

**THE IMPACT OF SPIRITUALITY ON THE SELF-REPORTED RECOVERY
OF ADULTS WHO EXPERIENCED CHILDHOOD TRAUMA**

by

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DEDICATION

This dissertation is dedicated to the loving memory of my mother, Mrs. Virginia O. Chigbo, who relentlessly carried on the duty of caring and providing for the needs of my siblings and mine from the early stage of our family life when our father died. Through her initiative, hard-work and numerous sacrifices, she provided us with a balanced upbringing which solidly contributed to the success of this project. I remain eternally grateful to her for all the hardships she endured so that my siblings and I might have a better future.

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PREFACE

As the term implies, childhood trauma is a deliberate, harmful act of commission or omission that a child unexpectedly experiences from their parent/parents, custodian or any adult which results in an injury or a threat of injury. The injury may not be intended in the act. But it is intentional and may produce mental and behavioral disabilities such as: depression, anxiety, low self-esteem, dissociative disabilities, cognitive dysfunction, self-harm, suicide, posttraumatic stress disorder (PTSD), anger, alcohol and substance abuse, smoking, eating disabilities, obesity, heart disease, chronic lung disease, skeletal fractures, liver disease, sexual disabilities, feeling of worthlessness, and many others.

If the act is not stopped and its initial mental outcomes or disabilities treated early, it could slowly disrupt and impair the normal development and mechanism of the different domains of functioning in the child. These domains include emotion, cognition and physical/behavioral health. The adverse effects the psychological disabilities produced in the child's domains may not go beyond childhood developmental stage if their duration and intensity are short-term and light, and receive adequate treatment. Whereas, the effects may prolong into adulthood with increased trauma symptoms, and lower mental, physical and general health conditions in the affected individuals if the contrary is the case. This would also lower their overall productivity to society.

The purpose of this research study was thus to examine if adults who had experienced childhood trauma, and who had a higher sense of personal meaning or spirituality, would have improved mental, physical and general health conditions and

lower trauma symptoms. Abundant literature shows personal meaning or spirituality as an effective therapeutic and an empowering treatment resource for this population. It (spirituality) has been shown to assist them to transcend their life issues and attain the highest level of well-being in the areas of lasting meaning, hope, love, happiness, improved mental health, satisfaction, optimal emotional functioning in life, increased productivity and the like. It (spirituality) has been linked with prevention, coping and quick recovery from depression and anxiety, and decrease in the rates of suicide and substance abuse.

Again, its use in treatment for mental disabilities has shown to produce priceless health and social benefits for the affected individuals in particular and society in general. It, among other things, assists society to adequately address their spiritual issues which have negative impacts on public order, finance and overall productivity.

This study tested its participants with demographic questionnaire, Personal Meaning Profile (PMP) and Trauma Symptom Checklist-40 (TSC-40) clinical measures to assess their levels of well-being and mental disability. The demographic questionnaire asked questions such as: “Have you been to treatment? What type of treatment have you had?” and so on. The Personal Meaning profile (PMP) survey measured the extent each of its items such as “I relate well with others, I am at peace with God” and others, characterizes your own life in a scale of 1 to 7. Trauma Symptom Checklist-40 (TSC-40) measured symptoms in adults associated with childhood traumatic experiences. Participants were asked to indicate in a scale of 0 to 3 how often they had experienced each of the survey’s items such as headaches, weight loss (without diet), stomach

problems and sexual problems in the last two months (0 =Never; 1 = Seldom; 2 = Periodically; 3 = Often). The data collected were analyzed using a multinomial logistic regression statistic at an alpha level of 0.05. The results showed statistically significant relationships between the two predictor variables (that is, the items of PMP and TSC-40) of this study and the mental, physical and general health conditions of the study sample, respectively.

Chijioke Al Chigbo
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CHAPTER 1 INTRODUCTION

Scope of the Problem

Childhood trauma or abuse is a persistent universal problem that adversely affects children under the age of 18 all over the world (Mersch, 2009; CDC, 2010). It is a non-accidental injury inflicted on a child by a parent, caretaker or any adult in the form of physical abuse, sexual abuse, emotional/psychological or verbal abuse, or child neglect (Libby, Orton, Novins, Beals, Manson, & Al-SUPERPFP Team, 2005; Gilbert, Widom, Browne, Fergusson, Webb, & Janson, 2009; CDC, 2010). This deliberate harmful act perpetrated on children by adults is as old as human civilization and has a deep root in the cultures of all nations, both rich and poor alike (Thomas, 1971-1972; Gilbert et al., 2009).

Recent reports from some advanced nations of the world illustrate the prevalence and incidence rates of childhood trauma or maltreatment in their societies. The United Kingdom (England) reports 0.3% of its children on child protection plan were abused in 2007. It occurred as follows: neglect 44%, physical abuse 15%, psychological abuse 23%, sexual abuse 7% and multiple abuses 10% (Gilbert et al., 2009). The report of Canada substantiates the abuse of 0.97% of its children in 2003. Its incidence rates were: neglect 38%, physical abuse 23%, psychological abuse 23%, and sexual abuse 9%. Australia confirms that 0.68% of its children were abused in 2002-03 with the incidence rates of: neglect 34%, physical abuse 28%, psychological abuse 34%, and sexual abuse 10% (Gilbert et al., 2009).

