedure" near the end of this chapter. Here, it is important to note that I will be conducting the spiritual assessment interview and analyzing the results, and based on the results might refer the youth for a full trauma assessment with their therapist. In other settings, the SRTST could be directly incorporated into a counselor's trauma assessment or spiritual assessment procedure, depending on the client's presenting problem and the correlating histories received (trauma history or spiritual history) which indicated the potential need to screen for religious trauma.

Timing of a Religious Trauma Screening

Oakes and Raphael remind counselors that the nature of spirituality and spiritual experiences is extremely personal, private, and sensitive; and encourage counselors to allow time to develop trust and rapport with a client before initiating a spiritual assessment. Counselors in many settings might benefit from following their clients' lead to discuss spirituality and by facilitating the assessment gradually over time. This is distinctive from most healthcare settings in which professionals are typically with patients for a limited period and must complete the assessment within a given timeframe to maintain compliance with standards of care. Bethany, like many behavioral healthcare agencies, must take a blended approach to the timing of spiritual assessments and trauma screens. More about adherence to standards of care is noted in the section "A Spiritual Assessment Procedure" near the end of this chapter. What is important here is to remember Bethany's relationship with the Joint Commission and how this relationship influences our agency's goal setting for performance improvement.

To improve our performance in conducting spiritual assessments, we set an agency goal to complete a spiritual assessment with each youth during the intake process. Because our procedure involves multiple team members conducting multiple parts of the screening process, we needed to determine two separate timing related goals. First, the youth's case manager must complete the spiritual screen, spiritual history, and Shepley Religious Trauma Screen within three business days of a youth's admission to BCH. Second, youth who are referred to the chaplain for a full spiritual assessment must be scheduled to meet with me within their first 30 days of placement with our agency. Our timing goals allow for the triage of youth's spiritual needs, wants and expectations and help ensure we are responding within an appropriate amount of time to resist re-traumatization of our youth.

Assessor Competencies

In this section I have summarized and adapted the competencies highlighted by major conversation partners Sue, Hays, and the SAMHSA documents to develop a checklist (Table 4.1) of competencies necessary for a trauma-informed spiritual assessment procedure that considers intersectionality:

1. **Trauma Competent:** Assessors must be adept at assessing trauma and complex trauma, adept at facilitating relational safety and avoiding re-traumatization, and continuously engage in self-reflection and increasing cultural awareness, including being mindful of cultural variances that influences a person's relationship with power and oppression.^{325,326}

Assessors must remember that when asking about trauma, not to assume the youth will

³²⁵ Yates, Jennifer, and Jill L. Snodgrass. "The Religious Locations of LGBTQ+ Survivors: Survivors of Christian Nonsexual Spiritual Abuse." *Navigating Religious Difference in Spiritual Care and Counseling*, edited by Jill L. Snodgrass, 2:251–80. Essays in Honor of Kathleen J. Greider. Claremont Press, 2019. <https://doi.org/10.2307/j.ctvwrn4c3.18>. 253.

³²⁶ Sue, Derald Wing. *Counseling the Culturally Diverse: Theory and Practice*. United Kingdom: Wiley, 2022. 37.

disclose.³²⁷ When working with youth who lack psychological and verbal abilities to express their experiences, be more aware of their behaviors, presenting symptoms, and trauma responses,³²⁸ and pay careful attention to the assessor's own vulnerabilities and the potential for secondary or vicarious trauma.³²⁹

2. **Multicultural/Culturally Responsive:** Assessors need to have a healthy practice of acquiring awareness, knowledge, and skills pertinent to various cultures and co-cultures³³⁰ and should engage voices from various cultures to develop a deeper understanding of how a person's cultural identities overlap with religious beliefs and practices to induce experiences of intersectionality. Assessors must also acquire cultural humility to function effectively in a pluralistic democratic society.³³¹
3. **Cultural Humility:** Assessors have an attitude of respect for others, an egalitarian stance, and diminished superiority over youth which leads to an "other-orientation," rather than the assessor's inclination towards self-focus.³³² Assessors must remember that the youth's perspectives regarding traumatic events might differ from that of the dominant culture.³³³
4. **Aware of Biases:** Assessors must be aware of their own sociocultural location, or positionality (beliefs, values, characteristics, attitudes, theories), since we each bring our

³²⁷ Hays, Pamela A. *Addressing Cultural Complexities in Counseling and Clinical Practice: An Intersectional Approach*. 4th ed. Washington DC: American Psychological Association. 2022.

³²⁸ Ibid.

³²⁹ Ibid. 173-177.

³³⁰ Sue, Derald Wing. *Counseling the Culturally Diverse: Theory and Practice*. United Kingdom: Wiley, 2022. 37. Examples of co-cultures include African Americans, Asian Americans, Latinx, Native Americans, Pacific Islanders, and LGBTQ+ groups.

³³¹ Ibid.

³³² Ibid.

³³³ Hays, Pamela A. *Addressing Cultural Complexities in Counseling and Clinical Practice: An Intersectional Approach*. 4th ed. Washington DC: American Psychological Association. 2022.

own lens into relationships and the therapeutic environment.³³⁴ Assessors must be aware of the influences of implicit biases and stereotypes on how an assessment is conducted, what is actually assessed, and the interpretation of clinical data.³³⁵

5. **Self-Reflective of Religious Location:** Assessors need to be self-reflective of their religious location to recognize and navigate their own biases, beliefs, and assumptions that may influence their assessment process.³³⁶
6. **Adept with Family Systems:** Assessors of a full spiritual assessment, in their praxis of evaluating the SRTST might be interested in understanding the youth's spirituality through family systems and might ask questions during the verbal spiritual history to elicit information about the youth's familial religious affiliation, childhood rituals, how family members use religious and spiritual beliefs to cope with challenges, and the role of various family members in the youth's spiritual development.³³⁷
7. **Integrative Approach:** Assessors are encouraged to incorporate multicultural competencies and collaboration between the youth and the interprofessional care team into their praxis; deliberately look for the person's strengths and resources.³³⁸
8. **Collaborative Approach:** Assessors and youth work together to construct an accurate definition of the problem; formulate hypotheses regarding the cause of the problem,

³³⁴ Sue, Derald Wing. *Counseling the Culturally Diverse: Theory and Practice*. United Kingdom: Wiley, 2022. 207.

³³⁵ Ibid. 208.

³³⁶ "Religious location" refers to an individual's or a group's position within the spectrum of religious beliefs, practices, affiliations, and cultural contexts. It encompasses various factors such as one's religious beliefs, traditions, upbringing, affiliations with religious institutions, cultural heritage, and personal experiences related to religion. Yates highlights that individuals' religious backgrounds and affiliations shape their worldview and perceptions, potentially impacting their interactions with clients, particularly in cases involving religious trauma or psychospiritual care. (Yates and Snodgrass, "The Religious Locations of LGBTQ+ Survivors," 251–80.)

³³⁷ Oakes, K. Elizabeth, and Mary M Raphael. "Spiritual Assessment in Counseling: Methods and Practice." *Counseling and Values* 52, no. 4 (April 2008).

³³⁸ Hays, Pamela A. *Addressing Cultural Complexities in Counseling and Clinical Practice: An Intersectional Approach*. 4th ed. Washington DC: American Psychological Association. 2022.

brainstorm ways to confirm or disconfirm the hypotheses; and develop a treatment plan that responds to the problem;³³⁹ Assessors must remember that language used to describe traumatic experiences can be interpreted differently, so the assessor should use behavior specific language in questions to lessen ambiguity in communication.³⁴⁰

9. **Contextual Viewpoint:** Assessor considers the cultural identity of the youth, the youth's cultural conceptualization of distress, psychosocial stressors, cultural features of vulnerability and resilience, and cultural differences between the youth and the assessor.³⁴¹ Assessor must be aware of their own cultural identity and how it might trigger a youth's symptoms or make it more challenging for them to share trauma-related information,³⁴² and remember not to limit assessment to the individual; instead, consider trauma in the context of the youth's culture and community.³⁴³

10. **Cultural Formulation:** Assessors must be comfortable with a variety of tools for gathering a youth's cultural formulation. I am suggesting Hays' ADDRESSING framework for use in our setting at Bethany and those similar. The ADDRESSING acronym stands for *Age and generational influences, Developmental or other Disability,*

³³⁹ Sue, Derald Wing. *Counseling the Culturally Diverse: Theory and Practice*. United Kingdom: Wiley, 2022. 213-214.

³⁴⁰ Hays, Pamela A. *Addressing Cultural Complexities in Counseling and Clinical Practice: An Intersectional Approach*. 4th ed. Washington DC: American Psychological Association. 2022.

³⁴¹ Sue emphasizes the importance of understanding the socio-political context in which clients from marginalized communities operate (Sue, *Counseling the Culturally Diverse*, 2021, 145). For instance, a counselor working with a Hispanic client experiencing anxiety might explore how systemic discrimination and immigration policies impact their sense of safety and belonging, thus informing the therapeutic approach. Sue also argues that adopting a contextual viewpoint involves recognizing the influence of historical and intergenerational trauma on clients' lived experiences (Sue, *Counseling the Culturally Diverse*, 2021, 212). A counselor working with Indigenous clients might incorporate traditional healing practices and acknowledge the lasting effects of colonization, fostering a culturally sensitive therapeutic environment. Sue also encourages practitioners to learn more about the primary cultures of the clients with whom they work (Sue, *Counseling the Culturally Diverse*, 2021, 72). Practitioners can learn more about the primary cultures of their clients through engagement with cultural communities, cultural immersion and experiential learning, and continuous education and professional training.

³⁴² Hays, Pamela A. *Addressing Cultural Complexities in Counseling and Clinical Practice: An Intersectional Approach*. 4th ed. Washington DC: American Psychological Association. 2022.

³⁴³ Ibid.

*Religion and spirituality, Ethnic and racial identity, Socioeconomic status/social class, Sexual orientation, Indigenous heritage, National origin, and Gender identity.*³⁴⁴

11. The Therapeutic Milieu (Environment): Spiritual assessment interviews require physically, psychologically, and spiritually safe environments, as defined by the assessee (youth).³⁴⁵ The assessor must communicate openly and honestly to develop trustworthiness, including being transparent about the purpose of the assessment and how it will be used in the youth's treatment plan. Additionally, assessors are urged to consider the following:

- a. Proximity to Youth:³⁴⁶ Respect youth's sensitivity about their bodies, personal space, and personal boundaries to maintain the youth's comfort level with the assessor's closeness during the screening and interview process. Approach the youth in a matter-of-fact and supportive manner to destigmatize their lived experiences and avoid using judgmental phrases about the youth's presentation with AREs or RT. Adjust tone and volume of speech according to youth's level of engagement and comfort in the screening and interview process and allow enough time in the screening and interview processes for youth to return to baseline in the event they become triggered into an emotional escalation when recalling or acknowledging an ARE or RT. Do not hold the youth in the screening environment any longer than necessary to complete the screen and ensure they are at a safe emotional baseline.

³⁴⁴ Ibid. 19.

³⁴⁵ Ibid.

³⁴⁶ Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. *Treatment Improvement Protocol (TIP) Series 57*. HHS Publication No. (SMA) 13-4801. Rockville, MD. 2014. 96.

- b. Adjust for Communication Barriers:³⁴⁷ Provide written tools in youth's first/primary language when possible and provide an interpreter when necessary to assist the youth with understanding written tools and during the interview process. Interpreters should be familiar with agency screening and assessment procedures. Offer an interview format for the SRTST if a youth has trouble reading or writing, is otherwise unable to complete the self-reporting checklist, or seems likely to minimize their trauma (presents with significant symptoms of dissociation or repression).
- c. Self-Reporting Tools:³⁴⁸ The Shepley Religious Trauma Screening Tool is a self-reporting checklist of "yes" or "no" questions. Assessors should be mindful that religious traumas can evoke shame, guilt, anger, or other intense feelings that can make it difficult for youth to discuss them out loud during the interview process. Interviews should accompany the SRTST to create a sense of safety for the youth and to verbally follow up to collect additional data after the SRTST is completed.

³⁴⁷ Ibid.

³⁴⁸ Ibid. 97.

