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**FAITH, EARLY LIFE SEXUAL ABUSE, & OLD AGE, ARE THERE
CONNECTIONS?**

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INTRODUCTION/BACKGROUND

The horrific events of September 11, 2001, traumatized all of our communities to various degrees. The immense ramifications and pervasive consequences that these traumatic events are having on our way of life are evidenced in our airports, postal services, workplaces, schools, and homes. Our sense of safety from terrorist attacks and our previously unshakable belief that such devastation could not happen here have been severely eroded. The resulting anxieties, fears, and apprehensions about the future have permeated our daily lives and are potent ingredients for discord, disconnection, and disharmony among communities, families, and individuals. Much is at stake when individuals and communities are traumatized, and a “community as family” approach is offered here as one way to enhance resilience relative to the chronic conditions that trauma often entails.

Trauma following crisis events occurs in national, communal, familial, and personal domains. Whether trauma is associated with a cancer diagnosis, a household fire, sexual abuse, or terrorist acts, the responses to a particular crisis are nuanced and varied. In my research with aging Catholic nuns (heretofore referred to as women religious) who suffered early life sexual abuse, I addressed trauma from a “community as family” approach. In this chapter I describe the application of symbolic interaction theory when interpreting the strengths that helped these participants mitigate the unwelcome effects that they associate with their sexual abuse.

The twelve participants in this study were recruited from an original study conducted by Saint Louis University School of Medicine to determine prevalence rates of

sexual abuse among Catholic women religious (Chibnall, Wolf, & Duckro, 1998). Participants in the follow up study were sexually abused before the age of 18 and at the time of the study were over the age of 65, with a mean age of 74. I explored the variety of later life responses that they associated with early life sexual abuse and their self-reported resilience as aging women religious living in community (Behrman, 2009).

SIGNIFICANCE OF THIS TOPIC

Because 911 transformed our collective experience of trauma there is a pressing need to reevaluate and reassess resilience theories and clinical approaches to healing individuals and communities following trauma (Kaltman & Bonanno, 2003). Working with scarce resources and seeking common ground amidst polarized social, economic, and religious factions, mental health professionals, along with physicians, nurses, teachers, law enforcement officers, and firefighters, share a common goal of serving traumatized individuals, families, and communities, and helping them to achieve and maintain resilience when traumatic events intrude into our lives.

It is both imperative and opportune to be asking, “What are the potential strengths that exist in our communities when facilitating resilience among individuals and families, and how do we recognize and activate these strengths when serving those whose lives are disrupted by trauma?” Such questions are addressed in this chapter by presenting the scaffolding for a “community as family” post-trauma intervention approach. This approach is based upon my professional training and experiences providing critical incident stress debriefings (CISD) (Everly & Mitchell, 1997), clinical work as a licensed social worker, and subsequent research. As the stories of these women religious indicate,

sometimes human service providers overlook strategic community approaches to scaffolding resilience when serving persons with histories of trauma.

LITERATURE REVIEW

Research on resilience has proliferated since World War II (Figley, 1985; Saigh & Bremner, 1999; Walsh, Zautra, & Hall, 2010). Identifying individual and environmental strengths over a lifespan that sustain resilience is an immensely complex process (Rigsby, 1994). “Like stress and coping research, resilience research looks for factors which maintain and protect health” (Bengel, Strittmatter & Willmann, 1999, p. 58). A broad variability exists on individual and community levels in terms of what is needed to be resilient following trauma (Kaplan, 1999; Kemmis & McTaggart, 2000). Defining resilience is both an empirical and a political challenge, with the goal of discovering what lowers the risk of undesirable outcomes following trauma without unjustly or irresponsibly diagnosing persons as pathological who do not fit scientific, cultural, religious, or professional standards of what constitutes successful outcomes. According to Masten (1994), “resilience implies a qualitative evaluation of functioning based substantially on normative expectations for adaptations that vary according to age and environmental contexts (p. 19).” Paying attention to the community context in which the client/family is located is critical when assessing trauma and interpreting resilience.

Crisis events categorized as having the potential to create traumatic effects generally have been defined in a variety of ways, but many social scientists utilize the “trilogy definition” (Kanel, 1999): a highly unexpected event, perceived by the individual (or group) as physically, socially, psychologically, or spiritually life threatening, which overwhelms available coping methods and resources. During the past fifty years,

measuring, recognizing and diagnosing post-crisis bio-psycho-social-spiritual effects as traumatic have shifted and expanded as indicated in the revisions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV-R (American Psychiatric Association, 2000). Both the literature and the DSM indicate a deeper understanding of the complexity and multiple nuances in measuring, assessing and diagnosing mal-adaptation as traumatic following a crisis event. Research findings on trauma resulting from a crisis event in the areas of epidemiology, phenomenology, neurobiology and treatment are summarized in McFarland & Yehuda (2000).

Studies consistently report that trauma influences individual development in myriad of ways depending upon particular environments and available resources (Alaggia, R. & Michalski, J., 1999; Bell, 2003; Black & Jeffreys, 1993; Graham, 1993; Greenburg & Keane, 1997; Levine, 2001; Pomeroy, Kiam, & Green, 2000). The levels of trauma associated with the effects of sexual abuse are related to the situation of the person who is abused. Environmental context such as available resources, family and professional supports, and the general health condition of the person are some of the factors that influence both manifested effects and treatment outcomes (Kaplan, 1999).

This study does not measure the effects of early life sexual abuse in later life nor is there an attempt to diagnose for trauma, but what is recorded is what these participants identify as unwelcome consequences in old age that they associate with their early life sexual abuse. It is important to understand that early life sexual abuse generally meets criteria as a crisis event with the potential to create a continuum of effects varying in degree of severity. Whether the effects reported by this study's participants can be

assessed as traumatic is a topic for future studies. The scarcity of research regarding the effects of childhood sexual abuse in old age calls for further investigation.