The U.S. official report on child maltreatment for the Federal fiscal year (FFY) 2008 was at the prevalence rate of 10.3 per 1000 children. An estimated 772,000 children were

victims during the year, based on the data collected from 50 States. Also within the year, an estimated 1,740 children who died nationally from abuse and neglect were at the prevalence rate of 2.33 per 100,000 children, based on the data collected from forty-eight States of the Union (Child Maltreatment, 2008).

According to the report, parents and close relatives of maltreated children were the major perpetrators of the abuse. The figures of abuse were: 80.1% were parents; 6.5% other relatives; 4.4% unmarried partners of parents. Of the parents who were perpetrators, 90.9% were biological parents; 4.4 percent were stepparents, and 0.7 percent adoptive parents. Research studies agree that parents and close relatives of children are the major perpetrators of child abuse, and that the rest of the perpetrators are in the minority (Mersch, 2009; Gilbert et al., 2009; Child Maltreatment, 2008; van der Kolk, 2005). The latter are individuals or professionals who are in caretaking relationships with children. They include teachers, nannies, coaches, religious leaders, and others (Mersch, 2009). They account for only 2% of the perpetrators of children (Mersch, 2009). There are another 10% of perpetrators he classifies as non-caretakers or unknown (Mersch, 2009).

Among all the perpetrators of child abuse in the United States, 61.1% neglected children, 13.4% committed a multiple abuse, 10.0% physically abused children, and 6.8% sexually abused children (Child Maltreatment, 2008). In all, research findings show that perpetrators of childhood trauma come across all economic, ethnic, racial, cultural and religious groups (Mersch, 2009; Thomas, 1971-1972; Gilbert, et al., 2009). Children are abused at their homes, communities, schools, religious and other public institutions (Mulvihill, 2005).

Statement of the Problem

Although other forms of early adverse experiences contribute to adult mental disabilities, childhood trauma, namely: physical abuse, sexual abuse, child neglect and psychological/emotional or verbal abuse, appears to have particularly long-lasting and negative effects on the adult survivors (Chaikin & Prout, 2004; Rogosch, Cicchetti, & Aber, 1995). Several research studies have documented a strong link between childhood trauma and adult psychiatric and medical disabilities, and poorer overall health conditions such as: depression, mood and anxiety disorders, post-traumatic stress disorder (PTSD), anger, dissociative disorders, alcohol and substance abuse, smoking, eating disorders, obesity, heart disease, chronic lung disease, skeletal fractures, liver disease, sexual disorders, feeling of worthlessness, deliberate self-harm, suicidal ideation, and many others (Schafer, Ross & Read, 2008; Chaikin & Prout, 2004; Ford, 2005; Briere & Jordan, 2009; Grover et al. 2007; Thombs, Lewis, Bernstein, Medrano, & Hatch, 2007; Grella, Stein, & Greenwell, 2005). These psychiatric disabilities disrupt and impair the psychological, cognitive, and physical/behavioral domains of human functioning and reverse their vital roles to become developmental sources of psychopathologies (Ford, 2005; De Bellis, 2001). The latter (psychopathologies) are trauma symptoms which lower mental, physical and general health conditions of the affected adults and who negatively have some impacts on society (Gilbert et al., 2009; Mulvihill, 2005; Messina, Grella, Burdon, & Prendergast, 2007; Grella, Stein, & Greenwell, 2005).

Purpose of the Study

The purpose of this study is to examine whether adults who have experienced childhood trauma, and who have a higher sense of personal meaning or spirituality; would have better mental health and lower trauma symptoms. In other words, this study will investigate whether a higher sense of personal meaning or spirituality is directly related to better mental health and lower trauma symptoms.

Research Questions and Hypotheses

Research Questions

1. Will adults who have experienced childhood trauma, and who have a higher sense of personal meaning or spirituality, have better mental health and lower trauma symptoms?
2. Will adults who have experienced childhood trauma, and who have a lower sense of personal meaning or spirituality, have poorer mental health and higher trauma symptoms?

Hypotheses

H₁: Adults who have experienced childhood trauma, and who have a higher sense of personal meaning or spirituality, will have better mental health and lower trauma symptoms.

H₂: Adults who have experienced childhood trauma, and who have a lower sense

of personal meaning or spirituality, will have poorer mental health and higher trauma symptoms.

Need for the Study

There is certainly need for this study. Childhood trauma is a hidden problem in society which poses substantial threats to the mental health of its population, finance and public order (Mulvihill, 2005; Messina et al., 2007). It disrupts and impairs the normal development and mechanism of the different domains of human functioning such as emotion, cognition and physical health (Crozier & Barth, 2005; Schafer, Ross, & Read, 2008; De Bellis, 2001). Impaired cognitive functioning, for instance, has important implications in a range of areas in society such as public policy, public health, education and social welfare (Bremner et al., 2004; Gilbert et al., 2009; Crozier & Barth, 2005; Slade, & Wissow, 2007). It inflicts society with heavy financial burdens associated with traumatic outcomes in the forms of special education funding, medical and psychological care, government services such as criminal justice and child protection agencies, and lost earnings and productivity related to impaired functioning in the labor market (Mulvihill, 2005). It has been estimated that the total cost of childhood abuse and neglect in the United States for both immediate needs and indirect costs associated with its long-term and secondary effects is \$94 billion per year (Mulvihill, 2005). Thousands of children also die every year as a result of physical maltreatment, intentional killing or child neglect. The World Health Organization (WHO) estimates that 155,000 children below the age of 15 die worldwide every year as a result abuse or neglect (Gilbert et al., 2009).