Table 4.1

Assessor Competencies	
<ul style="list-style-type: none">1. Trauma Competent2. Multicultural/Culturally Responsive3. Cultural Humility4. Aware of Biases5. Self-Reflective of Personal Religious Location (<i>in relation to youth's</i>)6. Adept with Family Systems7. Integrative Approach	<ul style="list-style-type: none">8. Collaborative Approach9. Contextual Viewpoint10. Cultural Formulation11. Therapeutic Milieu (<i>Proximity, Physical Environment, Communication Barriers, Self-Reporting options for trauma screening</i>)

Content Recommendations

In this section I have summarized and adapted spiritual assessment and trauma screening content recommendations highlighted by major conversation partners Sue, Hays, SAMHSA, Oakes and Raphel, and Hodge to develop a checklist of what to look for in the available tools I surveyed for this project and to develop a trauma-informed religious trauma screening tool and spiritual assessment procedure that considers intersectionality. The checklist included in my survey of published spiritual assessment tools is featured here in Table 4.2 and in each assessment survey. The reader will be able to recognize which recommendations were met by each assessment by seeing which items were checked off on the checklist. If an item is checked off, I was able to identify something about the content of the assessment as meeting the recommendation set forth in the table. The tables also serve as a quick visual which accompanies each narrative in the survey results section below.

I need to address one point of contention in the content recommendations. Person-centered questions are used in trauma-informed assessments to elicit responses that are relevant to the person's lived experiences, which can lead to the sharing of personal narratives from that person's perspective. Understanding how an experience impacted an individual, knowing what happened to them from their own viewpoint, can help the assessor determine whether a person is living with symptoms of religious trauma. Therefore, I included the recommendation to use person-centered questions during a trauma-informed assessment.

However, person-centered questions may present challenges for individuals in communal cultures. The work of assessing youth from communal cultures should be supported through evidence-based practices in psychology (EBPP).³⁴⁹ Hays asserts that the APA definition of EBPP³⁵⁰ supports an integrative approach to psychotherapy while she also acknowledges that controlled studies do not exist regarding the effectiveness of psychotherapy with many minority groups, including communal cultures.³⁵¹ Yet, when assessors engage best practices for multicultural counseling, the importance of individualism and collectivism should be balanced in their assessment of a youth and the youth's communal systems.³⁵²

It is for this reason that I have included Hays' ADDRESSING framework to help assessors complete a cultural formulation during a spiritual assessment interview. This process not only allows the assessor to identify cultural differences between themselves and the youth,

³⁴⁹ Hays, Pamela A., *Addressing Cultural Complexities in Counseling and Clinical Practice: An Intersectional Approach*. 4th ed. Washington DC: American Psychological Association. 2022. 19.

³⁵⁰ Ibid, 19. EBPP is "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."

³⁵¹ Ibid, see pgs 161-178 for discussion on the relationship between race and trauma, trauma and people with disabilities and older adults, trauma and sexual or gender minorities, and trauma in immigrant populations.

³⁵² Sue, Derald Wing. *Counseling the Culturally Diverse: Theory and Practice*. United Kingdom: Wiley, 2022. 26, 37. Western European concepts of mental health stress the importance of independence, while collectivist cultures tend to value interdependence.

but it can also shed light on the influences of a communal culture on an individual. Therefore, assessors can use the youth’s culture sketch to formulate exploratory questions regarding the youth’s relationship with their communal culture and then adjust their lines of questioning appropriately. Assessing religious trauma within communal cultures is an avenue for further research that I will explore in chapter five.

Table 4.2

Content Recommendations for Trauma-Informed Spiritual Assessment
<ul style="list-style-type: none"> ● Includes screening and history questions ● Questions are directly related to presenting clinical problem ● Questions screen specifically for religious trauma symptoms ● Questions are holistic (<i>considers youth in context of physical, psychological, and spiritual safety and wellness</i>) ● Questions are person-centered ● Includes self-reporting “yes” or “no” questions in trauma screening portions ● Includes open ended questions in interview portions (<i>spiritual screen, history, assessment</i>) ● Questions look for youth’s strengths and resources ● Includes clear steps to take if a youth screens positive for religious trauma or needs additional assessment

The Survey of Published Spiritual Assessment Tools

The spiritual assessments that I surveyed included the FICA Spiritual History Tool, the HOPE assessment, Four FACTS assessment, Searle-Vance Spiritual Assessment, Kathryn Hope Keller’s Spiritual Abuse Questionnaire, Rebecca Drumstra’s Adverse Religious Experiences Questionnaire; plus, a light review of four spiritual assessment tools developed by social work researcher and professor David Hodge. Hodge’s instruments and methods included spiritual genograms, spiritual lifemaps, spiritual history narratives, and spiritual eco-maps. I chose to include these assessment tools in my survey for a combination of reasons. Preliminary research

informed my decisions to include tools which were developed by a variety of professionals within and for specific service fields and showed up most commonly in my search for spiritual assessment tools and resources.

The FICA Spiritual History Tool was the tool recommended to me for use as the Chaplain at Bethany, as the tool was specifically named in the assessment procedure that was passed onto me. The FICA tool was always in the top search results in my research for “spiritual assessment.” The HOPE assessment came to me as a recommendation from a clergy colleague who was serving as the Chaplain in a private university setting who suggested this tool might provide deeper insights into the spiritual locations and needs of my youth population than the FICA Spiritual History Tool. This suggestion prompted my initial search for a “more robust” spiritual assessment that could help me recognize the unique needs of the youth I was attempting to serve, including adverse religious experiences and religious trauma. The HOPE assessment was another common result in my research for “spiritual assessment,” as well as the Four FACTS assessment.

While the FICA Spiritual History Tool and HOPE assessment were designed by physicians and for use within healthcare settings by healthcare professionals, the Four FACTs assessment combines two screening tools developed by Chaplain Mark LaRocca-Pitts for use by professional chaplains and pastoral care providers. To offer a sample from each of the professional fields contributing to the intersection where my research interests collided: chaplaincy and healthcare, psychology and counseling, and social work, I searched for tools used in each specific field. FICA and HOPE were the most common results for searches for “spiritual assessment in healthcare” while the Four FACTs recurred in searches for “spiritual assessment in chaplaincy.” I decided to include a less formal review (not in my formal survey) of the four tools

recommended by Hodge, based on his suggestions for their use in social work practice and because his name and resources surfaced frequently in searches for “spiritual assessment in social work” and “clinical spiritual assessment.”

The Searle-Vance Spiritual Assessment was the first screening tool I found that intentionally sought to screen for and respond to spiritually or morally related injuries and incorporated attention to both “spiritual assessment and spiritual abuse.” The assessment was developed by Robert F. Searle and C. Garland Vance while Searle served as Division Chaplain of the US Army Reserves 98th Training Division. The large number of spiritual assessments meant that I could not do an in-depth examination of spiritual assessments for use with military related populations; however, considering links between military related PTSD research and contemporary research on PTSD in RT sufferers, including this tool felt appropriate.

The Spiritual Abuse Questionnaire developed by psychologist Kathryn Hope Keller offers insight into the types of questions currently being asked to assess for AREs and RT. Dr. Keller offers counseling services in the Dallas, TX area for those suffering from spiritual abuse - those presenting with adverse religious experiences and/or religious trauma. I selected this tool for its contributions to the conversation on spiritual assessment in psychology and counseling and because the content of this tool attended to the presence of spiritual abuse.

I decided to survey the Adverse Religious Experiences Questionnaire developed by Rebeka Drumsta when it was introduced to me in the course I completed on Religious Trauma Studies from GCRR. Her questionnaire was adapted from questions asked during a congregational study on religious trauma at Sanctuary Community Church in Iowa City, IA that

began in 2017.³⁵³ The congregation's questions are accessible on the church's website.³⁵⁴ I theorized that the questions in the AREs Questionnaire would significantly inform the types of questions I would include in the Shepley Religious Trauma Screening Tool.

Survey Results for the FICA Spiritual History Tool

The FICA Spiritual History Tool was developed in 1996 by a team of primary care physicians, led by Dr. Christina Puchalski in collaboration with Drs. Daniel Sulmasy, Joan Teno, and Dale Matthews.³⁵⁵ The FICA tool was intended for use by non-chaplain health care providers who could easily incorporate the spiritual history questions into the patient's standard medical history. The tool focuses on the main factors that could be relevant to the medical provider in a medical or clinical setting. According to Puchalski, the FICA tool is based on four areas of spiritual assessment: "the presence of Faith, belief, or meaning; the Importance of spirituality on an individual's life and the influence that belief system or values has on the person's health care decision making; the individual's spiritual Community; and interventions to Address spiritual needs."³⁵⁶ While this tool is generally sufficient to assess a person's spiritual history as it pertains to their immediate medical condition, its use becomes less helpful in non-medical settings or long-term care settings.

As Hays and others have noted, assessing for trauma requires asking direct questions regarding specific adverse experiences. In the context of my research, these questions would relate to AREs, and this assessment does not ask any questions about adversity in the person's

³⁵³ Drumsta, Rebekah. "How Religious Trauma Hits Home." *GCRR: Religious Trauma Studies*. Lecture, 2022.

³⁵⁴ For more on Sanctuary Community Church and their congregational study, see: <https://www.sanctuaryic.org/blog/adverse-religious-experiences>

³⁵⁵ Borneman, Tami, Betty Ferrell, and Christina M. Puchalski. "Evaluation of the FICA Tool for Spiritual Assessment." *Journal of Pain and Symptom Management* 40, no. 2 (August 1, 2010): 163–73. <https://doi.org/10.1016/j.jpainsymman.2009.12.019>.

³⁵⁶ Ibid.

spiritual history. Further, this tool focuses on what the medical team can offer a patient while they are receiving specific medical care for a specific amount of time in a specific place. It assumes that the patient will and can maintain a healthy spiritual life within their own community if that is what the patient desires. Meaning, the tool assumes that the health care setting is not the patient’s primary spiritual care setting. Chaplains and pastoral care providers serving in specialized behavioral healthcare settings are often a person’s primary spiritual care provider, and therefore need a more in-depth exploration of the person’s spiritual history and current needs. See Table 4.3 for survey results for the FICA Spiritual History Tool.

Table 4.3: Survey Results for FICA Spiritual History Tool

Content Recommendations for Trauma-Informed Spiritual Assessment
Tool Surveyed: FICA Spiritual History Tool
<ul style="list-style-type: none"> ● Includes screening and history questions ● Questions are directly related to presenting clinical problem ● Questions screen specifically for religious trauma symptoms ● Questions are holistic (considers youth in context of physical, psychological, and spiritual safety and wellness) ● Questions are person-centered ● Includes self-reporting “yes” or “no” questions in trauma screening ● Includes open ended questions in interview ● Questions look for youth’s strengths and resources ● Includes clear steps to take if a youth screens positive for religious trauma or needs additional assessment

Research Questions:

1. **How did the FICA Spiritual History Tool screen for adverse religious experiences and religious trauma? What was missing?** This tool did not specifically screen for AREs or RT. Since these questions are intended for use in

taking a spiritual history, it is reasonable to conclude that further questioning would be needed to assess for AREs and/or RT symptoms.

2. **In what ways is the FICA Spiritual History Tool trauma-informed? What was missing?** This tool checked a lot of boxes for content recommendations for a trauma-informed spiritual assessment. The questions were crafted to address the youth's spirituality in the context of their current situation and presenting health concerns and could easily be adapted in a verbal spiritual screen and history process to meet the engagement level of the youth. They are open-ended and search for youth's strengths in their beliefs or meaning making, in the importance of spirituality to the youth and its influences in their life, sense of community, and their autonomy in decision-making regarding their care. Questions are holistic in addressing the influence of spirituality on the youth's behavior and how they care for themselves. Questions are easily adapted to be youth inclusive and take a collaborative approach by including the youth in developing next steps by asking the youth, "How would you like me, your chaplain, to address these issues during your placement?"
3. **How did the FICA Spiritual History Tool address intersectionality? What was missing?** The spiritual history tool does not instruct additional steps to develop a cultural formulation; however, questions are open-ended and inclusive in their approaches. Considering the tool was developed for use in medical healthcare settings, it makes sense the tool would adapt questions to be appropriate for use with a diverse population. The questions make as few assumptions as possible, give power and voice to the youth by gathering

information from their perspective, and are absent of religion specific language, such as “God” language.³⁵⁷

Survey Results for the HOPE Questions

The HOPE questions were also developed with medical professionals in mind, and serves as a teaching tool to help medical students, residents and practicing physicians begin to use spiritual assessments in the medical history interview process.³⁵⁸ The HOPE questions are open-ended and work well in a conversational approach, allowing a person to naturally include whatever information or stories they deem relevant.³⁵⁹ Since the questions begin with themes of “hope” and do not immediately use specific spiritual or religious terms, I find this assessment to be helpful in my setting where many of the youth identify as spiritual nones, simply do not have the language to discuss themes of spirituality or religion, practice spiritualities beyond traditional religions, or have experienced AREs or RT.