In summary, trauma is a complex and disabling process, which has the potential to create detrimental effects on self-awareness and relationships with others (McFarlane & Bookless, 2001). What is important is both understanding how and why people thrive following a crisis and what constitutes resilience for persons who report successful adaptation. Norman Garmezy (1993), a founder of contemporary research on resilience, states that “resiliency is the extension of competencies in a variety of adaptive behaviors despite a background of high stresses” (Rolf, 1999, p. 7). According to Rutter (1990), resilience refers to “maintaining adaptive functioning in spite of serious risk hazards” (p. 209). For Masten (1994), resilience relates to “how effectiveness in the environment is achieved, sustained or recovered despite adversity (p. 4).” As a concept, resilience “is explicitly, if not tacitly implicit, in almost all explanatory models of behavior ranging from biological to social (Glantz & Sloboda, 1999, p. 110).”

Understanding resilience as the individual’s ability to interact and relate effectively in his/her particular environment assumes that no *a priori* definition of resilience exists separate from the individual’s environmental context and his/her relationships within that context. Indeed, the complexity and diversity of community cohorts and the plurality of social, cultural, and religious structures interact to create subjective interpretations of what qualifies as resilience. However, according to Ungar (2005), a “broad developmental perspective on resilience that can fully account for how (individuals) become resilient in multiple contexts and across cultures has yet to be fully articulated” (p. xvii). Some researchers recommend abandoning any definition for

resilience, yet “some aspects of resilience are so ubiquitous as to appear universal” (Ungar, 2005, p. xix). These essential elements of resilience surface in global studies on health, such as the ability to maintain meaningful relationships and perform essential tasks that enable individuals to transfer from one developmental stage to another (Luthar, 2003).

How one adapts to trauma within his/her environmental context is at the heart of understanding resilience through the lens of the “community as family” approach. The theoretical framework I utilize views resilience more as a verb (relationship) than a noun (characteristics of the person or the environment). The focus is upon relationships between the individual and her environment that have been disrupted by the trauma rather than each examined in isolation from the other. Consistent with a strengths perspective, I understand resilience as “a continuing growth and articulation of capacities, knowledge, insight, and virtues derived through meeting the demands and challenges of one’s world” (Saleebey, 1997, p. 9).

An immense amount of research on post-childhood sexual abuse research, especially relative to children and adolescents, has been conducted (Glantz & Johnson, 1999; McFarlane, 2000; McFarlane & Yehuda, 2000; Walsh, 1998). The prevalence and characteristics of sexual childhood abuse are discussed by Finkelhor, Hotaling, Lewis, and Smith (1990). Polusny and Follette (1995) provide a review of the literature on the consequences of childhood sexual abuse, and Moeller, Bachmann, and Moeller (1993) report the effects of childhood sexual abuse upon women in adulthood. A review of the long term effects of child sexual abuse also can be found in Beitchman et. al. (1992).

Much of this research focuses on the immediate negative developmental impact and/or the impact during adolescence, and early or middle adulthood. Research that is relevant to my study is provided by Moeller et al., (1993), who report a marked loss of hope and meaning among women following childhood sexual abuse that leads to various forms of depression and anxiety in later life. Other studies indicate that there may be a prevalence of destructive behaviors that are harmful to self and society, such as a propensity for enduring and engaging in abusive relationships, various types of substance abuse, and an inability to remain faithful to commitments (Greenwood, Tangolas & Maruta, 1990). All of these symptoms could be the results of an early life sexual abuse (Nash, Hulsey, Sexton, Harralson, & Lambert, 1993). In addition to the behavioral and social outcomes of childhood sexual abuse, the spiritual effects may diminish a belief in a Divine Presence and a mistrust of people in authority in adulthood (Rossetti, 1995; Sipe, 1990).

The finding of various research studies are consistent in suggesting that childhood sexual abuse has the potential to create a wide range of responses during adulthood consisting of 1) emotional dysfunction characterized by depression, poor impulse control, and anxiety disorders; 2) somatic dysfunction such as eating disorders, sleep disturbance, chronic pain, and sexual maladjustment; and 3) social problems such as substance abuse, addictions, violent behaviors, and disrupted relationships (Caplan, 1961; Cole, Benore, Pargament, 2004; Finkelhor, 1994; Hall, Sachs, Rayens & Lutenbacher, 1993; Moeller et al., 1993; Parad, 1965; Parad & Miller, 1963; Polusny & Follette, 1995).

THEORETICAL FRAMEWORK

Linking practice with theory is imperative for being effective when serving individuals and communities who are traumatized (Bengston, Burgess, & Parrott, 1997) . Theory and practice are inexorably connected (Turner, 1996), and the theories we hold within our professional disciplines deeply influences how we interpret data, explain behavior, and design our interventions (Guba & Lincoln, 1986). Three perspectives comprise the foundation for this discussion of resilience following trauma, including the person in environment (PIE), a strengths perspective, and symbolic interaction theory.

The PIE perspective suggests that resilience is deeply embedded in the person's ability to interact effectively and efficiently with his/her environment. People will yield different coping behaviors based upon environmental factors that both impede and enhance resilience (Compton & Galaway, 1989). Thus the focus of assessment and intervention is the interaction of the person with his/her environment, not the individual in isolation from his/her environment or vice versa. Accordingly, consideration is given to cultural, economic, and religious/spiritual characteristics in both the individual and the community that may enhance or diminish a person's resilience

Paying attention to strengths in the environment shifts understandings and interpretations of resilience beyond the individual to include the community as a part of the healing process (Becker, 1997). Sometimes community strengths are concealed and submerged due to harsh economic disparities that diminish transparent strengths. Some socio-economic structures create environments that make it extremely demanding for individuals and families to be resilient following trauma (Marshall, 1995). Further, the use of binary diagnostic labels that divide people and communities into either resilient or non-resilient categories may pathologize individuals and communities, both diminishing

and dismissing their strengths following trauma. This may occur when perceived strengths are solely measured and narrowly defined within normative categories based upon community expectations (Becker, 1997). Indeed, the process of identifying strengths is influenced by who decides what constitutes healthy outcomes and why some behaviors are considered successful adaptation (Garmezy, 1993). These biases are not wrong or necessarily detrimental until they overlook ethnic, cultural, religious, socio-economic, and age factors by narrowly labeling non-normative behaviors as psychopathology (Kaplan, 1999). Non-normative behaviors are not necessarily pathological, and potentially they could be a sign of resilience.