These huge human and financial losses to society due to childhood trauma causes are unacceptable. They (losses) call for urgent need for this study and allied studies to come up with possible remedial findings that could reduce these unhealthy outcomes to the barest minimum (Mulvihill, 2005; Gilbert et al., 2009). One of the essential findings that would be had from this study is that it would create awareness that having a higher sense of personal meaning or spirituality engenders enduring mental well-being (Cloninger, 2006 & 2007). Research shows that psychological or mental health is dependent on spiritual health (Frankl, 1954). Thus, fostering personal meaning or spirituality among individuals abused in childhood during treatment means engendering better mental, physical and general health conditions for them; and decreasing their trauma symptoms (Mascaro & Rosen, 2006; Cloninger, 2006).

Also, this study gives this treatment approach the credit of having some financial benefit or gain for society. Research studies have found that using a treatment approach with aspects of spirituality in the care of individuals with mental disabilities is inexpensive and powerfully restores their psychobiological integrity (Cloninger, 2006; Sperry, 2010; Wilkinson, 2008). Integrating personal meaning or spirituality in treatment for this population would not only lead to their holistic recovery and their becoming functional and independent individuals who are able to provide for themselves and make some meaningful contributions to society. It would also lead to society spending far lesser money on mental and medical healthcare and other public services (Mulvihill, 2005; Cloninger, 2006).

Limitations of the Study

There are some limitations to this study. First, the scope of this study is fairly broad. The study will examine whether all adults, both male and female, who have experienced childhood trauma in all its various forms, namely: physical abuse, sexual abuse, psychological, emotional or verbal abuse and child neglect, and who have a higher sense of personal meaning or spirituality, would have better mental health and lower trauma symptoms. The scope of the study is not focused on a mixture of limited and specific characteristics of the population such as: gender, a form of the trauma (for instance, physical abuse), race, and the like.

Another limitation of the study borders on the measurement of spirituality (Piedmont, 2001). Although study on spirituality is rapidly growing, it is however very difficult to measure spiritual constructs such as well-being. Agreement regarding the conceptualization and scale development of spirituality is poor, and this is partly responsible for the numerous measures on spirituality that have been created (Kapuscinski & Masters, 2010). Again, some of these existing spiritual measures which are currently in use may have some validity errors. Thus, it may be a little difficult to find psychometrically sound measures that can be useful in empirically documenting the unique contribution of spirituality in predicting salient life outcomes (Piedmont, 2001).

Definition of Terms

The following terms will be defined and/or explained in this section to assist readers to know the exact meanings given to them in the context of this research study. The terms are: trauma, victimization, childhood trauma or abuse and its various forms, namely:

physical trauma, sexual trauma, emotional trauma, child neglect and exposure to domestic violence; psychotherapy, spirituality, and healing process.

Victimization

Victimization refers to a tendency of a perpetrator or perpetrators within or outside a relationship to inflict a physical or emotional harm on an unsuspecting individual, known as a victim, for no just cause (Mishna, 2007). The victims usually feel a sense of betrayal of trust by the abuse they experience from the perpetrators, and are consequently traumatized by their experience of the incident (Vachss, 1994). They are at risk for developing internalized problems such as anxiety and depression (Mishna, 2007).

Trauma

Trauma generally refers to an unexpected and/or sudden event inflicted on an unsuspecting individual by a natural or human agent resulting in an experience of excruciating emotional pain in the individual (Allen, 2005; Vachss, 1994). It (trauma) changes the course of the individual's life (Wise, 2007). A traumatic event thus creates an exceptional situation of helplessness and distress which could jeopardize the psychobiological integrity of the individual or that of those close to the victim (Cloninger, 2006; Wise, 2007). In the stricter context of mental health, trauma refers to the psychologically stressful experiences which induce fear and helplessness in the survivors (Draijer & Langeland, 1999). Following traumatic experiences, each survivor faces the question of how to fit those events, whether a one-time occurrence or an ongoing situation, into new understandings of life's meaning and purpose (Wise, 2007).

This study focuses primarily on the following traumatic experiences that occurred in childhood, namely: physical abuse, sexual abuse, emotional/psychological abuse and child neglect, and their negative effects in later life.