The questions begin by asking about the youth’s sources of **hope** and allow them to volunteer what they are comfortable with sharing in a language they find more comfortable or familiar. The next two letters in the mnemonic, **O** and **P**, open the door for youth to discuss their relationship with **o**rganized religion and their **p**ersonal spiritual **p**ractices. **E** questions relate to the **e**ffects of the youth’s current situation on their spirituality. These questions attempt to get at how the youth’s placement might impact their ability to continue certain spiritual practices and

³⁵⁷ Best practices in chaplaincy, counseling, and social-work promote avoiding religion-specific language in spiritual assessment questions. This promotes inclusivity, respect for diversity, avoidance of assumptions, adherence to professional standards, and the effectiveness of the assessment process, ultimately enhancing the quality of care provided to individuals seeking support for their spiritual well-being.

³⁵⁸ Anandarajah, Gowri, M.D., and Ellen Hight, M.D., M.P.H. "Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment." *American Family Physician* 63, no 1. (2001) 81-88. <https://www.aafp.org/dam/brand/aafp/pubs/afp/issues/2001/0101/p81.pdf>

³⁵⁹ Ibid.

any specific practices or restrictions that the chaplain or other care providers would need to consider, such as dietary restrictions.

Since this tool was designed to be used by medical professionals and the medical setting/provider is not the patient's primary source of pastoral care, the tool has similar limitations as the FICA tool. While the **O** portion of the assessment opens the door for youth to discuss their relationship with organized religion, and might lead to a discussion of adversity, the questions are not related to adverse experiences and do not lead the assessee to explicitly reflect on AREs. See Table 4.4 for survey results for the HOPE Questions.

Table 4.4: Survey Results for the HOPE Questions

Content Recommendations for Trauma-Informed Spiritual Assessment
Tool Surveyed: HOPE Questions
<ul style="list-style-type: none"> • Includes screening and history questions • Questions are directly related to presenting clinical problem • Questions screen specifically for religious trauma symptoms • Questions are holistic (considers youth in context of physical, psychological, and spiritual safety and wellness) • Questions are person-centered • Includes self-reporting "yes" or "no" questions in trauma screening • Includes open-ended questions in interview • Questions look for youth's strengths and resources • Includes clear steps to take if a youth screens positive for religious trauma or needs additional assessment

Research Questions:

1. **How did the HOPE Questions screen for adverse religious experiences and religious trauma? What was missing?** This tool did not specifically screen for AREs or RT symptoms. However, two lines of questioning stood out to me as possible elicitors of personal narratives that could indicate the presence of AREs

or RT symptoms and prompt additional assessment. First, when assessing for sources of Hope, meaning, strengths, etc., “For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life’s ups and downs; is this true for you?” If the youth answers “no” the questions prompt the assessor to consider asking “was it ever?” and “what changed?” Second, in an exploration of the youth’s relationship with organized religion, asking, “What aspects of your religion are helpful or not so helpful to you?” Both questions could prompt the youth to share experiences of adversity, though neither is explicitly screening for AREs or RT.

2. **In what ways are the HOPE Questions trauma-informed? What was missing?** This tool checked a lot of boxes for content recommendations for a trauma-informed spiritual assessment. Questions are holistic, person-centered, open-ended, and intentionally look for the youth’s strengths and resources. The last section of the questionnaire addresses the effects of beliefs and practices on medical care and end-of-life issues. These questions are easily adaptable for my setting, as they are collaborative and youth inclusive. The questions place the youth in a seat of power regarding their decision making in care. In their adapted form, they can help me understand what the youth wants, needs, and expects from me as their chaplain and BCH as their general spiritual wellness providers. The tool offers three clear suggestions for next steps, all respectful of the youth, and includes modification of the treatment plan based on spiritual assessment findings.

3. How did the HOPE Questions address intersectionality? What was missing?

The HOPE Questionnaire does not incorporate steps to complete a cultural formulation of the youth; however, the HOPE Questions are recommended for completing a culturally sensitive spiritual assessment and is often applauded for its collaborative, inclusive, multidimensional approaches.³⁶⁰ It encompasses secular and religious perspectives related to the youth's cognition of religion or spirituality, the youth's experiences of religion or spirituality, and the youth's behaviors and life choices in relation to their beliefs and/or values.³⁶¹

Survey Results for the Four FACTs Tool

The Four FACTs Spiritual Assessment Tool combines the Four Fs and the FACT spiritual assessment tool, both developed by LaRocca-Pitts.³⁶² The Four Fs provide a tool for the chaplain to gather relevant information, including: **Facts** - the youth's factual information; **Feelings** - how the youth feels about their current situation; **Family/Friends** - who does the youth consider as family/friends or who is important to them; and **Faith** - what is the youth's faith tradition or religious worldview and what are their spiritual practices.³⁶³ According to LaRocca-Pitts, the FACT Tool provides an algorithm for evaluating information and a mechanism for developing a plan of care.³⁶⁴ The combined tools offer the following suggested outline for questioning, in which the four Fs account for 25% of the screening:

- F ¼ F-category (Facts, Feelings, Family/Friends, Faith);

³⁶⁰ Ibid.

³⁶¹ Ibid.

³⁶² LaRocca-Pitts, Mark. Four FACTs Spiritual Assessment Tool. *Journal of Health Care Chaplaincy* 21, (April, 2015): 51–59.

³⁶³ Ibid.

³⁶⁴ Ibid.

- A ¼ Access, Available, or Anxiety;
- C ¼ Coping (Conflict and/or Comfort);
- T ¼ Treatment³⁶⁵

Using this tool, I am able to gather much of the information I need to provide spiritual care in a residential environment. **A** in the mnemonic relates to the youth's **a**ccess to and/or **a**nxiety surrounding the F categories. For example, while discussing the youth's family and friends, the assessor might ask about the youth's access to these relationships and explore any anxieties within or pertaining to these relationships. Next, depending on the youth's responses, the assessor could continue the line of questioning to determine where on the spectrum of conflict and comfort these relationships lie. The **C** line of questioning explores the concept of coping and attempts to understand how the youth's facts, feelings, family/friends, and faith help or hinder their coping processes. Finally, the **T** in the mnemonic refers to **t**reatment. This last part of the assessment is about the treatment plan which "involves an intervention or series of interventions, along with a desired outcome, and an evaluation about whether the outcome was achieved."³⁶⁶ LaRocca-Pitts adds that this final step distinguishes this spiritual assessment from spiritual history interviews used in medical settings.³⁶⁷ See Table 4.5 for survey results for the Four FACTs tool.

³⁶⁵ Ibid.

³⁶⁶ Ibid.

³⁶⁷ Ibid.

Table 4.5: Survey Results for the Four FACTs Tool

Content Recommendations for Trauma-Informed Spiritual Assessment
Tool Surveyed: Four FACTs Tool
<ul style="list-style-type: none"> • Includes screening and history questions • Questions are directly related to presenting clinical problem • Questions screen specifically for religious trauma symptoms • Questions are holistic (considers youth in context of physical, psychological, and spiritual safety and wellness) • Questions are person-centered • Includes self-reporting “yes” or “no” questions in trauma screening • Includes open ended questions in interview • Questions look for youth’s strengths and resources • Includes clear steps to take if a youth screens positive for religious trauma or needs additional assessment

Research Questions:

1. **How did the Four FACTs Tool screen for adverse religious experiences and religious trauma? What was missing?** This tool did not specifically screen for AREs or RT symptoms. The questions generally assume the presence of beliefs or spiritual practices is representative of a youth’s strengths to help them cope with their current situation; they do not allow for an exploration of beliefs or practices as causes of conflict or suffering. The author of the tool does suggest further spiritual assessment depending on the youth’s presentation, and it is during that follow up assessment when the chaplain would intentionally screen for AREs or RT symptoms.
2. **In what ways is the Four FACTs Tool trauma-informed? What was missing?**
This tool checked a lot of boxes for content recommendations for a trauma-informed spiritual assessment. Questions are holistic, person-centered, open-ended, and intentionally look for the youth’s strengths and resources. It includes

similar topics as the HOPE Questions and helps the assessor recognize what the youth needs, wants, or expects from the chaplain and/or BCH Spiritual Wellness providers. It also specifically includes “Treatment Plan” components and recommendations for next steps, including followup from the chaplain to complete a full spiritual assessment.

3. How did the Four FACTs Tool address intersectionality? What was missing?

This tool does not incorporate steps to complete a cultural formulation of the youth; though the tool is intended by the author to be functional in acute care settings and is considered by the author to be short, easy, versatile, and focused. I find the tool to be somewhat *too* focused for my screening and assessment needs, as the questions do not lean enough into an exploration of cultural factors. The questions, intended to be short for a quick history and assessment, miss opportunities to explore ways in which the youth’s cultural identities overlap with their beliefs/values to create experiences of intersectionality.

Survey Results for the Searle-Vance Spiritual Assessment

The authors of the Searle-Vance Spiritual Assessment structured their study of existing assessments similarly to how I structured this research project. They surveyed spiritual assessments approved for use by chaplains in the 98th Division and used their findings to develop a more comprehensive assessment.³⁶⁸ Three assessments were surveyed in their study: the Duke University Religion Index Score, the Berg Spiritual Injury Scale, and the Multi-Level Spiritual Assessment.³⁶⁹ The Searle-Vance Spiritual Assessment can be administered as a self-

³⁶⁸ Searle, R. F., & Vance, C. G. “A Chaplain’s Comprehensive Spiritual Assessment And Military Mission.” *Journal of Pastoral Care & Counseling*, 75(1), 2021. 40-50. <https://doi.org/10.1177/1542305020968051>.

³⁶⁹ Ibid. 40.

reporting tool and can be completed by the assessee within fifteen minutes.³⁷⁰ The chaplain can interpret the assessment in another fifteen minutes and develop a treatment plan based on the results.³⁷¹

The efficacy of the assessment at identifying spiritual/moral injuries is illustrated through a vignette in an article by the same authors, “A Chaplain’s Comprehensive Spiritual Assessment and Military Mission” published in *The Journal of Pastoral Care & Counseling* in 2021. The authors briefly outline the results of a soldier’s spiritual assessment and what the chaplain was able to infer based on the results. Despite scoring positively regarding the soldier’s spiritual support system, the chaplain was able to recognize potential signs of suicidal ideation or self-harm.³⁷²

Although the soldier's spiritual injury score fell below the threshold for the screening tool, he frequently experienced feelings of guilt and shame, which contradicted his perceived spiritual support system.³⁷³ The soldier specifically indicated thoughts of suicide and/or harming others over the past two years.³⁷⁴ Given the association between guilt/shame and depression, as well as suicidal ideation and attempts, it was crucial for the chaplain to closely examine the soldier's losses and life changes. The soldier reported changes in his personal schedule, devotional practices, his family’s living situation, and financial status. He also revealed increased emotional distance within his home and family.³⁷⁵

³⁷⁰ Ibid. 41, 43.

³⁷¹ Ibid. 43

³⁷² Ibid. 42.

³⁷³ Ibid.

³⁷⁴ Ibid.

³⁷⁵ Ibid.

Any practitioner beholden to the policies of mandated reporting understands how important it is to not only be able to recognize signs of suicidal ideation and harm to self or others, but to also be able to directly ask the assessee if they have a plan to complete suicide, to harm their self, or to harm others. Searle and Vance note that the soldier in the vignette did not have a plan and expressed gratitude that someone reviewed their assessment and was concerned enough to pay attention to their responses.³⁷⁶ The soldier's responses allowed the chaplain to intercede as a supportive aid and to advocate for and initiate additional support to address the various issues the soldier was facing before they became life threatening. In essence, the assessment proved effective as a prevention tool.³⁷⁷ See Table 4.6 for the survey results of the Searle-Vance Spiritual Assessment.

Table 4.6: Survey Results for the Searle-Vance Spiritual Assessment

Content Recommendations for Trauma-Informed Spiritual Assessment
Tool Surveyed: Searle-Vance Spiritual Assessment
<ul style="list-style-type: none"> ● Includes screening and history questions ● Questions are directly related to presenting clinical problem ● Questions screen specifically for religious trauma symptoms ● Questions are holistic (considers youth in context of physical, psychological, and spiritual safety and wellness) ● Questions are person-centered ● Includes self-reporting “yes” or “no” questions in trauma screening ● Includes open ended questions in interview ● Questions look for youth's strengths and resources ● Includes clear steps to take if a youth screens positive for religious trauma or needs additional assessment

³⁷⁶ Ibid.

³⁷⁷ Ibid.