Thirdly, connecting resilience with how a person interacts with his/her community is consistent with a core principle of symbolic interaction theory that creating and maintaining meaning within a particular environment is central to all human relationships (Blumer, 1969; Stryker, 1980). Accordingly, persons and their environments cannot be understood independent of one another. For example, how the participants in my study interpret who they are as Catholic women religious who were sexually abused does “not arise simply from intra-psychic or physiological processes. Rather, they develop through the process of interaction and are shaped, in part, by the views and attitudes that others hold about us” (Robbins, Chatterjee & Canda, 1998, p. 269). The cultural expectations regarding how they self identify and what resilience should look like play a significant role in their coping responses following trauma.

It is essential when assessing and designing interventions to facilitate resilience that the environment’s impact on the individual, as well as the reverse, are considered. According to symbolic interaction theory, people are actively engaged with their

environment when interpreting trauma and making choices to resolve problems that they associate with this crisis (Longress, 2000). They are interpreting the trauma through the lens of their community's beliefs about what it means to be resilient and what roles people must assume in order to be considered resilient. A community that overtly values work as a primary role will claim that a person is being resilient when he/she returns to work.

The concept of role is central to symbolic interaction theory (Longress, 2000). According to Robbins et. al. (1998, p. 269), "A role is a social category or position with a set of expected behavior patterns. Roles do not exist in isolation and are defined by their relationship to one another." Persons who experience trauma often undergo tremendous changes in their roles that shape how they interpret themselves in relationship to others. In order to be resilient, individuals re-negotiate and re-interpret what a crisis event means within their communities when faced with the task of maintaining or creating new roles following the trauma (Becker, 1997). When utilizing symbolic interaction theory, attention is given to the subjective interpretation of an event within particular environments. Noticing what the community and the individual believe and value about resilience are paramount to designing assessments and shaping interventions (Stryker & Stratham, 1985).

A crisis event such as sexual abuse has the ability to disrupt meaningful relationships, and subsequently there can be fragmentation of self and alienation from the person's roles in the community (Becker, 1997). In order to be resilient, individuals must re-negotiate and re-interpret what this event means within the order established by community norms. Each is faced with the task of maintaining or creating new roles that

will enhance the possibilities for experiencing life in a holistic and meaningful way. Key to mastering this challenge is the capacity to successfully create new relationships with self (identity) and with others (roles) in order to craft meaning and significance within religious, cultural, and social environments (Behrman & Reid, 2002). When this is not possible, often people will remove themselves from those situations and institutions that are obstacles in maintaining or creating meaningful relationships with self and others. In environments where leaving is perceived as being not an option, people will sometimes succumb to various types of disruptive and in some cases, destructive relationships with self and others (Becker, 1997).

RESEARCH FINDINGS

When analyzing the data from my study, the participants clearly reported that they are living in a unique cultural and religious environment, and that the trauma of sexual abuse had an impact upon their identities as well as their relationships with their community. What was expected of them in order to claim resilience was clearly defined by the community (Behrman, 2009). The cultural, social and religious coping behaviors reported by these women religious following early life sexual abuse were organized around a set of beliefs and expectations that were established by the community, which each person identified. Together with her community, each Sister engaged in psycho-social, familial, and spiritual rituals, creating meaning through shared behaviors that made sense within her religious community. Whether it was through prayer, novenas, spiritual direction, or yoga, these women and their communities named the trauma, interpreted the impact, and designed coping behaviors that each believed would enhance

resilience based upon their unique culture. Problems surfaced when interpretations and expectations conflicted.

Some members of the religious communities questioned participants' strategies for being resilient when they perceived these strategies to be non-normative and not what is expected of a member of the particular religious community given their unique interactions with each other (Behrman, 2009). Such perceptions are shaped by what is meaningful or what "makes sense" in a given context: "Meaning and social interaction are interdependent; meaning is shaped in and by interaction, and meaning shapes the course of the interaction" (Stryker & Stratham, 1985, p. 321). Thus, one of the first tasks following trauma is examining and redefining social roles and what is expected of the individual whose role is prescribed by her community.

Social roles are not the only relationships that are negotiated following trauma according to symbolic interaction theory. Thus, "individuals also negotiate their own identities with the situation, that is, how they present themselves. Two working agreements must be reached, one with the self and one with the others in the situation" (Longres, 2000, p. 398). Many of the Sisters reported an identity crisis in adulthood when their religious faith and community no longer could provide the language needed to make sense of their childhood sexual trauma as religious women (Behrman, 2009).

Further, "an important additional implication is that a totally determinant explanatory model of social interaction is not possible...neither interaction nor meaning can be taken as unilateral cause and effect...reciprocal rather than unidirectional causal models are essential" (Stryker & Stratham, 1985, p. 322). This reciprocal relationship is at the heart of symbolic interaction theory, which guides and informs this "community as

family” approach. The roles that a person assumes following trauma and the attempts to create a new personal identity are interacting and informing each other as the individual attempts to create new ways of relating and being with others.

Many of the Sisters spoke about their struggle to find meaning in their adult lives with their histories of sexual abuse (Behrman, 2009). Trauma is a crisis of meaning (Becker, 1997). Our relationships, and the environments in which we function, contain constructed meanings, with both assigned social roles and agreed upon mutual responsibilities. When an unexpected, life-threatening event occurs, overwhelming coping strategies and resources, these roles and constructed meanings shift, and often identities are permanently disrupted. Becoming a widow, being unemployed or diagnosed with cancer, these experiences can leave people vulnerable, overwhelmed, frightened, mistrustful, resentful, and fragmented. A significant majority of participants reported that such experiences surfaced for them in adulthood (Behrman, 2009).