Childhood Trauma

Childhood trauma or abuse is a non-accidental act of commission or omission by a parent or other child custodian that results in an injury or a threat of injury to a child below the age of 18 years (CDC, 2010). The injury may not be intended in the act. But the act itself is intentional and does inflict some emotional damage to the child with attendant psychiatric and behavioral problems (Gilbert et al., 2009; CDC, 2010; Rees, 2010; Libby et al., 2005; Allen, 2005). The following are the different types of childhood trauma:

- **Physical Abuse**

Physical abuse is an intentional use of physical force or implements by a parent or caretaker against a child which results in a physical injury. It includes flogging, kicking, pushing, punching, dragging, slapping on the face, beating, burning, grabbing and choking around the neck, locking a child out of the home in unsafe conditions, threatening with a knife or gun, and the like (Gilbert et al., 2009; CDC, 2010; Miller-Perrin, Perrin & Kocur, 2009).

- **Sexual Abuse**

Sexual abuse refers to a completed or an attempted sexual act or contact, or a non-contact sexual interaction with a child by a parent or caretaker. It includes

penetration, fondling, filming and exposure to other sexual activities (Gilbert et al., 2009; CDC, 2010; Yates & Wekerle, 2009; Teicher et al., 2006).

- **Psychological, Emotional or Verbal Abuse**

Psychological, emotional or verbal trauma refers to a parent's or a caretaker's non-accidental behaviors that convey messages that harm a child's self-worth, level of functioning and general well-being. They include scolding, yelling, shaming, cursing, blaming, criticizing, insulting, debasing or undermining, rejecting, withholding love, threatening, and others (Gilbert et al., 2009; CDC, 2010; Rees, 2010; Sperry, 2010; Teicher, Samson, Polcari & McGreenerly, 2006; Yates & Wekerle, 2009).

- **Child Neglect**

Child neglect is the failure of a parent or caretaker to meet a child's basic needs. Examples include adequate housing, food, clothing, education and access to medical care (Gilbert et al., 2009; CDC, 2010; Wright, Crawford & Castillo, 2009).

- **Exposure to Domestic Violence**

It refers to a child's exposure to a chaotic home environment resulting from persistent noisy family conflicts taking place between parents, or between parents and their child/children. Instances include bickering, fighting and other degrading psychological acts happening among parents, or between parents and their child/children (Allen, 2005; Yates & Wekerle, 2009; Greenfield & Marks, 2009).

Psychotherapy

The most basic assumption of psychotherapy is that people have problems in living, and that those problems negatively affect their psychological or emotional functioning (Kunst & Tan, 1996). Psychotherapy is thus seen as an interpersonal process designed to bring about modifications in feelings, cognitions, attitudes, and behavior which have proven disabling or troublesome to the person seeking help from a trained professional (Kunst & Tan, 1996). As an interpersonal process, there is a co-operation or relationship between the two parties involved in psychotherapy, one party offering help to another in need of help, to assist them to cope with their difficult situations or problems (Kunst & Tan, 1996; Karasu, 1999).

In traditional or secular psychotherapy, a psychotherapist and a client enter into a personal relationship to work together as the former assists the latter with some counseling techniques and assignments to achieve their therapeutic goals of managing their existential problems (Corey, 2005).

While, in spiritual psychotherapy, the person in need of help or an uninitiated human being co-operates with a higher power or God in his (God's) own work of preserving and transforming the original, now-fallen creation through the help of a spiritual therapist (Karasu, 1999; Kunst & Tan, 1996; Blanch, 2007). The primary goal of spiritual psychotherapy is to repair a broken human personality by addressing the spiritual issues that clients bring in therapy (Martens, 2003; Sperry, 2010). Their issues constitute the concerns of the spiritual psychotherapist. They include human anguish of isolation and alienation, sense of meaninglessness, serious health problems, personal or professional

losses, interpersonal conflicts, situations of betrayal, deaths of our beloved ones, and existential guilt of losing one's potential. Real psychopathology is thus human diminution or conscious awareness of self-loss (Karasu, 1999; Martens, 2003; Sperry, 2010).

Spiritual psychotherapists also identify the past and present conflicts and deficits, not for the purpose of resolving them, but to transcend them. They accept clients as they are, with all their limitations. However, they do not settle for the limitations of clients as an end in itself. They rather assist clients toward a harmonious emancipation from their limitations (Karasu, 1999). To achieve these therapeutic goals with clients, spiritual psychotherapists have to transcend selves and opt for such a higher state of universal consciousness and growth that targets the spiritual center of man (Karasu, 1999).

In both traditional and spiritual psychotherapies, a client or an uninitiated person has the duty to disclose relevant personal information and emotions in a therapeutic relationship to enable a psychotherapist to help them with some techniques and home-works to achieve their goals for coming to therapy (Barrett & Berman, 2001). The clients' self-disclosure has been viewed as a central feature of psychotherapy and a necessary condition for an effective treatment (Barrett & Berman, 2001).

Spirituality

Spirituality and religion are two transcendent concepts that are both synonymous and different in meaning at the same time. They are synonymous in meaning in their general sense of use and can thus be used interchangeably in this context (Koenig, 2004; Sullivan, 2009; Moberg, 2005). The two concepts, however, differ from each other in their strict senses or applications (Blanch, 2007). Spirituality, in its sense, refers to the

experiential and existential focus of an individual on their privately internalized meaning, purpose, beliefs, and values about realities which influence their daily behavior (Moberg, 2005; Stanard et al., 2000). It enables them to transcend the corporal body and material world to connect with that which stands outside of their selves on many levels. Spirituality, also in this context, provides self-awareness, an empathetic encounter with other human beings and a personal experience with a higher Power, Supreme Being, God or any other thing which an individual holds supreme in their lives (Eliason, Hanley & Leventis, 2001).