Research Questions:

1. **How did the Searle-Vance Spiritual Assessment screen for adverse religious experiences and religious trauma? What was missing?** The authors of the Searle-Vance Spiritual Assessment use the language of moral injury to describe experiences in which one's human spirit is so bruised and broken that they cease to find meaning and hope in life and no longer seek either meaning or hope.³⁷⁸ Questions 13-20 specifically ask users to rate how often they experience certain feelings or thoughts, including: guilt or shame over past behaviors; sadness or grief; anger or resentment that blocks peace of mind; despair or hopelessness; that life has no meaning or purpose; worry over doubt in God; fear of death; belief that God/life has treated them unfairly. Additional questions address changes in the person's life and evaluate a range of adverse experiences, including AREs. Most of the questions regard themes of potentially adverse or negative experiences, such as those inducing shame or humiliation, exclusion or expulsion from participation in the faith community, and severe discord within the community. It also explicitly asks, "Have you ever experienced abuse (verbal, physical, emotional, sexual, other) in a religious setting or by a religious authority figure?"³⁷⁹
2. **In what ways is the Searle-Vance Spiritual Assessment trauma-informed? What was missing?** The authors assert that a military chaplain must be able to assess for active military service people's spirituality and spiritual/moral injuries

³⁷⁸ Searle, Robert F, and C Garland Vance. "A Chaplain's Comprehensive Spiritual Assessment And Military Mission." *The Journal of Pastoral Care & Counseling* 75, no. 1 (March 2021): 40–50. <https://doi.org/10.1177/1542305020968051>. 44.

³⁷⁹ Ibid.

that could impact the service person's overall sense of well-being, and further, prove detrimental to the military mission if not identified and treated.³⁸⁰ This speaks to the authors' awareness of the benefits of holistic care and the potential community impacts of individual AREs and RT; and aligns with my search for an assessment approach that proves effective in a holistic care setting that assumes trauma happens in community and must be healed within the communal context. The questions are somewhat more generalized to function as a self-reporting tool, though they are as inclusive as possible in their response options. The questions utilize a rating system for users to check boxes related to frequency of feelings or experiences, rather than "yes" or "no" questions. Since the tool is a self-reporting written tool, the questions are not open-ended or interview structured. The user's responses could indicate additional spiritual assessment is necessary, during which time the chaplain could incorporate open-ended questions in a verbal interview process.

3. **How did the Searle-Vance Spiritual Assessment address intersectionality?**

What was missing? This tool does not incorporate steps to complete a cultural formulation of the youth. Opportunities to explore ways in which the youth's cultural identities overlap with their beliefs/values to create experiences of intersectionality would need to be explored in a follow-up spiritual assessment. The authors note that the assessment was reviewed and authorized for use by an Executive Officer, the Judge Advocate General, the Equal Employment Opportunity Officer, Command Sergeant Major, and other leaders within the 98th

³⁸⁰ Ibid. 40.

Division; inferring that the assessment was reviewed for ethical concerns including cross-cultural awareness and themes of inclusivity and accessibility.³⁸¹

Survey Results for Keller's Spiritual Abuse Questionnaire

One source that offers insight into the types of questions currently being asked to assess AREs and RT is the Spiritual Abuse Questionnaire developed by Kathryn Hope Keller. Keller makes two claims that align with the claims I am making. One, she claims that clinical assessors need to be culturally competent and understand that religion and spirituality can be an element of a person's cultural identity; two, she claims that trauma competency is essential to assessing and responding to AREs and RT.³⁸² Through her own qualitative research of spiritual abuse, Keller developed a scale to measure experiences of spiritual abuse including abuse of power, suppression of self-expression, and moral injury.³⁸³ The scale includes seventeen statements in a self-reporting format that uses a Likert scale³⁸⁴ to note the degree to which the person agrees or disagrees with the statements.³⁸⁵ These statements were derived from emerging patterns in the psychiatric or therapeutic treatment of survivors of AREs and RT, meaning these are statements that might commonly apply to those suffering from AREs and RT.³⁸⁶

³⁸¹ Ibid. 41.

³⁸² Keller, Kathryn Hope. "Spiritual and/or Religious Abuse: Emerging Understanding and Clinical Implications." *GCRR: Religious Trauma Studies*. Lecture, 2022.

³⁸³ Ibid.

³⁸⁴ A Likert scale is a commonly used psychometric tool for measuring attitudes, opinions, or behaviors. It typically consists of a series of statements or items to which respondents indicate their level of agreement or disagreement on a numerical scale. The scale is named after its creator, psychologist Rensis Likert. Responses are usually scored on a numeric scale, such as 1 to 5 or 0 to 10, with higher scores indicating stronger agreement or endorsement of the statement. Likert scales are widely used in research and assessment due to their simplicity, versatility, and ability to quantify subjective phenomena in a standardized manner.

³⁸⁵ Keller, Kathryn Hope. "Spiritual and/or Religious Abuse: Emerging Understanding and Clinical Implications." *GCRR: Religious Trauma Studies*. Lecture, 2022.

³⁸⁶ Ibid.

A major limitation of the tool is that it focuses on involvement in a Christian or Bible-based church or group, as opposed to a more inclusive involvement in a generally religious or spiritual group. However, for youth who screen as having a history with Christian or Bible-based churches or groups, this questionnaire could elicit helpful information. See Table 4.7 for the survey results for Keller’s Spiritual Abuse Questionnaire.

Table 4.7: Survey Results for Keller’s Spiritual Abuse Questionnaire

Content Recommendations for Trauma-Informed Spiritual Assessment
Tool Surveyed: Keller’s Spiritual Abuse Questionnaire
<ul style="list-style-type: none"> ● Includes screening and history questions ● Questions are directly related to presenting clinical problem ● Questions screen specifically for religious trauma symptoms ● Questions are holistic (considers youth in context of physical, psychological, and spiritual safety and wellness) ● Questions are person-centered ● Includes self-reporting “yes” or “no” questions in trauma screening ● Includes open ended questions in interview ● Questions look for youth’s strengths and resources ● Includes clear steps to take if a youth screens positive for religious trauma or needs additional assessment

Research Questions:

1. **How did Keller’s Spiritual Abuse Questionnaire screen for adverse religious experiences and religious trauma? What was missing?** The questions intentionally seek to explore four themes of spiritual or religious abuse: abuse of power, conditionality, suppression of expression, and spiritual injury in clinical patients presenting with spiritual abuse histories. Abuse of power explored experiences with religious leaders who disregarded clergy confidentiality, used fear to control people, and engaged in public scolding of people. Conditionality is

explored through questions related to beliefs that God's love and acceptance is dependent on personal performance and assimilation into the group; and feeling dependent on group leaders and following their instructions to get things right. Suppression of expression is explored through questions related to acceptance of true emotions and freedom to ask questions or express concerns while spiritual injury shows up in an exploration of self-trust, lasting impacts of public shaming, feeling cynical about church or religious groups, and feeling lonely or misunderstood because of church or church group experiences.

2. **In what ways is Keller's Spiritual Abuse Questionnaire trauma-informed?**

What was missing? During a lecture on Spiritual and/or Religious Abuse and relevant clinical implications, Keller described rationales for conducting a RT screen and the multicultural and trauma competencies of ideal assessors. She reminds clinicians that conditionality may manifest during the assessment session and to be mindful of Herman's trauma model (safety, remembrance/mourning, reconnection),³⁸⁷ which is similar to Bloom's S.E.L.F. trauma model (safety, emotions, loss, future). She included distinguishing spiritual abuse as its own construct as a goal of the questionnaire.³⁸⁸ The questions are presented on a Likert scale of "Strongly disagree" to "Strongly agree" which allows the youth to consider their experiences as adverse or not. More open-ended, person-centered, ideographic questions would be appropriate to ask in a follow-up spiritual assessment.

³⁸⁷ Keller, Kathryn Hope. "Spiritual and/or Religious Abuse: Emerging Understanding and Clinical Implications." *GCRR: Religious Trauma Studies*. Lecture, 2022.

³⁸⁸ Ibid.

3. **How did Keller’s Spiritual Abuse Questionnaire address intersectionality?**

What was missing? This assessment does not incorporate steps to complete a cultural formulation of the youth. The questions are specific to a youth population with lived experiences with Christian or Bible-based churches or groups, which excludes a large portion of the population I serve. However, the tool could provide significant insight for youth who have a spiritual history including Christian or Bible-based churches or groups.

Survey Results for Drumsta’s Adverse Religious Experiences Questionnaire

Drumsta’s Adverse Religious Experiences Questionnaire consists of eighteen “yes/no” questions and explains that if a person answers “yes” to one or more questions they may have AREs or RT. She includes a disclaimer that this questionnaire is not intended as a diagnostic tool and is best used as a personal reflection tool that could increase the chances of a person struggling with AREs or RT to seek support. Available literature suggests that this tool has been used primarily in the local church setting or life coaching sessions to help individuals reflect on their experiences of faith. The assessment does not include questions to help the assessor identify the person’s spiritual history or current spiritual location and therefore should be utilized as part of a full spiritual assessment, including a spiritual history and verbal interview. See Table 4.8 for the survey results for Drumsta’s AREs Questionnaire.

Table 4.8: Survey Results for Drumsta’s Adverse Religious Experiences Questionnaire

Content Recommendations for Trauma-Informed Spiritual Assessment
Tool Surveyed: Drumsta’s Adverse Religious Experiences Questionnaire
<ul style="list-style-type: none"> • Includes screening and history questions • Questions are directly related to presenting clinical problem • Questions screen specifically for religious trauma symptoms • Questions are holistic (considers youth in context of physical, psychological, and spiritual safety and wellness) • Questions are individualistic and ideographic • Includes self-reporting “yes” or “no” questions in trauma screening • Includes open ended questions in interview • Questions look for youth’s strengths and resources • Includes clear steps to take if a youth screens positive for religious trauma or needs additional assessment

Research Questions:

1. **How did Drumsta’s Adverse Religious Experiences Questionnaire screen for adverse religious experiences and religious trauma? What was missing?** The questions are directly related to recognizing AREs through acknowledging adverse lived experiences and manifestations of Slade, et.al. 's six major religious trauma symptoms, including: anxiety, stress, fear, depression, and shame.³⁸⁹ “Nightmares” as a major manifestation of RT is not explored in this questionnaire, though social or cultural isolation is a recurring theme.
2. **In what ways is Drumsta’s Adverse Religious Experiences Questionnaire trauma-informed? What was missing?** The tool provides a definition of “adverse religious experiences” and recommends follow up with a

³⁸⁹ Slade, Darren M., Adrianna Smell, Elizabeth Wilson, and Rebekah Drumsta. “Percentage of U.S. Adults Suffering from Religious Trauma: A Sociological Study.” *Socio-Historical Examination of Religion and Ministry* 5, no. 1 (2023): 1–28. <https://doi.org/10.33929/sherm.2023.vol5.no1.01>.

spiritual/mental health counselor if a person answers “yes” to at least one question. It includes 18 questions which are all “yes” or “no” oriented. The tool is intended to screen for AREs and should function as part of a full spiritual assessment procedure, including a spiritual history and follow up verbal interview.

3. **How did Drumsta’s Adverse Religious Experiences Questionnaire address intersectionality? What was missing?** This tool does not incorporate steps to complete a cultural formulation of the youth. An exploration of the ways in which the youth’s cultural identities overlap with their beliefs/values to create experiences of intersectionality would need to be included in a follow-up spiritual assessment.

David Hodge’s Four Spiritual Assessment Tools for Social Workers

The available literature suggested that Hodge’s four recommended spiritual assessment models for social workers were intended for use as full spiritual assessments to elicit specific, ideographic information; and that Hodge recommends the use of all four tools as an integrative approach to spiritual assessment. I decided not to include these tools in my formal survey, and to instead summarize the tool’s implications for religious trauma screening in a youth population. I primarily considered these tools as aids in the full spiritual assessment procedure.