In the case of these women religious, their identities as victims of early life sexual abuse and their social roles as educated, professional women had to be renegotiated as both their own and their community’s interpretations of childhood sexual abuse changed significantly over time. New ways of being contemporary women religious coincided with the dramatic shifts associated with the reforms of the Catholic Church that took place during the 1960s and 1970s (O’Sullivan, 2002). Gradually, and in some situations dramatically, immense changes were introduced that dynamically altered the environments of community religious life and subsequently their social interactions and identities. The outward gestures of removing medieval garb and replacing it with contemporary clothing is just one of many symbols of the inward reinterpretation of what

it means to be a Catholic woman religious in the twenty-first century. What is more, there now existed a safe platform from which to speak about their sexual abuse experiences, and there were new opportunities to integrate and heal some of the lingering effects that they identified as being associated with their early life trauma (Behrman, 2009).

When exploring resilience following trauma, we are investigating what both the person and her community have determined to be expected developmental, orderly levels of functioning, which are being inhibited and thwarted by the trauma. As reported by the participants, these community and individual expectations radically shifted for them following the changes of Vatican II, and this had an immense positive impact on their ability to be resilient.

Another key feature of symbolic interaction theory is the human ability to create symbols that convey meaning (Blumer, 1969). The symbols that are utilized by persons are chosen within environmental contexts that make sense to a particular community. Accordingly, paying attention to the metaphors participants used when describing trauma and resilience informed my methodology and is recommended in the assessment process in clinical contexts as well. What metaphors describe the effects that the trauma is having upon the person and her relationships with her community, and which metaphors depict the ideal outcome that is being sought? Metaphors are pervasive in communicating what we believe to be important and vital in maintaining our community identity and subsequent roles in that community. They are the fundamental structures when trying to make sense of our trauma, embody cultural expectations, and keep life unified and understandable (Lakoff & Johnson, 1980). Studies bear out the role of metaphor in

naming trauma and how language is used in attempts to create meaning out of chaos and disorder (Becker, 1997).

People symbolically represent their experiences of trauma by selecting metaphors familiar to them. Through metaphor, people reinterpret the crisis event in order to recreate meaningful relationships and to socially construct new identities in the community that will usher in a sense of order following trauma's devastating chaos (Becker, 1997). To the degree that they are able to realign their interpretation of what is expected of them in their community they will be identified as resilient and roles will be restored and/or new ones created. The use of narrative and metaphor assist in grasping the complexity of identifying and understanding resilience. How people represent their experiences of trauma through metaphor is a critical component of the "community as family" approach in understanding what is needed to be resilient (Behrman, 2009).

CURRENT ISSUES

America's population is aging at a rapid pace. In 2008, Americans over the age of 65 numbered 38.9 million, an increase of 4.5 million or 13.0% since 1998; one in every eight, or 12.8% of the population, is an older American (Administration on Aging, 2010). Because of this expanding aging population it is imperative for mental health professionals to re-examine and challenge prevalent assumptions about what social roles and identities are most important to people during the later years of life. It is opportune to be identifying resources and approaches that are effective in sustaining and increasing resilience for aging populations (Walker & Salt, 2006).

During the past fifty years, measuring, recognizing and diagnosing post-crisis bio-psycho-social-spiritual effects as traumatic have shifted and expanded as indicated in the

revisions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) IV-R (American Psychiatric Association, 2000). Both the literature and the DSM indicate a deeper understanding of the complexity and multiple nuances in assessing mal-adaptation following a crisis event (McFarlane & Yehuda, 2000). Yet the tendency to claim causal relationships between effective clinical interventions and successful resilience continues, discrediting some people's experiences following trauma. My study with women religious did not seek to measure the effects of early life sexual abuse in later life, but reports what these participants identified as consequences in their life in later years that they associated with their histories of sexual abuse. They also identified what worked for them developmentally to assuage unwelcome characteristics that they associated with their childhood trauma as co-creators of knowledge about resilience (Stringer, 1999). Health care providers who utilize the "community as family" approach challenge the limited attention paid to the social and cultural contexts in which resilience occurs, with an implicit assumption that the dominant culture decides what signifies successful coping (Ungar & Teram, 2005)

Many marginalized persons in today's society are labeled as not being resilient because they never quite meet the standards established by those whose voices dominate what constitutes resilience from a position of power, advantage, and entitlement.

The participants' stories in my research offer a critical window into the lives of early 20th century women, not because of their unique religious status, but because their early life sexual abuse experiences are perhaps representative of other women of that time (1930's -1950's). My approach can deepen and broaden our understanding of aging populations with histories of sexual abuse. Although these religious women served in

many public and professional capacities, their personal stories of sexual trauma, like those of other women of their era, demanded silence. Ecclesial as well as socio-political-economic-familial structures defined the limitations of women's voices in telling their stories, and patriarchal structures limited how and whether women could address, interpret, and speak about their sexual abuse (O'Sullivan, 2002).

These women's stories of self reported resilience are potential references for others who struggle within their environments to recreate social roles and identities, which connect their lives with others in meaningful ways. As they interpret both their trauma and their resilience in their own language, the capacity to experience wholeness and meaningful relationships in life can be enhanced.

All of the participants reported personal strengths in later life in dealing with unwelcome effects of sexual abuse. For most, they gained personal strength by breaking the silence that surrounded their abuse (Brown & Gilligan, 1991). Most participants would concur with what this participant believes is central to resilience:

But through the years I've gotten a voice. I mean, I don't really have anything to be ashamed of. When I was going through my traumatic experience of depression and anxiety, the anxiety I haven't quite conquered but I had depression, is pretty capped. My therapist said to me, "You have a good mind." It's probably the most important thing she has ever said to me.