While on the contrary, religion, in its strict sense, refers to an individual's commitment to a faith community such as Christianity, Judaism or Islam, and holds to the beliefs that faith community advocates while participating in the rituals and other activities associated with that faith (Moberg, 2005; Koenig, H. G, 2004). Religion can also be viewed as a potentially adaptive resource, a frame of reference for interpreting life events. It is seen as a "meaning system" used by individuals to help them find understanding in the world, to predict and control events, and to maintain self-esteem. Religion may provide a sense of hope, feelings of intimacy with others, emotional release, opportunities for self-actualization, a sense of comfort, impulse control, closeness to God, or problem-solving aid (Newman & Pargament, 1990).

For the purpose of this study, spirituality will be used in the context of its general meaning where it is used interchangeably with religion. This inclusive option of its application is chosen because both spirituality and religion have been found to be

powerful sources of support, strength, comfort, hope, meaning, and recovery to individuals with chronic mental illness (Koenig, 2004; Sullivan, 2009). In this study, therefore, spirituality includes:

- A personal quest for meaning and connection to a higher power or God that can occur either within or outside of a formal religion (Blanch, 2007)
- Belonging to a faith tradition, participating in its ritual and other forms of worship
- Spending time in prayer and meditation
- Reading of the Bible, Torah, Koran and other Holy Books
- Being able to grieve and let go, that is, cultivating the habit of forgiveness
- Listening to singing and/or playing sacred music, including songs, hymns, psalms and devotional chants
- Giving oneself in acts of compassion (especially teamwork)
- Spending time in contemplative reading (of literature, poetry, philosophy, and the like)
- Following traditions of yoga, Tai Chi and similar disciplined practices
- Making and keeping friendships, especially those with trust and intimacy
- Being able to grieve and let go
- Cultivating the ability to forgive (Royal College of Psychiatrists, 2010; Revheim & Greenberg, 2007)
- Practicing self-transcendence, which is a constitutive characteristic of being human that it always points, and is directed, to something other than itself (Frankl,

1966)

Applying existential factors resolutely in daily life especially in moments of injustice, betrayal, disappointment, suffering, and other difficult situations of life by:

- Recognizing that life is at times unfair and unjust
- Recognizing that ultimately there is no escape from some of life's pain and from death
- Recognizing that no matter how close I get to other people, I must still face life alone
- Facing the basic issues of my life and death, and thus living my life more honestly and being less caught up in trivialities
- Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others (Yalom & Leszcz, 2005).

Recovery

Recovery or healing refers to the level or degree of functioning and well-being a given treatment approach engenders in an individual with a mental disability (Sperry, 2010). For instance, Sperry (2010) identifies that CBT and other non-spiritual conventional treatment approaches produce only Levels 0 to 1 quality of functioning in patients, while other treatment approaches integrated with aspects of spirituality raise the level or quality of functioning and well-being of the affected individual to Level 2 and beyond.

CHAPTER 2 REVIEW OF LITERATURE

Introduction

Research literature identifies childhood as a particularly important and vulnerable developmental stage in the life of a child (Shaw & Krause, 2002; van der Kolk, 2005; De Bellis, 2001; Messina et al. 2007; Mulvihill, 2005). It is a critical period that determines the nature of social relationships a child would have later in life. This is based on the type of relationship they have with their parents and/or caregivers at this developmental stage which would serve as a prototype for the development of social ties in adult years (Shaw & Krause, 2002). Children who receive intimate and loving care at this stage tend to develop a sense of trust and security that facilitates the development of healthy social relationships throughout their lives (Shaw & Krause, 2002; De Bellis, 2001).

Secure children learn to trust both what they feel and how they understand the world. This allows them to rely on both their emotions and thoughts with confidence while reacting to any given situation knowing that they can make good things happen (van der Kolk, 2005). These children immediately seek help from others if they are unable to deal with certain difficult events or things. They thus learn a complex vocabulary to describe their emotions such as love, hate, pleasure, disgust and anger. They also communicate their feelings easily as well as any other matter they want to address or express (van der Kolk, 2005).

Whereas, children who are not fortunate enough to receive intimate and loving care, tend to become vulnerable to traumatic experiences, especially those of interpersonal

nature such as parental physical violence (Shaw & Krause, 2002; Messina et al. 2007; Teicher, Anderson, Polcari, Anderson, Navalta & Kim, 2003; Mulvihill, 2005; Libby et al., 2005). They often have parents and/or caregivers who are emotionally absent, inconsistent, frustrating, violent, intrusive, and/or neglectful in their care. The former (the children) are likely to become intolerably distressed and are not likely to develop a sense that they would derive anything valuable from the external environment. Children with insecure attachment patterns have trouble relying on others to assist them and are unable to regulate their emotional states. As a result, they tend to experience excessive anxiety, anger and longing to be taken care of. These feelings may worsen and cause dissociative states or self-defeating aggression (van der Kolk, 2005).