Hodge recommends spiritual genograms to gain a “tangible graphic representation of spirituality across at least three generations.”³⁹⁰ Spiritual genograms can help the chaplain and youth develop a deeper understanding of the connection of historically rooted patterns to the

³⁹⁰ Hodge, D. R. *Spiritual Assessment: A Handbook for Helping Professionals*. Botsford, CT. North American Association of Christians in Social Work. 2003.

youth. This tool could be especially useful when working with youth who screen positive for AREs or RT symptoms and can help identify “complex intergenerational spiritual interactions.”³⁹¹ The author cited limitations of the tool include its particular utility when the family system plays a more salient role in the youth’s life, while being potentially inappropriate as an assessment instrument when the youth’s family history is of minor importance to their sense of spirituality.³⁹²

The second tool Hodge recommends is spiritual lifemaps, or a pictorial representation of the youth’s spiritual journey. In this method, the youth’s spiritual history is mapped over a timeline. This resource has limited use in my setting, though I could potentially incorporate it in an individual pastoral care session with the youth to explore their spiritual journey through a visual modality. Hodge’s “Guidelines for conducting spiritual histories” offers an alternative list of questions and themes to explore when taking a spiritual history. The questions are open-ended, inclusive, collaborative and contextual, and allow for positive and negative experiences of religion and spirituality. The guidelines suggest a two-part framework: the initial narrative framework, and the interpretive anthropological framework.³⁹³ The anthropological framework addresses spirituality in the context of the youth’s affect, behavior, cognition, communion, conscience, and intuition. These questions are easily adaptable in my setting and could support a full spiritual assessment procedure that is trauma-informed and considers experiences of intersectionality with my youth population.

The final suggestion from Hodge is the use of spiritual eco-maps which depict the relationships between the youth’s family systems and the youth’s spiritual systems. These

³⁹¹ Ibid.

³⁹² Ibid.

³⁹³ Ibid.

systems and their connections are represented by various shapes and sketched lines.³⁹⁴ Much like the spiritual lifemaps, spiritual eco-maps have limited use in my current setting. They have potential to support spiritual explorations in individual or group sessions with youth who express interest in such an activity.

Survey Conclusions

An important consideration in my survey of spiritual assessment tools was the author's intended use/setting for their respective tools. Some are specifically designed to take spiritual histories in acute settings while others are designed to conduct trauma screens or full spiritual assessments. What I found interesting is that with exception to the FICA and Four FACTs tools, each of the other tools has the potential to screen for AREs and religious trauma symptoms, though none of them currently do so.

The HOPE Questions do not specifically ask about adversity or trauma, though two helpful lines of questioning are noted in my survey results. These questions could lead to a discussion about AREs or RT symptoms during the spiritual history with the case manager or while the chaplain is conducting a full spiritual assessment. The Searle-Vance Spiritual Assessment is too specific for use with military related populations for direct application with my youth population; however, the themes related to AREs and RT symptoms could be adapted for utilization within a youth population. The Keller Spiritual Abuse Questionnaire and Drumsta's AREs Questionnaire both have strengths in screening for AREs and RT symptoms, though neither is suitable for direct application in my setting.

All of these spiritual assessment tools are adaptable for use with a youth population in a trauma-informed therapeutic environment. Recognizing the strengths of the FICA, HOPE, and

³⁹⁴ Ibid.

Four FACTs tools, a chaplain could utilize either tool in an interview process to gather a youth's spiritual screen and history. Of these, the Four FACTs is the only tool that explicitly includes treatment planning. However, the other two suggest a collaborative approach with youth to determine any next steps in the helping relationship which could include treatment planning.

None of the tools I surveyed explicitly incorporate steps to complete a cultural formulation of the youth. Instead, opportunities to explore ways in which the youth's cultural identities overlap with their beliefs/values to create experiences of intersectionality would need to be explored in a follow-up spiritual assessment interview with the chaplain. Most of the tools do have some strengths related to multiculturalism/culturally responsive care.

Highlighted in my survey, the FICA questions make as few assumptions as possible, give power and voice to the youth by gathering information from their perspective, and are absent of religion specific language, such as "God" language. The HOPE Questions encompass secular and religious perspectives related to the youth's cognition of religion or spirituality, the youth's experiences of religion or spirituality, and the youth's behaviors and life choices in relation to their beliefs and/or values. The authors of the Searle-Vance assessment note that the assessment was reviewed and authorized for use by a collective group of leaders within the 98th Division, inferring that the assessment was reviewed for ethical concerns including cross-cultural awareness and themes of inclusivity and accessibility.

The Shepley Religious Trauma Screening Tool (SRTST)

The SRTST questions are intended to elicit information from the youth that is directly related to their adverse religious experiences and/or symptoms of RT.³⁹⁵ The questions were

³⁹⁵ Oakes, K. Elizabeth, and Mary M Raphael. "Spiritual Assessment in Counseling: Methods and Practice." *Counseling and Values* 52, no. 4 (April 2008).

developed based on qualitative research which indicates certain experiences or symptoms might be more prevalent amongst those suffering from AREs or religious trauma. The tool adapts questions from Drumsta's AREs Questionnaire and incorporates similarly structured questions to elicit information about whether the youth experiences any of the six major manifestations of RT: anxiety, stress, fear, depression, shame, and nightmares.³⁹⁶ Other questions explore common symptoms identified by Winell in her qualitative research on religious trauma syndrome, including themes of perfectionism, identity fracturing, social disruptions, and hell trauma.

It makes use of 20 "yes" or "no" questions in the written self-reporting tool and encourages the chaplain to ask open ended questions during the interview and discussion with the youth to elicit personal stories from the youth's perspective that can inform the chaplain of how the youth's experiences and presenting symptoms are influenced by their cultural identities overlapping with religiosity and spirituality. Questions are holistic in that they explore the youth's lived experiences and symptoms in the context of the youth's sense of their physical, psychological, and spiritual safety and wellness. In their attempt to screen for common manifestations of religious trauma, the questions are more generalized than person-centered; though the chaplain should take special care to incorporate person-centered questions into their interview and discussion with the youth.³⁹⁷

Since we understand that spirituality and trauma are both personal and experienced on a spectrum, I decided the tool would not measure AREs or RT using a hierarchy of symptoms, or tiered indicators. Instead, the screen utilizes a simple tabulation of responses to indicate whether

³⁹⁶ Slade, Darren M., Adrianna Smell, Elizabeth Wilson, and Rebekah Drumsta. "Percentage of U.S. Adults Suffering from Religious Trauma: A Sociological Study." *Socio-Historical Examination of Religion and Ministry* 5, no. 1 (2023): 1–28. <https://doi.org/10.33929/sherm.2023.vol5.no1.01>.

³⁹⁷ Hodge, D. R. *Spiritual Assessment: A Handbook for Helping Professionals*. Botsford, CT. North American Association of Christians in Social Work. 2003.

additional assessment is needed. Answering “yes” to any one question warrants additional spiritual assessment. For youth with a positive RT screen who agree to participate in an interview with the chaplain, it is important to again intentionally search for the youth’s strengths and resources that might contribute to their healing and recovery from AREs and religious trauma.

When using a religious trauma screening tool, it is important to adhere to best practices to ensure the assessment is conducted effectively and ethically. Best practices include receiving the youth’s informed consent to participate in the screening process, employing cultural sensitivity and humility, and applying a trauma informed approach. By following these best practices, assessors can conduct the religious trauma screening in a responsible and effective manner, ultimately supporting youth in their journey toward healing and recovery.

When using the SRTST, it is important for the assessor to be attentive to the youth’s verbal and nonverbal cues. This can help the assessor recognize when someone is emotionally triggered during the screening process. Here are some signs that someone may be triggered:

1. **Physical Signs:** Watch for physical manifestations of distress, such as increased heart rate, shallow breathing, sweating, trembling, or signs of tension like clenched fists or jaw.
2. **Emotional Signs:** Look for changes in mood or affect, such as sudden onset of fear, sadness, anger, or numbness. They may also appear emotionally overwhelmed, tearful, or withdrawn/shut down.
3. **Behavioral Signs:** Notice any changes in behavior, such as restlessness, agitation, avoidance, desire to flee, or dissociation (disconnecting from the present moment).
4. **Verbal Cues:** Listen for verbal expressions of distress, such as statements indicating discomfort, fear, or a sense of being overwhelmed.

If the assessor recognizes that the youth is triggered during a trauma screen, it is essential to employ emotional regulation practices to help them de-escalate. Here are some strategies:

1. **Stay Calm:** Maintain a calm and composed demeanor. Your own calm presence can help reassure the youth and provide a sense of safety.
2. **Validate their Experience:** Acknowledge the youth's feelings and experiences without judgment. Let them know that it is understandable to feel overwhelmed and that you are there to support them.
3. **Grounding Techniques:** Guide the youth through grounding exercises to help bring them back to the present moment. This could include focusing on deep breathing, identifying objects in the room, or engaging in sensory activities like holding a comforting object. Grounding also includes focusing on tactile sensations such as feeling their feet on the floor or recognizing their body in a chair by letting the chair support them.
4. **Provide Space:** Respect the youth's need for space and autonomy. Offer them the option to take a break or pause the screening process if they feel too overwhelmed to continue.
5. **Normalize Emotions:** Help normalize the person's emotional responses by letting them know that it's okay to feel the way they do. Remind them that their feelings are valid and understandable given their experiences.

By employing these emotional regulation practices, the assessor can help individuals navigate moments of distress during the religious trauma screening and support them in regaining a sense of safety and calm. The Shepley Religious Trauma Screening Tool questions are listed below. The SRTST form is included in the Appendix. The following section includes a step-by-step procedure to include the SRTST into a full spiritual assessment.

SRTST Questions:

1. Have you ever experienced abuse (*verbal, physical, emotional, sexual, other*) in a religious setting or by a religious authority figure?
2. Do you ever feel triggered (*anxiety, stress, fear, anger*) when you think about going to a religious event, being around religious people, or being in a religious setting (*church, synagogue, temple*)?
3. Have you been forced to "choose sides" concerning a religious leader, belief, person, or situation? (*Ex: certain lifestyles as sinful or not*)
4. Does being near a pastor, religious leader, church or religious building, or religious materials ever make you feel anxious, stressed, afraid, or angry?
5. In a religious setting or by a religious leader, have you ever been shamed or humiliated?
6. Because of religious pressure, have you treated other people in a way that you now regret?
7. Have you ever been excluded, expelled, or shunned from a religious community?
8. Do your past religious experiences keep you from attending or participating in a religious environment or group?
9. To fit in or avoid trouble, have you ever "gone along with" religious activities or practices with which you did not agree or feel comfortable?
10. Have you ever been harshly criticized, scolded, or made to feel ashamed by a religious leader, in a religious setting, or by other religious people?
11. Have you ever thought God does not love or accept you because of what you were told in a religious setting, by a religious leader or religious people?
12. Have you ever felt like you had to hide your true self in religious settings or around religious people?
13. Do you ever experience nightmares, night terrors, or other sleep disturbances because of what you've been told or experienced in religious settings, with religious people, or from religious beliefs?

14. Have you ever felt like you couldn't live up to the expectations of a religious leader, person, or group?
15. Have religious messages, religious beliefs, or religious people ever caused you to feel afraid of damnation (*spiritual eternity in hell*)?
16. Do you often worry about being forgiven for your childhood actions, behaviors, attitudes, or beliefs?
17. Do you ever engage in self-harm, violence, or suicidal ideation because of your thoughts or feelings about religion/spirituality?
18. Do you ever use drugs or alcohol to cope with your thoughts or feelings about religion/spirituality?
19. Has your family system or social support network ever been disrupted because of religious beliefs or practices, or because of a religious person or group?
20. Do you feel lonely or misunderstood because of your experiences in a religious setting or with religious people?

In summary, the Shepley Religious Trauma Screening Tool can be used by chaplains, counselors, and social workers in behavioral healthcare or child welfare settings to assess individuals who may have experienced psychological distress due to harmful religious beliefs or practices. The SRTST helps identify symptoms such as anxiety, depression, guilt, or shame associated with religious trauma. It can be utilized in clinical settings during therapy sessions, intake assessments, or as part of research studies to better understand the prevalence and impact of religious trauma. Additionally, the SRTST may be used by religious leaders or counselors who work closely with individuals struggling with adverse religious experiences or RT. Overall, the aim is to provide support and appropriate interventions for those affected by religious trauma.

A Spiritual Assessment Procedure

This section defines the steps to take to complete spiritual screen, spiritual history, the SRTST, and a spiritual assessment in a behavioral health or child welfare setting. The steps are assigned to certain team members or teams that are relevant to my setting at Bethany Children's Home. The titles assigned to the spiritual screen, history, and SRTST are not exclusive, as these team members and other professionals with similar backgrounds and qualifications in another setting might work under varying titles or positions. Additionally, a psychotherapist or counselor could complete these steps. The title assigned to the spiritual assessment is "Chaplain" and I recommend only those with professional chaplain qualifications for this role. Professional chaplains are clergy with authorization to serve in clinical settings and have trained in clinical pastoral education or possess similar clinical experience. The combination of clergy education/training/experience and clinical education/training/experience is an essential competency for professional chaplains, and as such, these professionals are typically the only members of the interprofessional care team especially qualified to conduct the full spiritual assessment.