For participants, claiming their personal authority and identifying strengths as they created new roles within their communities, were critical when addressing their

trauma. By acknowledging that she has a “good mind” she was assuming responsibility for interpreting what sexual abuse means to her today and what she believes are the lingering effects, rather than having the community craft this claim for her. This metaphor, ‘*I’ve gotten a voice*’ resonated with most participants when describing how they confronted institutional structures, whether familial, religious or cultural, who expected them to remain silent:

You know, the effects of alcoholism and child abuse on keeping secrets and not trusting and being isolated are probably the hardest things. And once you can get into a 12 step program or once you can break the silence and it takes enormous, enormous strength . . . I’m beyond some of that now, you know. Now, I say again, that I don’t go from total keeping secrets to total blabbermouth, but that there’s a middle road and I’ve chosen that. And I get nothing but affirmation for this.

Finding their voice means discerning what new roles they must create in their communities in order to tell their stories. This breaking the silence is the first step to challenging institutional structures that silence them and prevent them from speaking in their own voice and trusting that they will be heard with respect and safety. In one participant’s words, this step is “mind blowing”:

It’s like, God, was my whole life a waste? But it’s just all a part of the process in my healing, so I know I have come through and survived and it’s been very, very hard. But the hardest part for me was, you know, being isolated and not knowing I could trust people with this story...I had spoken to about forty of my friends in our congregation, all of whom, you know, have just loved me, you know, which blows

my mind. 'You love me anyway?' And everyone has said the same thing, 'Thank you for trusting me. I'm sorry this happened to you.'

Trusting people in authority who have power over them was an issue that many of the participants carried with them into adulthood. By breaking the silence and receiving positive affirmation and protection against further abuse, participants found agreement with their community in interpreting what sexual abuse means and how to approach this together:

It was very hard for me to break this secret the first time I told it was a small gathering (Sisters she lived with) where none of us were professional counselors in that sense. But I decided it's time for me to break the silence. And so I told them and I was weeping. And I got all kinds of sympathy, compassion, affirmation and there were some other parallel disclosures from people saying, 'well I too...' So I know that disclosure invites more disclosure. And so each time I share it, which isn't easy, cause I do it only with trusted people, because I'm protecting myself psychologically in terms of what I tell, who I tell and when I tell.

In general, all participants in this study who reported their histories of sexual abuse to religious leaders, spiritual directors and fellow Sister in their communities experienced overwhelming support and affirmation. However, all were reticent to disclose their sexual abuse non-discriminately to community members. Each Sister defined her own boundaries of who should know and who needs to know. This circle of confidants varied considerably among the Sisters, but all echoed the value of telling their stories in their own voices.

It appears from the data that members of religious communities will respond to a community member who was sexually abused in a variety of supportive ways. As indicated in the data, a majority of the participants have chosen not to disclose their histories of abuse to members at large, but have been selective in confiding with religious superiors, spiritual directors, and friends within their communities.

All of the participants presented with remarkable strengths in later life, demonstrating a personal authority that is able to negotiate social roles to varying degrees of competency and self assuredness. A strengths perspective suggests that, with appropriate environmental resources, individuals can create helpful change for themselves and others (Henderson, 2007; Saleeby, 1997). All participants reported positive change in their current lives that they attribute to their religious communities functioning as families that enhanced their personal strengths:

“When it was time, God put the right people there to ask the question and to say ‘share the secret.’ You know, the more courageous I get, the more breaking silence with trusted people like this encounter, (our interview). I’ve been able to mentor other women. It’s very helpful.”

When analyzing the data I intentionally listened for changes in their relationships with others and what the participants identified as resilience according to their interpretations. I was also curious about how effective professional therapists were for these women religious. Most spoke how long it took to find an effective therapist:

I have told several people...when you get into therapy, don't go to a generalist. You go to someone without specialized training, they don't get it. They miss it and I've suffered through that, when I think of it, money and time spent, and I, you know, I was dancing as fast as I could, so the spiritual piece comes last, they don't all have the training, and the woman that I went to in the end was very, very good. She had training in bio-spirituality that you can use in spiritual direction

Through the metaphor, *I was dancing as fast as I could*, this sister is interpreting her experience of ineffective therapy that did not give her a voice in telling her story and she wasn't getting better and going nowhere:

Twenty, twenty five years ago generalists didn't have a clue (about sexual abuse recovery), and so I stopped being angry with them, but I went through a time when I was very angry, you know that people were not helping me the way I needed to be helped, and even my own community said we don't know what you need but go get it. I mean who do you go to? Who'll believe you? But, but this is a very, very hard nut to crack, you know.

The metaphor, "hard nut to crack," describes her trauma, hidden beneath a hard surface of years of repression and secrecy.

What was significant is that most participants reported how integral professional help was for achieving resilience once they found a knowledgeable therapist. Adding a trained spiritual director to their bio-psycho-social medical treatment plan shifted their self understanding:

So you can get healed psychologically, you know sexually and psychologically, but spiritual healing is the last piece. So what I've learned is that you don't talk about spirituality to somebody who is on the front end coming in to it, first time breaking silence and telling the stories. You bring them through the process, like in spiritual direction, and then, finally you're looking at spiritual healing. Most people don't go through spiritual direction for sexual abuse, until they've healed the psychological thing because it's the last piece to be taken care of.

This aspect of spiritual resilience following sexual abuse was the most significant factor for these participants. Without spiritual resilience they believed that their lives as women religious were not whole and integrated. Because of their religious environment, spiritual direction is an expectation and normative relationship for these participants. All reported that their spiritual director served as a noteworthy platform in learning how to find their voice and be resilient. When therapists missed combining psychological services with spiritual insights, a significant lapse was reported by all of the participants.

I was doing much spiritual direction towards the end, but also what helped me make the jump from psychological to spiritual was I had that wonderful theological re-framing from that protestant woman therapist on the west coast. She was able to say, in non-clinical terms, a framework that I was comfortable with theologically, what was going on, and she's brilliant with this.