These early adverse childhood experiences may negatively affect the developmental processes of the brain; altering its structure, organization, function and neurobiological systems (Yates, 2007; van der Kolk, 2005; Mulvihill, 2005; De Bellis, 2001). A number of neurobiological consequences may occur with the disruption of the brain processes. The consequences include weakened or reduced development of hippocampus, amygdala and other impaired neurobiological systems (Teicher et al, 2003). Alterations in the development of hippocampus have been implicated in memory difficulties, posttraumatic stress disorder (PTSD) and dissociative disorders (Teicher et al, 2003; van der Kolk, 2005). While alterations in the development of amygdala, would dysfunction its crucial role in fear conditioning and control of aggressive, oral and sexual behaviors, formation and recollection of emotional memory, and the triggering of fight-or-flight responses (Teicher et al, 2003). Impaired amygdala may cause PTSD and major

depression (Teicher et al, 2003). In short, early traumatic experiences leave distinctive footprints on the brain (Byington, 2007) and do have a profound long-term impact on major areas of human functioning, namely: emotion, cognition, and physical health (van der Kolk, 2005). They tend to reverse the vital roles of emotion and cognition to become the developmental sources of psychopathologies (Briere & Jordan, 2009; Gilbert et al. 2009; Ford, 2005; Thombs et al., 2007; Chaikin & Prout, 2004; Grover et al., 2007). These psychopathologies include: depression, anxiety disorders, feeling of worthlessness, low self-esteem, poor educational achievement, psychosis, posttraumatic stress disorder (PTSD), deliberate self-harm, suicidal ideation, dissociative disorders or chronic interpersonal difficulties, anger, alcoholism, drug use, sexual dysfunction, domestic violence, cigarette smoking, avoidance responses, borderline disorders, obsessive-compulsive disorders, passive-aggressive disorders, obesity, physical inactivity, sexually transmitted diseases, and many others (Greenfield & Marks, 2009; Schafer, Ross & Read, 2008; van der Kolk, 2005; Crozier, & Barth, 2005; Grover et al. 2007; Rogosch, Cicchetti, & Aber, 1995). Although there is not yet a clear understanding of the mechanisms connecting childhood trauma and psychiatric disabilities, consistent findings of numerous research studies link childhood trauma with adults' mental and overall poor health outcomes (Chartier, Walker & Naimark, 2009; Ford, 2005; Gunstad, Paul, Spitznagel, Cohen, Williams, Kohen & Gordon, 2006).

Psychological and Other Outcomes of Childhood Trauma

Cognitive Dysfunction

As already documented, hippocampus is one of the neurobiological systems of the brain that is impaired by childhood trauma (Teicher et al, 2003; Yates, 2007; van der Kolk, 2005; Mulvihill, 2005; De Bellis, 2001). Its alterations during development have been implicated in the incidence of memory difficulties and a number of other cognitive disabilities (Teicher et al, 2003). These outcomes negatively influence cognitive functioning and educational achievements (Crozier, & Barth, 2005). Several studies have consistently shown that individuals with histories of childhood trauma usually perform poorly in education (Gilbert et al. 2009; Crozier, & Barth, 2005; Yates, 2007; Maughan & Kim-Cohen, 2005; Briere & Jordan, 2009; Shaw & Krause, 2002).

The individuals also have a lower school attendance and lower educational achievements than their peers. The former are more likely to receive special education than the latter (Gilbert et al. 2009). A study found that 24% of children who experienced abuse received special education at a mean age of 8 years, compared with 14% of children with no maltreatment record (Gilbert et al. 2009). The difference in the percentage of the two groups is huge. The percentage of the abused children who received special education almost doubled that of those children who had no record of maltreatment (Gilbert et al. 2009).

Society invests a lot of money in training teachers for students of special educational needs and also in providing their learning technologies (Mulvihill, 2005). Despite these

special provisions, most of these educational deficits persist in these children during their early school days until their adolescent and adult lives (Gilbert et al. 2009). The long-lasting consequences of the persistent cognitive deficits of the survivors of childhood trauma include: compromised occupational functioning (Maughan & Kim-Cohen, 2005), employment problems (Gilbert et al. 2009), and economic or financial problems (Shaw & Krause, 2002; Gilbert et al., 2009).

Low Self-esteem

Childhood trauma is an adverse early experience associated with low self-esteem (Chartier, Walker & Naimark, 2009; Grella, Stein & Greenwell, 2005; Miller-Perrin, Perrin, & Kocur, 2009). The Chaikin & Prout (2004) study specifically links low self-esteem with emotional abuse, while Briere & Jordan (2009) relate it to one of the effects of cognitive dysfunction. According to this study, other effects of the dysfunction include: self-blame, hopelessness, expectations of rejection or abandonment, and preoccupation with danger (Briere & Jordan, 2009). Other studies have also enumerated other mental and behavioral problems that emanate from low self-esteem. These are: anxiety, depression, anger (both inwardly and outwardly directed), alcohol and substance abuse, self-destructive behaviors, impulsivity, increased dissociative disorders, homelessness and others (Chartier, Walker & Naimark, 2009; Grella et al., 2005; Low et al., 2000; Stein, Leslie & Nyamathi, 2002).