This spiritual assessment procedure aims to include a cultural formulation of the assessor (chaplain) and youth using Hays' ADDRESSING framework in the form of cultural sketches. The procedure is written to help the chaplain evaluate the youth's spiritual assessment in the context of the youth's presenting clinical issues and/or related diagnosis. A copy of the BCH Spiritual Assessment Procedure is included in the Appendix for reference.

Step 1: Case Manager (CM)/ Behavioral Specialist (BS), Psychoeducation & Informed Consent - Provide youth with information to help them understand the steps within this procedure, ensuring they understand what happens with a positive religious trauma screen. Inform youth of why specific questions are asked. Be prepared to review relevant definitions and concepts

throughout each portion. Provide additional psychoeducation and support as needed. Receive youth's informed consent to participate in each portion: spiritual screen, spiritual history, and SRTST. Ensure youth understands their rights to decline participation in each portion of the spiritual assessment and note on the Spiritual Assessment Checklist whether the youth provided their informed consent or declined to participate.

Step 2: CM / BS, Spiritual Screen - Proceed with the spiritual screen. Ask the following "yes" or "no" questions and record youth's responses:

1. Do you think of yourself as spiritual or religious?
2. Is religion or spirituality important to you?
3. Do you believe you are currently suffering from religious trauma? (see definition)

Step 3: CM / BS, Spiritual History - Obtain youth's informed consent to proceed. If youth completed the spiritual screen and declined the spiritual history, proceed to the SRTST. Otherwise, proceed with the spiritual history interview. Do not read the questions, instead, ask them in a conversational way. Ask the following questions and record youth's responses:

1. What gives your life meaning?
2. What are your sources of hope, comfort, strength, and connection?
3. Do you have spiritual/religious beliefs or values that help you cope when you feel angry, anxious, or afraid?
4. Are you part of a religious/spiritual community?
 - a. If "yes" ask: How does this community support you?
 - b. If "no" ask: Is there a group of people who are really important to you?
Who are they and what makes them important to you?
5. How have your beliefs or values been influenced while in placement?

6. Which parts of your spirituality are most helpful to you personally? (prayer, meditation, time in nature, singing, dancing)
7. Are there any specific practices or restrictions we should know about in providing your spiritual care? (dietary, prayer space/time)
8. What do you need, want, or expect from the BCH Spiritual Wellness team?

Specifically offer individual sessions with the chaplain, participation in groups/workshops on campus, connection with a faith/spiritual community off campus, supplies and/or resources, and advocacy. Note any additional requests from the youth.

Step 4: CM / BS, Shepley Religious Trauma Screening Tool - Obtain youth's informed consent to proceed. If youth completed the spiritual history interview and declined the SRTST, proceed to Step 5. Otherwise, proceed with the SRTST. Provide youth with a printed copy of the SRTST self-reporting form. Explain the form, answer any questions the youth may have, and remind them they do not have to answer a question if they choose not to. Allow enough time for the youth to answer the screening questions and process any thoughts or feelings that might come up during the screen, ensuring the youth is presenting at a safe baseline before departing. When the youth has completed the SRTST, record your own clinical observations of each portion and proceed to Step 5.

Step 5: CM / BS + Compliance Team + Chaplain, Follow-up and Standards

Compliance - First, CM / BS schedules the youth for a spiritual assessment interview with the chaplain if one of the following applies: a. Youth has a positive religious trauma screen, b. Youth indicates a need, want, or expectation to meet with the chaplain, c. CM / BS determines that further assessment is needed. CM / BS has the ability to refer the youth for additional spiritual

assessment regardless of the SRTST results. CM / BS obtains youth's informed consent to schedule the spiritual assessment interview. **Second**, CM / BS forwards youth's responses and assessor's notes to the chaplain.

If the youth declines to participate in a spiritual assessment interview, the chaplain should a. analyze the available information, add their own notes, and forward the full spiritual assessment, including each portion, to the CM / Compliance team; b. consider their option to refer the youth for specific counseling with their therapeutic team, regardless of the results of the SRTST, if other responses and/or observations in either portion warrant the referral; and make necessary referrals. If the youth agrees to participate in the spiritual assessment interview, the chaplain proceeds to Step 6. **Third**, a member of the CM / Compliance team completes tracking for Joint Commission performance improvement goals.

Step 6: Chaplain, Spiritual Assessment Interview - When the youth arrives, again obtain their informed consent to participate. Consistently search for youth's strengths. **First**, engage the youth in a conversation regarding their spiritual screen, spiritual history, and results from the SRTST. Ask questions to build on what the youth has already shared and to bridge information gaps from the screens and history. Elaborate on the youth's perception of the importance of their spirituality/religion, the role of beliefs, practices, community in their personal healing and growth, and the spectrum of positive/negative impacts of religion/spirituality on the youth's life. **Second**, invite the youth to complete a culture sketch using the ADDRESSING framework. **Third**, try to identify any gaps in the youth's access to their spiritual beliefs, materials and resources, or community. **Fourth**, confirm specific practices or restrictions we should be aware of as the youth's care team. Confirm the youth's needs, wants, and/or expectations of their spiritual care team. **Finally**, the chaplain should a. analyze the

available information, add their own notes, and forward the full spiritual assessment, including each portion, to the CM / Compliance team; b. consider their option to refer the youth for specific counseling with their therapeutic team, regardless of the results of the SRTST, if other responses and/or observations in either portion warrant the referral; and make necessary referrals. If referring youth for additional trauma assessment or specific counseling with their therapeutic care team, inform youth you are taking this step.

Chapter 5: Next Steps

During a webinar developed for the Global Center for Religious Research, Gill Harvey explained that as a child her behaviors were manipulated via fear (strictness) and the threat of going to hell. She talked about the fundamentalist perspective of her family's faith community that was driven by fear and shame, and perpetuated a narrative that "you are a sinner before you are ever loved."³⁹⁸ Harvey was raised in the Welsh Revival tradition and speaks out about the power and control dynamics of growing up in an Abrahamic faith tradition.³⁹⁹ Harvey discussed her adverse religious experiences within the context of a fundamentalist family system in which the relationship between parents and children is hierarchical beginning with God, then the father, then the mother, and finally the children.

The hierarchical nature of the family/faith system contributed to Harvey's belief that it was her church versus the rest of the world, and the suppression of her critical thinking skills.⁴⁰⁰ She often felt scared or anxious in social situations, including school where she never felt a sense of belonging.⁴⁰¹ And she was often told, "because God says so" in response to her questions about following certain rules or expectations.⁴⁰² Because Harvey's parents were raised in the same church, they imposed this intergenerational trauma on her and set high standards for her behavior.⁴⁰³ She understood that she had to be absolutely obedient to her parents and the church, or else she would be punished. Her parents' threats of punishment and fear mongering were constant reminders that hell was not metaphorical, but rather a very real place where she might

³⁹⁸ Harvey, Gill. "Developmental Religious Trauma in the Familial Setting: Imagination or Experience." *Religious Trauma Studies*. Lecture, 2023.

³⁹⁹ Ibid.

⁴⁰⁰ Ibid.

⁴⁰¹ Ibid.

⁴⁰² Ibid.

⁴⁰³ Ibid.

end up.⁴⁰⁴ She cited the delayed development of her critical thinking skills as a major obstacle to overcome during her healing and recovery.⁴⁰⁵ Today, Gill Harvey holds a doctorate in psychology and researches developmental religious trauma in the familial setting.

This project attempted to explore spiritual assessments further due to observations made during my work as a chaplain for youth in placement, where I identified the presence of adverse religious experiences and religious trauma, along with a noted gap in available screening tools. This chapter reviews the highlights from each previous chapter and presents potential next steps in this line of research on religious trauma and assessment methods. The end of the chapter presents my theological reflection on what I have learned during this project.

In chapter one, my research question asked, of current spiritual assessments, a. how are they screening for adverse religious experiences and religious trauma, b. how are they trauma-informed or not, c. how are they addressing experiences of intersectionality or not? My State of the Field section provided the reader with an understanding of the emerging field of religious trauma studies and research. This section highlighted the field's challenges with defining the concept of religious trauma (vs spiritual abuse or religious trauma syndrome) and offered some insights into how adverse religious experiences manifest as religious trauma through stress, anxiety, fear, depression, shame, and nightmares.

Chapter two indicated that my project would primarily contribute to evidence-based, trauma-informed approaches in clinical settings. The Literature Review explored major conversation partners in several subgroups. First, I explored those related to trauma theory and adverse religious experiences or religious trauma. These sources included Bloom's input on how

⁴⁰⁴ Ibid.

⁴⁰⁵ Ibid.

to create “sane societies” through shared communal practices and a shared anchoring moral system that values safety, emotional intelligence, and social learning. Next, I explored personal stories of AREs and RT as an additional foundation to understanding how and where religious trauma happens and what people are doing in response. These stories have shown up throughout this dissertation and were a major component of my research method. I then included sources related to intersectionality, such as Pamela Hays and the ADDRESSING framework. Finally, I explored sources related to spiritual assessments, and paid close attention to those related to the assessments I surveyed. These sources provided additional insight into my survey of assessments that is presented in chapter four.

In chapter three, I presented my research process as an essay that explored evolutionary changes to the praxis and content recommendations of a spiritual assessment. This chapter provided a brief overview of the evolution of spiritual screening tools and explored the utilization of spiritual assessments in chaplaincy, healthcare, counseling, and social work. I discussed various rationales for conducting a spiritual assessment, jurisdictional matters, timing of the assessment, and a range of assessor competencies. In this chapter, I also outlined contemporary recommendations for how various professionals define “spiritual assessment” and perform assessments and interviews in order to better understand how a spiritual assessment procedure could be conducted in child welfare settings. And since I knew I wanted to develop a resource that would screen for religious trauma, this chapter specifically explored current evidence-based practices for administering trauma screens and made the case for the importance of self-reporting options.

Chapter four showcased what I did with what I learned - the Shepley Religious Trauma Screening Tool and a step-by-step procedure for including the SRTST in a full spiritual

assessment were presented here. Pulling from the fields of counseling and social work, I adapted a combination of Hodge's and Richards and Bergin's conceptual reasons for conducting a spiritual assessment to help me develop a spiritual assessment procedure for direct application to clinical practices in my context at Bethany and in similar settings. I presented the competencies of the ideal assessor for the SRTST, including specific recommendations for the therapeutic milieu. I also shared a checklist of content recommendations by which to check the spiritual assessments I surveyed and presented each assessment survey, along with the survey conclusions.

Further Research on Religious Trauma

As an understudied field of research, many steps must be taken to advance our efforts to collect relevant data on religious trauma and effective screening tools. My State of the Field included a direct call to action for those involved in these intersecting fields to contribute to the research on AREs and RT, and I echo that call to others. An overwhelming majority of people in the U.S. believe we are currently experiencing a national mental health crisis, according to a new survey from CNN in partnership with the Kaiser Family Foundation. While we might be tempted to cite the COVID-19 pandemic as a reason for the increase in mental illness, the literature reveals another story that indicates our country was heading towards our current crisis before the pandemic began. Nine out of ten adults reported they believe the mental health crisis is real and more than half identified mental health issues in children and teenagers as a specific major concern, especially the increase of suicide mortality in youth.⁴⁰⁶ Considering what I have

⁴⁰⁶ McPhillips, Deirdre. "90% of US Adults Say Mental Health Is a Crisis in the United States, CNN/KFF Poll Finds," CNN, October 5, 2022, <https://www.cnn.com/2022/10/05/health/cnn-kff-mental-health-poll-wellness/index.html>.

presented here on religious trauma, my hypothesis that RT is contributing to the crisis is not far reaching. We simply do not have the empirical data to support it yet.

Slade, Anderson, and Drumsta continue their efforts to increase awareness of the concept of religious trauma and have just in the last two years begun to collect empirical data from those suffering from AREs or RT. Their research, among others, indicates a direct correlation between PTSD or Complex PTSD and religious trauma. The literature regarding this correlation, including personal stories, is heavily anecdotal and based primarily on individual observations. Certainly not everyone who suffers from RT will live with PTSD, so how many people do? How common is this diagnosis in RT survivors and what combination of treatment models is effective? I would like to see a progression of study on the correlation between RT and PTSD and effective treatment planning.