This points to the value of surfacing what the client values as most integral for resilience based upon her unique cultural meanings. For a Hindu male client who lost his prestigious job, a Jewish woman who has been raped, an agnostic widower, each client is seeking to be connected to what is most meaningful in his/her life and what roles and

relationships need to be restored and/or recreated following the trauma. Framed in this way, spirituality is an essential strength in scaffolding resilience in the community as family approach.

It is crucial for the therapist to nurture a capacity for self awareness of his/her own biases that we bring to the professional relationship. We may not believe that certain religious rituals, or options such as complementary and alternative medicine (CAM) (Behrman & Tebb, 2009), are helpful, but we need to be open to what the client names as meaningful and helpful in being resilient.

CLINICAL IMPLICATIONS

Applying PIE, strengths-based and symbolic interaction perspectives to the “community as family” approach to the systematic study of resilience following trauma is based upon the following seven assumptions about human identity and interactions:

First, human beings act toward things on the basis of the meanings that the things have for them. Second, meaning arises in the process of interaction between people. Third, meanings are handled in and modified through an interpretative process used by the person in dealing with things he/she encounters. Fourth, individuals are not born with a sense of self but develop self concepts through social interaction. Fifth, self concepts provide an important motive for behavior. Sixth, individuals and groups are influenced by larger cultural and societal processes. Seventh, it is through social interaction that individuals work out the details of social structure. (LaRossa & Reitzes, 1993, pp. 143-44).

These assumptions influenced data gathering and analysis in this study of women religious and the subsequent development of the “community as family” approach for

clinical assessment and intervention. We now look at practical ways how resilience is assessed and scaffolded, utilizing the theoretical perspectives presented as well as the use of metaphors, to illuminate the stories of trauma and resiliency in the voices of the participants.

The Community as Family Approach

1. Welcoming/ Building Trust

Without trust, the client/family members will not feel safe to speak with their own voices nor will they find the courage to interpret the trauma and attempt to remain resilient in ways that are consistent with what they believe to be meaningful, important, and essential. Rituals and a comfortable setting add to the trust that the client will feel towards the practitioner. I recommend asking, “Do you have any questions or concerns that need to be addressed before we engage in this helping relationship?”

2. Identifying Sources of Authority

Who are the influential voices in the clients’ lives that have the authority to interpret their story of trauma and to whom they tend to listen to either consciously or unconsciously? Who provides credence and credibility to their interpretations of their crisis experiences (family members, peers, professionals, government, schools, and/or religion)? It is important to understand the power these institutions have in defining clients’ identity following trauma, and how much influence they currently exert on shaping clients’ roles in their environments. By examining the ways in which these sources of authority may be discrediting their experiences and/or interpretations of their experiences. The following are questions that might be asked in this regard: Who is the person(s) you turn to when you want to know what to do in a difficult situation? Who do

you trust when you have questions about what is most important in life? Who are the people that you can rely upon to guide and instruct you? What religious commandments/leaders are reliable sources of knowledge for you?

3. Recognizing Multiple Sources of Authority

Often there are conflicting sources of authority competing for prominence in clients' reinterpretation of a new or renewed identity following trauma. Where do these sources of authority resonate and are in harmony, where do conflicts exist, and how much bio-psycho-social-spiritual discomfort is this creating? It is important to be aware of issues at each of these levels:

Bio: Stomach problems and headaches, changes in appetite, sleep patterns, sexual drive, etc.

Psycho: Levels of anxiety, depression, agitation, guilt, shame and resentments;

Social: Alienation from others, isolating from primary support persons, disengagement and/or enmeshment.

Spiritual: What is most meaningful in their lives? What needs to be restored first?

How has belief (lack of) in God changed, and does he/she pray? Why or why not?

Does the person attend religious services, cultural events, why or why or not?

4. Listening for Social Roles

Here I consciously listen for the language clients use when describing the relationships that are meaningful to them, and I especially pay attention to the roles that have changed dramatically because of the trauma. "The underlying premise of symbolic interactionism is that the subjective aspects of experience must be examined because the meanings people assign to things ultimately organize their behavior" (Stryker &

Stratham, 1985, p. 320). All persons engaged in social interaction are actors, creating meaning together through shared symbols and metaphors that make sense within their context and influence how they behave in their assigned roles. I may ask, “What roles changed because of your trauma immediately following the trauma, later on, and today?”

Additional questions may include the following:

I would like to ask you about your relationships with others who you claim to be a part of your community. Who are the most important people in your life and why? What relationships remain stable today? What relationships have dramatically changed and were disrupted? What comforts and strengthens you in managing the trauma? What role does God (if any) play in your ability to be resilient?

I suggest listening closely to how each person makes sense of this event. Notice the nuances that are unique to this person, while considering the environmental context he/she is interacting with and the sources of authority who may be interpreting his/her story for him/her. I then proceed to a second set of questions: “What helps you today to integrate your trauma into your life and make sense of what happened to you?” “I realize that trauma has many effects, but I am interested in finding out from you what you have noticed are the effects in your relationships with others.” Some people remember this vividly and are reminded of this often, while others do not think about this much, so I say, “Please answer the questions the best that you can.” “How does this trauma influence your life today?” “How has this trauma influenced your relationships with God?” “What effects of the trauma are most troubling today?” “What effects of the trauma have surprised you or caught you off guard?”

Applying symbolic interaction theory to understanding the roles that were disrupted, changed and/or permanently lost as a result of the trauma, I ask: “What has changed?” “Which roles provided the most meaning prior to the trauma, which ones were burdensome and disconnecting?” Making a list of these roles can assist in visually grasping how much the trauma has disrupted the person’s life. Teaching the person how to grieve these losses and working through the anger, sadness, and remorse can be helpful. In addition, which roles will be missed, which ones need to be released according to the client? What new roles might enhance growth and healing in line with the client’s priorities and values?