Depression

Depression is one of the early pervasive psychiatric disabilities occurring from childhood traumatic experiences (van der Kolk, 2005), and has been identified as one of the strongest predictors of suicide, especially, when it is accompanied by hopelessness (Koenig, 2007). Descamps (2003) describes depression resulting from childhood trauma as reactive because it is induced by some causes such as: divorce, abandonment/neglect, unemployment, death, departure of a child or a parent, aggression, fire, flood, childhood trauma, and so forth. The cause of depression may constitute its breaking element because it is latent or hidden in the affected individual for a long period of time. Recovery from depression may not be as fast as one would wish and may require deeper analysis (Descamps, 2003).

Suicide

Suicide is a devastating public health problem in the United States (Alexander, Haugland, Ashenden, Knight, Isaac & Brown, 2009), and has been ranked the ninth or eleventh most frequent cause of death in the United States (Beck, Brown, Berchick, Stewart, Robert & Steer, 2006; Alexander et al., 2009). In 2004 suicide took the lives of over 32,000 Americans of all ages, and an estimated number of about 380,000 – 780,000 individuals survived a suicide attempt the same year. Persons with mental and substance use disabilities, the elderly population, youths, and people with general medical illnesses are at particularly high risk of attempting suicide (Alexander et al., 2009).

Koenig (2007) identifies depression as one of the strongest predictors of suicide, especially when it is accompanied by hopelessness (Beck et al., 2006). People often tend to commit suicide when they perceive that there is no way out of an intolerably painful situation, or when they see no purpose or meaning to a life of seemingly unending suffering. Dumais and colleagues (2005) also include impulsive and aggressive behaviors and alcohol abuse or dependence as two independent predictors of suicide in major depression. The authors suggest that impulsive and aggressive behaviors seem to underlie these risk factors (Dumais, Lesage, Alda, Rouleau, Dumont, Chawky, Roy, Mann, Benkelfat & Turecki, 2005). Research on childhood trauma reports that traumatized children significantly display increased symptoms of major depression, for example, dysthymia, anxiety, suicidal ideation, oppositional-defiant disorder or conduct disorder, attention deficit hyperactivity disorder (ADHD), self-destructive behaviors, dissociative disorders, phobias, drug and substance abuse, binge/purge eating, compulsive sexual behaviors, irritable bowel syndrome, rheumatoid arthritis, autoimmune disorders, and others (Mulvihill, 2005; van der Kolk, 2005; De Bellis, 2001; Chaikin & Prout, 2004; Low, Jones, MacLeod, Power, Duggan, 2000).

Dissociative Disabilities/Chronic Interpersonal Difficulties

Dissociation refers to a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment, which may be sudden or gradual, transient or chronic (American Psychiatric Association, 1994; Low et al, 2000). Dissociative tendencies may arise from familiar daily experiences of life known as

psychological absorption, or a habitually used defense mechanism which may develop into one of the psychological dysfunctions formally known as dissociative disabilities or chronic interpersonal difficulties (Spiegel, 1993; Irwin, 1999). A study (Irwin, 1999) has investigated the relationship between childhood trauma and pathological and non-pathological dissociation using a sample of 100 Australian adults. Its findings show that pathological dissociation was positively predicted by the prevalence of childhood trauma, but no such relationship was found for non-pathological dissociation or psychological absorption (Irwin, 1999).

Several studies have documented some creditable evidence of link between a history of childhood trauma and dissociative disorders or chronic interpersonal difficulties (Ford, 2005; Briere & Jordan, 2009; Draijer & Langeland, 1999; Irwin, 1999; Low et al, 2000). In certain clinical populations, dissociative disability is reported to correlate positively with self-reported childhood history of sexual trauma, physical trauma, emotional trauma and child neglect (Irwin, 1999; Chu & Dill, 1990). Also, the study of Draijer & Langeland (1999) of 160 psychiatric inpatients similarly shows various forms of trauma or abuse is related to dissociative disabilities. It (the study) goes further to give the incidence rates among this inpatient population. It documents that early separation (from parents) was reported by 26.4% of the patients; 30.1% had witnessed inter-parental violence; 23.6% reported physical abuse; 34.6% reported sexual abuse; 11.7% reported rape before the age 16; and 42.1% reported sexual and/or physical abuse. Although each form of the trauma has some link with chronic interpersonal difficulties, it has been found that a combined, severe experience of sexual and physical

abuse is strongly related to the development of dissociative disabilities (Draijer & Langeland, 1999; Irwin, 1999). Individuals with high levels of dissociative disabilities have been reported to have a strong inclination to increased frequency of self-harming behaviors (Low et al, 2000).