Slade, et.al. made a special note in their sociological study on those suffering from religious trauma. The team recognized what I have often observed in youth during spiritual assessments; that RT can occur from mere exposure to Christocentric sociocultural influences, even without direct indoctrination. While the U.S. claims a pluralistic religious landscape, the nation presents as highly Christocentric - centering Jesus Christ in politics, entertainment, and supposedly secular values. The young people who come to Bethany are largely unchurched and many of them have never had direct experiences with a religious community; yet they consistently present with shame, fear, anxiety, and nightmares resulting from exposure to Christian ideals in one form or another. I hypothesize that many of these youth are suffering from “hell trauma,” or trauma resulting from receiving constant and consistent messaging that the youth is inherently bad/sinful and unless they can do better, they will spend eternity in the fiery landscape of hell. I did not include a question in the SRTST that addresses adverse

experiences that could lead to suffering from hell trauma, though additional research is needed to better understand how hell trauma happens within unchurched, non-religious communities and the lasting impacts of those AREs on children and youth populations.

A next step in this line of research would be to correlate effective treatment models with effective screening tools to help us better understand how to *respond* to AREs and RT. This could be done by collecting data within our setting at BCH and from clinicians, chaplains, and social workers who are using the tool in their praxis of care. The Shepley Religious Trauma Screening Tool has already been implemented as part of our full spiritual assessment procedure at Bethany Children's Home. Further work involves identifying counselors and chaplains and inviting them to begin using the screening tool in their assessment practices. Additionally, it involves partnerships with other behavioral health and child welfare agencies in order to get the SRTST into practice in a variety of settings that could provide significant insight into a youth population's presentation of RT symptoms and effective treatment planning.

In my own setting, more work is needed to continue building an infrastructure at Bethany that can support the type of data collection in which I am interested. This includes creating buy-in from team members and outlining additional roles and responsibilities for data tracking. Further, we need to identify exactly the data we want to collect from the use of the SRTST and decide how that data might be used in additional research and development in the field of religious trauma studies. I have identified four potential areas in which data could be collected from participating practitioners and agencies:

1. Where is the SRTST being used? In which settings and by which professionals?
2. For which populations is the SRTST being used? Is it effective at identifying AREs and RT across religious/spiritual communities and secular/unchurched

communities? Is it effective across cultural groups? In which cultural groups is the tool effective?

3. How did the SRTST inform the assessor's approach to developing treatment options?
4. What is the frequency of positive and negative screens?

As a relatively new wave in psychotherapeutic counseling and psychospiritual care, assessing for religious trauma will require buy-in from practitioners and agencies, as each will need additional education/awareness and professional training/development to conduct the SRTST as part of a full spiritual or trauma assessment. Additionally, those practitioners and agencies will need to understand the value of the data collection process and commit to the established steps to report data collection. I will continue to train our clinical team at BCH to recognize AREs and religious trauma through our screening and assessment procedure.

The clinical team has participated in two professional development sessions which are currently mandated training sessions for our clinical teams. First, they learned how to conduct a spiritual screen, spiritual history, and the SRTST and the roles and responsibilities of each team member in the spiritual assessment procedure. Second, the clinical team completed a workshop on recognizing and responding to AREs and RT. This session included a deeper dive into the concept of religious trauma, RT symptoms, and recommendations for treatment planning based on the shallow pool of research available. These same training sessions could be offered to individual practitioners and agencies who agree to use the SRTST and participate in data collection.

Congregational Life and Religious Trauma

One question lingered as I completed this research project. How does this pertain to congregational life? Particularly, why is it not standard practice to conduct spiritual assessments in congregational life? The answer might seem obvious. Clergy likely assume they know their parishioners' beliefs and how those beliefs impact their daily lives. Unlike parishioners' medical doctors or therapists, clergy tend to become more intimately involved in people's lives. Clergy are present at births, marriages, milestone celebrations, and deaths. They hear parishioners' secrets and their fears and help them sort through joys and concerns. So, what purpose would a spiritual assessment serve?

I recently attended a ministerial training session through Penn Central Conference of the UCC on how to incorporate a trauma-informed approach into congregational life. I was excited to see so many of my clergy colleagues show up to engage with the trauma-informed approach. I felt hopeful that more of us might begin to recognize the prevalence of trauma in our faith communities and want to explore theological and psychological responses to help us help our congregations heal from their individual and communal trauma wounds. Blending a trauma-informed approach with my theology of ministry was a natural, organic process for me; likely because I learned about trauma theory before I learned how to be pastoral and brought the trauma-informed approach with me as I developed my theology of ministry. I hope that my research speaks to these ministers who are interested in incorporating a trauma-informed approach into their theology of ministry.

Sometimes, the Church behaves exceptionally well, and other times it simply does not. Considering intergenerational trauma and vicarious trauma is common in congregational settings, faith communities need to be able to hear stories of RT without becoming defensive or

frustrated.⁴⁰⁷ I believe the Church has a responsibility to recognize the harm inflicted on individuals and communities, directly and indirectly, and that clergy have the power to initiate a process of healing and reconciliation within faith communities. The mental health crisis survey conducted by CNN reported that 39% of adults think churches and other religious organizations should play a major role in addressing mental health problems.⁴⁰⁸ This might speak to the broader mental health issues parishioners experience and the types of services they want to receive in church settings. To me, this specifically speaks to the need for clergy to lean into a trauma-informed psychospiritual approach to explore the lived experiences of parishioners who could be suffering from religious trauma. This includes teaching congregations about emotional intelligence, social emotional learning, and trauma response skills.

My project offers a screening tool and procedure for using the tool in trauma-informed clinical settings; however, I invite clergy serving in local churches to pay special attention to the rationale for conducting these screens. With the insight gleaned, perhaps clergy and lay leaders will begin to recognize how attitudes, behaviors, and beliefs in local churches can negatively impact people and evolve into a community of preventers of religious trauma. Local pastors could begin to incorporate a spiritual assessment procedure, including the Shepley Religious Trauma Screen, into their pastoral counseling with parishioners. Sue argues that the multicultural psychotherapist must also be a social justice advocate;⁴⁰⁹ I argue that the pastor, who is often a social justice advocate, must also become a trauma-informed, culturally responsive counselor to meet the needs of parishioners.

⁴⁰⁷ Harvey, Gill. "Developmental Religious Trauma in the Familial Setting: Imagination or Experience." *Religious Trauma Studies*. Lecture, 2023.

⁴⁰⁸ McPhillips, Deidre. "90% of US Adults Say Mental Health Is a Crisis in the United States, CNN/KFF Poll Finds," CNN, October 5, 2022, <https://www.cnn.com/2022/10/05/health/cnn-kff-mental-health-poll-wellness/index.html>.

⁴⁰⁹ Sue, Derald Wing. *Counseling the Culturally Diverse: Theory and Practice*. United Kingdom: Wiley, 2022.

Throughout this research, I became more interested in how someone might begin to reclaim spiritual practices that were at play in the adverse or traumatic experience. Very few of my major conversation partners mentioned how to support survivors of RT who want to remain in their religious/spiritual community, or one similar. Not all people who have AREs or RT leave their religion or spirituality. So, for those who want to stay, when is it appropriate and how might clergy help reclaim these protective factors? When prayer, or even the concept of prayer, is used to harm people, i.e. “pray away the gay” what are the steps for an LGBTQ+ youth to begin to trust and feel safe with prayer as a protective factor? When religious people and communities use holy scriptures to justify harmful attitudes and behaviors, what becomes the role of scripture in the recovery of those harmed? How can clergy reintegrate faith and spirituality into the lives of people who experienced tremendous harm through their faith community?

If clergy at large have not yet figured out how to respond safely and effectively to parishioners who are suffering from religious trauma, then we cannot be surprised by the decline of organized religion in the U.S., as I see a direct correlation between the two and theorize this is one of many factors contributing to the decline. While 90% of U.S. adults believe we are experiencing a national mental health crisis, approximately 65% believe people are suffering from religious trauma. The social media hashtag *#exvangelical* was coined by Blake Chastain in 2016, the same time that we saw an influx of podcasts and articles discussing the Evangelical Christian community and its mass exodus after Donald Trump was elected to the presidency.

For progressive Christian people, it might be tempting to assign the problem to strict, authoritarian communities who are “not like us.” However, we must remember that people outside of our specific faith communities do not necessarily distinguish between denominational lines or recognize our denominational nuances. For many people, Christians are Christians and

our respective beliefs and practices become blurred or conflated into one Christian community. It seems obvious to me that when people are harmed by religiosity, they are less likely to participate in religiosity. Additional research to determine the impact of AREs or RT on the decline of religion in the United States is crucial, particularly at this moment. If we take seriously the mental health crisis and equally as seriously our faithful response to the crisis, then perhaps the Church could experience a renaissance of sorts - a new flourishing in which the shared practices of the faith community are dedicated to overall safety and the anchoring moral system of the organized group leads the wider community to function as a “sane society.”

Conclusion

In summary, a religious trauma screening tool could be significant in congregational life for several reasons. A screening tool could help identify individuals who have experienced religious trauma within the congregation and this awareness would allow the community to offer appropriate support and resources to those in need. Additionally, by identifying potential sources of trauma, congregational leaders could take proactive steps to address harmful practices, beliefs, or dynamics within the community. This would help prevent further harm and promote a healthier religious environment for everyone.

My research indicates religious trauma can have significant impacts on mental health and well-being. A screening tool would help congregational leaders better understand the mental health needs of their parishioners and provide appropriate resources, referrals, or interventions to support recovery and resilience. Implementing a screening tool also signals a commitment to addressing religious trauma within the congregation. It provides an opportunity for education and awareness-building around the impacts of religious trauma, reducing stigma, and fostering a culture of empathy and support. By acknowledging and addressing religious trauma,

congregational leaders demonstrate care and concern for the well-being of all members, fostering a sense of belonging and trust within the community. This can strengthen bonds and promote a more inclusive and supportive religious community. As stated, clergy can easily include the SRTST into their praxis of pastoral care and counseling.

The Shepley Religious Trauma Screening Tool also integrates easily into a spiritual assessment or trauma screening procedure for chaplains, counselors, and those in the child welfare field. Chaplains in behavioral healthcare settings play a particularly crucial role in supporting patients' spiritual and emotional well-being. Many youth in behavioral healthcare settings have experienced trauma, including religious trauma. The SRTST helps chaplains and counselors identify potential trauma triggers related to religion or spirituality, allowing them to provide sensitive and appropriate support. Understanding if a person has experienced religious trauma informs chaplains about specific aspects of spiritual care to emphasize or approach with caution, ensuring their interventions are supportive rather than triggering. Chaplains generally strive to create a safe and supportive environment for patients. By being aware of religious trauma through use of the SRTST, chaplains can avoid inadvertently re-traumatizing patients through insensitive or triggering spiritual interventions.

Addressing religious trauma requires trust and rapport between patients and chaplains in behavioral healthcare and beyond. By acknowledging and validating patients' experiences through a screening tool, chaplains demonstrate empathy and understanding, fostering a therapeutic relationship built on trust. Behavioral healthcare is often multidisciplinary, involving collaboration among various professionals. When included as part of a full spiritual assessment, the SRTST enables chaplains to communicate effectively with other members of the treatment team, ensuring that spiritual care aligns with patients' overall treatment plans and goals. This also

contributes to the holistic care that is needed by survivors of religious trauma. Addressing religious trauma is integral to patients' healing and recovery journeys. Chaplains equipped with the Shepley Religious Trauma Screening Tool can provide tailored support and interventions that facilitate patients' spiritual healing, contributing to their overall well-being and recovery.

Appendix A: The Shepley Religious Trauma Screening Tool

Shepley Religious Trauma Screening Tool (SRTST)

The SRTST questions are intended to help chaplains, counselors, and other child welfare professionals elicit information from children and youth that is directly related to their adverse religious experiences and/or symptoms of religious trauma. The tool is intended for use as a trauma screening component of a full spiritual assessment and/or trauma assessment. The assessor can refer the youth for additional spiritual/trauma assessment regardless of the screening tool's findings.

Information

Youth Name	Pronouns	Youth Date of Birth
Cottage/Program		
Team Member Name	Team Member Signature	Date SRTST Completed

Instructions

Read the definitions below. Read each question and circle "Yes" or "No." It is okay to leave questions unanswered. Responding "Yes" to any one question warrants a more detailed assessment.

Definitions

Adverse Religious Experiences (AREs)	Any experience of a religious belief, practice, or structure that undermines an individual's sense of safety or autonomy and/or negatively impacts their physical, social, emotional, relational, sexual, or psychological well-being. ¹ AREs are generally categorized as resulting from three types of experiences that occur within a religious group or related to a set of religious beliefs: abusive , neglectful , and communal practices (forced confessions, shunning and/or excommunication, social isolation, behavior control, and forced ritual performance).
Religious Trauma (RT)	Refers to the lasting adverse effects on a person's physical, social, emotional, relational, sexual, or psychological well-being after an ARE has occurred. ²
Religious Trauma Symptoms	Lasting adverse effects on a person's well-being, resulting from AREs, commonly manifesting as: anxiety, stress, fear, depression, shame, and nightmares. ³

¹ Slade, Darren M., Adrianna Smell, Elizabeth Wilson, and Rebekah Drumsta. "Percentage of U.S. Adults Suffering from Religious Trauma: A Sociological Study." *Socio-Historical Examination of Religion and Ministry* 5, no. 1 (2023): 1–28.
<https://doi.org/10.33929/sherm.2023.vol5.no1.01>.