5. Surfacing Identity Issues

I want to understand what it means to be a woman religious, an electrician, a parent, a marathon runner, etc., based on each person’s lived experiences. Each client is given the opportunity to explore how he/she self identifies. For example, using this particular study I could begin by asking them about their lives today as religious women: “What is it like for you to be a Catholic religious Sister today?” “What do you appreciate most about being a religious Sister?” “What is most meaningful in your life today?” Along with these questions I invite the client to describe her identity through metaphor. For example, “If you could select a tree that captures the essence of your religious life today, what tree would that be and why?” My intent is help the person name how the trauma has disrupted her sense of identity within her community. Many of the primary losses following trauma are losses of identity: Who am I now that I am widowed, orphaned, unemployed or disfigured following a particular trauma?

Involved here is a grieving process that can be surfaced with the client to assist him/her in letting go of the past in order to create a future (Carnes, 1993). Identifying and listening for the metaphors used to describe losses as the result of a trauma paints a picture for each person to examine and explore. Within a cultural context the roles are interpreted and the meanings behind these metaphors and phrases are expanded. Exploring metaphors that appear on the surface can lead to a depth of understanding with which the clinician and client may work.

6. Naming Strengths

The following questions explore the internal and external strengths that have been most helpful according to the client: “I want you to focus upon how your trauma affects you today in any way. I realize that this is difficult but I am here with you and we will not go beyond your capacity to remember how this trauma has changed you and your relationships. Who or what helps you the most today when you remember the trauma? What environments, circumstances, resources or rituals have been most helpful in managing the effects of your trauma? Can you identify in particular what helps you with some of the effects you named earlier?”

7. Managing Triggers

The following questions open the door for clients to tell their story in their own voice, owning what has been most difficult, consistently pointing out where they have been resilient when recovery was painful and confusing.

“How often do you remember the trauma? Where does this memory show up the most frequently? What situations or people seem to trigger memories of the trauma? What has been most hurtful for you? What troubles you the most about this event? What

seems unfinished and remains painful and disruptive? What strategies get you through this? What gives you hope? Could you describe this time in your life as if you were describing the weather. What season, what type of day/night would you be in currently?”

It is important to respect what is most meaningful to the person. What does the person believe is most important for him/her to focus upon and why? Be open to details that seem insignificant initially but may be the source of his/her triggers with the trauma. Once the triggers are identified then techniques for managing them should be provided.

8. Identifying Community Resources

It is critical to identify community influences that are potent sources of strength for clients as they journey through the trauma. Who and what can they rely upon in an emergency as well as consistently during the everydayness of each step they take? These resources need to be meaningful, accessible, and available. Focus on hobbies, relaxation techniques, volunteer opportunities, exercise avenues, spiritual rituals, social networking, and more. Together, prioritize what needs to be put in place immediately and what may be a long term goal. Sometimes purchasing tennis shoes and encouraging walking comes before recommending gym membership. Simply walking in a soothing environment each day may be a beginning in getting through difficult days and months.

9. Logging Changes

It is critical to point out growth in the client that is accessible and tangible. This may include losing/gaining weight, how often he/she is exercising, hours sleeping, number of nightmares, telephone calls for support, books read, volunteer work, etc. Once again, it is essential that the client can recognize growth and change from a strengths

perspective. In the midst of the post trauma event, often it feels like no progress is being made for the emotions can cloud changes (Carnes, 1993).

Keeping a log with the client can diminish the tendency to slip into despair and the feelings that this will never get better. Thus, it is important to determine base line behavior prior to the trauma and at the time the person initiates professional services. This is an ongoing assessment that requires attentiveness to fluctuations and variations: What used to work in managing stress? What is no longer working? What would you like to try? What have you tried that did not work? The client must co-create these activities and explore new options.

10. Closing the Professional Relationship

It is important to remember that a strengths based assessment focuses on assisting the client in creating new meaning, renewed relationships, and revitalized roles. When concluding, be aware of assumptions about what constitutes resilience and inquire into the client's own assessment of progress or lack of it. What will be used to measure change and growth and who will determine which instrument to be used? What criterion is used to determine that the professional work is complete (for now) and what follow up plan is in place? Keep in mind that alcohol, drug, and lethality assessment takes place throughout this process

CASE STUDY

The following case study illustrates the “community as family” approach. Data are derived from the study in which I sought to identify strengths in later life among these women and how their experiences of sexual abuse affected their lives in their own words, always listening for metaphors that would enlarge my understanding of their experiences.

It is important to embrace what these participants identify as furnishing their lives with resilience in later life and what intensely disrupted and threatened their lives when the trauma occurred. I listened for strengths amidst their pain and confusion and how the effects of sexual abuse remain with them today.

Metaphor

The following is an example of the use of metaphor taken verbatim from the interview data as one participant describes her experience of sexual trauma:

I must have been alone because he kissed me, and I thought the weather, it was like a lightning bolt. I thought what in the hell; I couldn't imagine what was happening. I had nobody to tell, nobody to run to I was so young. I was just amazed; you know just, I don't know how to describe it.

She continues to describe, through metaphor, how traumatized she was by the sexual abuse, enabling me to empathize with her and to deeply understand what her experience means to her. She continues,

I don't know if it is the abuse, but the fact that I was like afraid of adults. I have an expression, 'I always felt half-baked.' Like I was never a real mature adult. I do not know. The fact that I was angry, always fussing at something. I am never really at peace. I myself cannot see how the connection is there, but there must have been something. I took the courses, I got the degree but, I just never felt really, really comfortable...and then the tree, my early life is the thorns, and right now during the fall across the street was the most beautiful maple tree. It was so red and so beautiful, and there was one on this property, too. I just picked this off as a reminder that I think in my later life, not that I am beautiful, but that I am at

peace (she shows me the red maple leaf). Because all during my life I was filled with anger. I talked to different priests and psychologists and so forth. There was always like a civil war within me fighting within myself, but not just the civil war, the Vietnam War because in Vietnam they could not tell the enemy, he looked the same, the same as the good guys. So I did not know what the heck I was fighting.