² Ibid.

³ Ibid.

Questions

Have you ever experienced abuse (verbal, physical, emotional, sexual, other) in a religious setting or by a religious authority figure?	Yes	No
Do you ever feel triggered (anxiety, stress, fear, anger) when you think about going to a religious event, being around religious people, or being in a religious setting (church, synagogue, temple)?	Yes	No
Have you ever been forced to "choose sides" concerning a religious leader, belief, person, or situation? (Ex: certain lifestyles as sinful or not)	Yes	No
Does being near a pastor, religious leader, church or religious building, or religious materials ever make you feel anxious, stressed, afraid, or angry?	Yes	No
In a religious setting or by a religious leader, have you ever been shamed or humiliated?	Yes	No
Because of religious pressure, have you treated other people in a way that you now regret?	Yes	No
Have you ever been excluded, expelled, or shunned from a religious community?	Yes	No
Do your past religious experiences keep you from attending or participating in a religious environment or group?	Yes	No
To fit in or avoid trouble, have you ever "gone along with" religious activities or practices with which you did not agree or feel comfortable?	Yes	No
Have you ever been harshly criticized, scolded, or made to feel ashamed by a religious leader, in a religious setting, or by other religious people?	Yes	No
Have you ever thought God does not love or accept you because of what you were told in a religious setting, by a religious leader or religious people?	Yes	No
Have you ever felt like you had to hide your true self in religious settings or around religious people?	Yes	No
Do you ever experience nightmares, night terrors, or other sleep disturbances because of what you've been told or experienced in religious settings, with religious people, or from religious beliefs?	Yes	No
Have you ever felt like you couldn't live up to the expectations of a religious leader, person, or group?	Yes	No
Have religious messages, religious beliefs, or religious people ever caused you to feel afraid of damnation (spiritual eternity in hell)?	Yes	No
Do you often worry about being forgiven for your childhood actions, behaviors, attitudes, or beliefs?	Yes	No
Do you ever engage in self-harm, violence, or suicidal ideation because of your thoughts or feelings about religion/spirituality?	Yes	No
Do you ever use drugs or alcohol to cope with your thoughts or feelings about religion/spirituality?	Yes	No
Has your family system or social support network ever been disrupted because of religious beliefs or practices, or because of a religious person or group?	Yes	No
Do you feel lonely or misunderstood because of your experiences in a religious setting or with religious people?	Yes	No

Appendix B: Bethany Children’s Home Spiritual Assessment Procedure

Document Title:	Procedure: Conducting a Spiritual Assessment
Effective Date:	02.12.2024
Version #	V 1.0
Standard:	3800 Regulations; JC: Care, Treatment, and Services; BCH Standard

Purpose:

Bethany Children’s Home Conducting a Spiritual Assessment procedure is written to conduct a complete spiritual assessment with each youth during the intake process and to help the Chaplain evaluate the youth’s spiritual assessment in the context of the youth’s presenting clinical issues and/or any related diagnoses. The complete spiritual assessment includes a spiritual screen, spiritual history, the Shepley Religious Trauma Screening Tool (SRTST), and spiritual assessment interview. A Case Manager or Clinician is responsible for conducting the spiritual screen, spiritual history, and SRTST portions within 3 business days. The Chaplain is responsible for completing the spiritual assessment within 30 days of intake if screening is deemed applicable. It is everyone’s role at BCH to maintain the safety of all youth. A Spiritual Safety Assessor can help provide additional direction related to safety concerns.

1.0 Spiritual Safety Assessor (SSA)

- 1.1 This is a team member who has received additional Bethany Children’s Home training specific to identifying safety concerns related to adverse religious experiences, religious trauma, self-harm, suicidal and homicidal thoughts, plans or intentions. These team members are currently Case Managers, Clinicians, and the Chaplain. All SSAs can complete the spiritual screen, spiritual history, and SRTST. Only the Chaplain is qualified to conduct the spiritual assessment.
- 1.2 They support youth by identifying their spiritual wellness needs and how the assessor can assist and develop a plan of action.
- 1.3 They connect with the youth in a calm and nurturing manner.
- 1.4 They provide psychoeducation and receive informed consent.
- 1.5 They clarify the extent of the spiritual safety concern.
- 1.6 They provide guidance related to next steps.
- 1.7 They can refer the youth for additional spiritual and/or trauma assessment regardless of screening outcomes.
- 1.8 They complete the Spiritual Assessment Checklist.
- 1.9 They ensure tracking is completed for performance improvement.

2.0 Adverse Religious Experiences (AREs) and Religious Trauma (RT)

- 2.1 Adverse Religious Experiences (AREs) are any experience of a religious belief, practice, or structure that undermines an individual's sense of safety or autonomy and/or negatively impacts their physical, social, emotional, relational, sexual, or psychological well-being.
 - 2.1.1 AREs are generally categorized as resulting from three types of experiences that occur within a religious group or related to a set of religious beliefs: abusive, neglectful, and communal practices (forced confessions, shunning and/or excommunication, social isolation, behavior control, and forced ritual performance).
- 2.2 Religious Trauma (RT) refers to the lasting adverse effects on a person's physical, social, emotional, relational, sexual, or psychological well-being after an ARE has occurred.
 - 2.2.1 Religious Trauma Symptoms are lasting adverse effects on a person's well-being, resulting from AREs, commonly manifesting as: *anxiety, stress, fear, depression, shame, and nightmares*.

3.0 Psychoeducation & Informed Consent

- 3.1 A Spiritual Safety Assessor should provide youth with information to help them understand the steps within this procedure, ensuring they understand what happens with a positive religious trauma screen.
 - 3.1.1 Inform youth of why specific questions are asked.
 - 3.1.2 Be prepared to review relevant definitions and concepts throughout each portion.
 - 3.1.3 Receive youth's informed consent to participate in each portion of the assessment.
 - 3.1.4 Ensure youth understands their rights to decline to participate in each portion of the spiritual assessment and provide simple declination option through the Spiritual Assessment Checklist.

4.0 Spiritual Assessment Checklist

- 4.1 Includes each portion of the spiritual assessment and notes whether the youth provided informed consent to participate in each respective portion or declined to participate.
- 4.2 If a youth declines to participate in any portion of the spiritual assessment the SSA checks the corresponding box on the Spiritual Assessment Checklist.
- 4.3 SSA should complete their respective portions on the checklist, sign and date, and include in documentation shared with interdisciplinary team at each pass.
- 4.4 Checklist goes in youth's file with any completed documentation from the assessment.

5.0 Spiritual Screen

- 5.1 SSA should obtain youth's informed consent and proceed with the spiritual screen.
- 5.2 If youth completed spiritual screen but declined the spiritual history, proceed to section 7.0. Otherwise, continue to section 6.0 and conduct the spiritual history.

6.0 Spiritual History

- 6.1 SSA should obtain youth's informed consent and proceed with spiritual history.
- 6.2 If youth completed the spiritual history interview and declined the SRTST, proceed to section 8.0. Otherwise, proceed with the SRTST.

7.0 Shepley Religious Trauma Screening Tool (SRTST)

- 7.1 SSA should obtain youth's informed consent and proceed with SRTST.
 - 7.1.1 Provide youth with a printed copy of the SRTST self-reporting form. Form can be found:
 - 7.1.1.1 Shared drive: Cottage Binder/Forms
 - 7.1.2 Explain the form, answer any questions the youth may have.
 - 7.1.3 Explain what happens if the youth has a positive RT screen:
 - 7.1.3.1 Youth with a positive RT screen should be encouraged to participate in the spiritual assessment interview to discuss their results.
 - 7.1.3.2 The Chaplain will analyze all completed portions of the screening/assessment to formulate next steps, including referrals for additional trauma assessment or specific counseling with therapeutic care team.
 - 7.1.4 Remind them they do not have to answer a question if they choose not to.
 - 7.1.5 Allow enough time for the youth to answer the screening questions and process any thoughts or feelings that might come up during the screening, ensuring the youth is presenting at a safe baseline before departing.
 - 7.1.6 When the youth has completed the SRTST, record your own clinical observations of each portion and proceed to section 8.0.

8.0 Follow-up

- 8.1 SSA schedules the youth for a spiritual assessment interview with the chaplain if one of the following applies:
 - 8.1.1 Youth has a positive religious trauma screen,
 - 8.1.2 Youth indicates a need, want, or expectation to meet with the chaplain,

- 8.1.3 SSA determines that further assessment is needed. SSA has the ability to refer the youth for additional spiritual and/or trauma assessment regardless of the SRTST results.
- 8.2 SSA schedules the spiritual assessment interview with the chaplain.
- 8.3 SSA forwards youth's responses and assessor's notes from each completed portion to the chaplain.
- 8.4 If youth agreed to participate in the spiritual assessment interview, the chaplain proceeds to 9.0.
- 8.5 If the youth declined to participate in a spiritual assessment interview, the chaplain should:
 - 8.5.1 Analyze the available information, add their own notes, and forward the full spiritual assessment, including each portion, to the youth's Case Manager.
 - 8.5.1.1 Case Manager ensures the spiritual assessment is added to the youth's file.
 - 8.5.1.1.1 Case Aid completes necessary filing.
 - 8.5.1.2 Case Manager ensures performance improvement tracking is completed.
 - 8.5.1.2.1 Case Aid completes performance improvement tracking.
 - 8.5.2 Consider their option to refer the youth for specific counseling with their therapeutic team, regardless of the results of the SRTST, if other responses and/or observations in either portion warrant the referral; and make necessary referrals.

9.0 Spiritual Assessment Interview

- 9.1 Chaplain should obtain youth's informed consent and proceed with interview:
 - 9.1.1 Consistently search for youth's strengths.
 - 9.1.2 Engage the youth in a conversation regarding their spiritual screen, spiritual history, and results from the SRTST.
 - 9.1.2.1 Ask questions to build on what the youth has already shared and to bridge information gaps from the screens and history.
 - 9.1.2.2 Elaborate on the youth's perception of the importance of their spirituality/religion, the role of beliefs, practices, community in their personal healing and growth, and the spectrum of positive/negative impacts of religion/spirituality on the youth's life.
 - 9.1.2.3 Confirm specific practices or restrictions we should be aware of as the youth's care team.

- 9.1.2.4 Confirm the youth's needs, wants, and/or expectations of their spiritual care team.
- 9.2 Chaplain should invite the youth to complete a culture sketch using the ADDRESSING framework.
 - 9.2.1 Chaplain should fill in any information already received through referral or intake documents, SSA's screening notes, and/or conversations with the youth.
 - 9.2.2 Ask additional questions in a casual conversational manner to help the youth share their lived experiences from their own perspective to glean additional information specific to the youth's cultural identities.
 - 9.2.3 Consider the youth's culture sketch while analyzing the spiritual assessment and formulating next steps or treatment options.
- 9.3 Chaplain should try to identify any gaps in the youth's access to their spiritual beliefs, materials and resources, or community.
- 9.4 Chaplain should analyze the available information, including the youth's Health & Safety and culture sketch, add their own notes, and forward the full spiritual assessment, including each portion and the checklist, to the youth's Case Manager.
 - 9.4.1 Chaplain should send Progress Note after initial spiritual assessment and/or any individual sessions with youth.
 - 9.4.2 Case Manager ensures the spiritual assessment is added to the youth's file.
 - 9.4.2.1 Case Aid completes necessary filing.
 - 9.4.3 Case Manager ensures performance improvement tracking is completed.
 - 9.4.3.1 Case Aid completes performance improvement tracking.
- 9.5 Chaplain should consider their option to refer the youth for specific counseling with their therapeutic team, including the chaplain for psychospiritual counseling, regardless of the results of the SRTST, if other responses and/or observations in either portion warrant the referral; and make necessary referrals.
 - 9.5.1 If referring youth for additional trauma assessment or specific counseling with their therapeutic care team, inform youth you are taking this step.
 - 9.5.2 Make referrals through youth's Case Manager.

Revision History:

Revision	Date	Description of changes	Approved By
1.0	01/16/2024	Initial Release	Leadership Team

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