By linking together key phrases and stories with each metaphor, categories begin to emerge and individual metaphors take on new meaning when clustered. The above participant uses powerful metaphors to describe the effects of her sexual abuse, a *civil war* in which she did not know who the enemy was, thus she could not trust nor identify with adults. Her metaphor, of being *half baked*, describes a person who is becoming what she is intended to be, but she is not there yet. She continues by further interpreting her metaphor of the *Vietnam War*.

It is the fact that now in my older season that I am more at peace like the beauty of the red maple. I am not fighting the Civil War. I am not fighting the Vietnam War any longer.

It is recommended that all questions, both research and clinical, be open ended, with no questions posing “yes or no” responses. This enables the participant to take the question wherever he/she values the most. Yet the questions do lead the participant in a direction that seeks to meet the purpose of a study or the goals of therapy.

Other participants reported similar gratitude for religious community resources:

I had to come to believe through a lot of therapy and a lot of good people, I couldn't tell you how many people reached out to me to help me and would go on

walks with me and take me someplace to get ice cream or go to dinner or ride with me. So probably all of that has some bearing on the abuse that I had as a child. It certainly gave me a sense of guilt and shame until someone did tell me, 'You know, you were a child and you didn't have the power to resist that.

What became apparent was how helpful the new relationships within their communities were:

Definitely. I said, if I don't have friends I will die. I will die of loneliness, you know not physically die but you just die, you know. I've got to do something about this (sexual abuse), so then I started connecting with people. I've been blessed by good friends and they help a lot. It's the tangibles and so God puts people in our lives to help us get through. So, I am really grateful that I came through it.

Many reported that the leaders in their religious communities were helpful:

I've had very good general superiors, very good ones, and each of them has been so very, very generous to me in my life. There was never a time in my life that they've said, 'now, I think you've had enough therapy. But they've never done that. They were just very giving women, you know, so I'm very, very, I'm a very grateful person for that.

Their religious communities provided them with the healthcare and support they needed to address their sexual abuse in a confidential and professional setting:

The gift is the community. I got the best of help. I got great doctors. I am grateful for the many religious experiences; there are many benefits of which I am grateful. It's like a marriage I guess. You have to learn to live together, that's it. I

*don't know how else to put it. Then you have to talk, you have to keep on talking.
The gift is the community.*

Other participants reported similar strengths in their community life:

The first word that comes into my mind is the security, I guess. Part of the community charism or spirituality is based on this sense of family and you know being there for each other, that sense of community. That's what drew me to the congregation in the first place when I was a little girl in, like the 3rd grade.

Just the whole culture of being in a Catholic religious community and, you know, being able to practice the religion and have that common shared understanding of looking at the world. Yes, and I got all kinds of sympathy, compassion, affirmation.

The most meaningful thing to me is that I have a religious community whom I call on for support, with whom I belong and with whom I interact. Of course, my very best friends are Sisters. Most of them have known me almost all of my life or at least almost all of my religious life. And our congregation is a very loving and caring group.

I love being here. I love the Sisters. I love the life. I love everything about it. I am in a good space right now, a really good space. I like being identified with them

The greatest enjoyment I have is the grassroots and the community.

They're wonderful ladies (religious sisters) and I like being with them

It's the relationships that are very pleasurable and meaningful to me but certainly not the institution

These women religious self reported that it is “community as family” that has facilitated resilience and given them the hope for meaningful relationships in later life.

RESEARCH IMPLICATIONS

The findings of my study both confirm and expand the data generated in the Chibnall study (1998), and will be valuable for women religious communities that are committed to providing healthy environments for the members of their communities. Whether any of the findings of my study can be applied to other aging populations requires significant further investigation. However, a critical component of this study raises awareness of the need to revisit theoretical understandings and clinical assumptions about the trauma of sexual abuse among aging populations who present with difficulties coping in later life. What does it mean to be resilient in late life with childhood histories of sexual trauma? Telling these stories of tragedy and suffering, hope and resilience has the potential to connect research participants with the members of other aging populations who suffer from sexual abuse and/or perhaps other forms of trauma.

Many of the spiritual resources that the Sisters reported as assisting them with resilience are supported in popular literature (Breazeale, 2009). Data from empirical research indicates that religion and spirituality play an important protective factor in well being and health in aging populations (Miller & Thoresen, 2003). The scientific evidence for incorporating spirituality in our clinical approach to scaffolding resilience is reviewed

and discussed in over 800 studies presented in the Koenig compilation (Koenig, 2000). My findings support the value of nurturing spiritual resources and religious identity in later life.

CONCLUSION

My intention is to identify both shared meanings and unique interpretations of what trauma and resilience meant to the study participants, and what holds most meaning for them as they live today as women religious. One does not have to be a woman religious who was sexually abused in early life to find common meaning with their experiences of loss and vulnerability when listening to their words. These participants' interpretations can create meaningful connections and encourage women from diverse cultures to initiate the process of interpreting their own stories in their own voices.

To be resilient often involves a quest for transformation amidst harsh environments that threaten our identities and relationships. Each of us has experienced this to varying degrees and at different points in our lives. We strive to create a language for these experiences through song, poetry, and prayer. We seek understanding and enlightenment in order not to be destroyed by the trauma but rather to be transformed because of it. One Sister sums up what it means to her to be resilient:

Hope is what most survivors cling to. It's not faith because sometimes faith has gone out the window, but it's the virtue of hope. There's something resilient in the hope that there's something good going to happen. But you can't see it yet...you don't know it. And when somebody is in tears in front of you because they can't see it, but down here, what keeps them coming back is that hope.

I began my research in order to unravel what it means for elderly women religious to have been sexually abused at a young age, how sexual abuse manifests in their lives today, and to identify the strategies and resources they utilize to remain resilient. During these interviews I listened to their struggles to address the trauma of sexual abuse and to painfully negotiate what is required to be resilient. What I heard is that claiming one's own authority in this process is painful and transforming. Each story portrays a woman who has carved a new personal identity for herself within her religious community and is engaged in the dynamic process of creating new relationships. Each voice holds hope for those who struggle with trauma in all of its multiple manifestations.

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