Posttraumatic Stress Disorder (PTSD)

Posttraumatic stress disorder (PTSD) is widely associated with sexual trauma, exposure to domestic violence, combat trauma and civilian catastrophes (Singer, 2007; De Bellis, 2001; Messina et al. 2007; Briere & Jordan, 2009; Ford, 2005). De Bellis (2001) reports prevalence rates of PTSD resulting from three types of trauma as: sexual abuse - from 42 to 90%, exposure to domestic violence - from 50 to 100% and physical abuse - up to 50%. The study (De Bellis, 2001) seems to refer to child neglect as an almost normal state of existence for children. However, it does observe that an unsupervised child, who is not abused, is more likely to experience interpersonal traumas such as domestic and community violence or some other traumatic accidents (De Bellis, 2001). A more current study (Gilbert et al. 2009) regards child neglect as a form of childhood trauma and reports the incidence rate of PTSD resulting from neglect in a study of children who were maltreated before the age of 12 and tested for PTSD when they were 29 years old. The report shows that 23% of them were sexually abused, 19% were physically abused, and 17% suffered child neglect (Gilbert et al. 2009).

PTSD is diagnosed with a number of symptoms. These symptoms include a fearful reaction or disorganized behavior to a terrifying or traumatic event or experience, for at

least one month, with these displays: (a) an intrusive reliving of the traumatic experience, such as sensory flashbacks and nightmares; (b) persistent avoidance of the people, places and situations associated with the experience, as well as detached or numb feeling (emotional numbing); and (c) persistent symptoms of increased physiological arousal, including heightened startle responses, sleep disturbance, irritability (De Bellis, 2001; Briere & Jordan, 2009; Gilbert et al. 2009; Mulvihill, 2005). The effects of PTSD on childhood trauma survivors are multifaceted and may endure for many years after the original traumatic experiences (Mulvihill, 2005).

PTSD has also been documented to increase the risk of behavior problems by causing the failures of behavioral and emotional self-regulation which can lead to externalizing and internalizing behaviors (De Bellis, 2001; Gilbert et al. 2009). Externalizing behaviors include explosive anger, acting out, aggression, suicide attempts, and the like; while, internalizing behaviors comprise anxiety, chronic depression, suicidal ideation and others (De Bellis, 2001; Gilbert et al. 2009).

Psychosis

Research on trauma has found a substantial connection between a high prevalence of physical and sexual trauma and the development of psychotic experiences (Kilcommons & Morrison, 2005; Schafer, Ross, & Read, 2008; Chaikin & Prout, 2004). It has also identified a strong association between childhood trauma and hallucinations (Read, Van Os, Morrison & Ross, 2005; Schafer et al., 2008). The Read & Argyle (1999) study of New Zealand inpatients found hallucinations in 53% of those subjected to

childhood sexual trauma, 58% of those subjected to childhood physical trauma, and 71% of those who suffered both childhood sexual trauma and childhood physical trauma. A similar study in New Zealand with outpatients found hallucinations in 19% of the non-abused patients, 47% of those subjected to childhood physical trauma, 55% of those subjected to childhood sexual trauma and 71% of those subjected to both childhood physical trauma and childhood sexual trauma (Read, Agar, Argyle & Aderhold, 2003).

Research literature has further reported figures for “command hallucinations” to harm self or others as follow: non-traumatized patients 2%, childhood physical trauma 18%, childhood sexual trauma 15%, childhood sexual trauma and childhood physical trauma 29%. For voices commenting, the following figures were given: non-traumatized patients 5%, childhood physical trauma 21%, childhood sexual trauma 27%, and, childhood sexual trauma and childhood physical trauma 36%. Generally, traumatized adolescent and child inpatients are more likely to experience hallucinations than their non-traumatized inmates (Sansonnnet-Hayden, Haley, Marriage and Fine, 1987; Famularo, Kinscherff, & Fenton, 1992). On another note, visual hallucinations are found to be more prevalent in individuals who have experienced multiple traumas, while auditory hallucinations are associated with physical trauma and more strongly with emotional trauma (Read et al, 2005; Schafer et al, 2008). Trauma literature has also identified a high prevalence of PTSD in individuals with a primary diagnosis of psychosis (Kilcommons & Morrison, 2005).

Physical Health Outcomes

Research studies suggest that individuals with histories of child neglect, physical and sexual trauma are more likely to become obese (Gunstad et al., 2006; Gilbert et al., 2009). Obesity/weight gain and eating disabilities have further been connected with anxiety, PTSD and depression (Gunstad et al., 2006; Chaikin & Prout, 2004). Other physical, health outcomes also result from childhood trauma. They include: chronic pain, earlier onset of sexual activity, teenage pregnancy, prostitution, a high rate of abortion, sexually transmitted diseases, and many others (Gilbert et al., 2009; Chaikin & Prout, 2004). These health outcomes might become long-term health problems that could cause higher healthcare utilization rates and cost (Child Welfare Information Gateway, 2008; Thombs et al., 2007). Public money is more likely going to be used to pay most of the hospital bills of the affected individuals who usually have economic or financial problems (Shaw & Krause, 2002; Gilbert et al., 2009; Thombs et al., 2007).

Social Consequences

Childhood trauma does negatively impact society through the psychologically disabled behaviors of the survivors, which include aggression, violence, re-victimization, homelessness, criminal activity and the like (Greenfield & Marks, 2009; Gilbert et al. 2009; Messina et al. 2007). Traumatized individuals often tend to revenge their pain and suffering on members of society through aggression, criminal activities and violence (Gilbert et al. 2009; Chaikin & Prout, 2004). The literature on childhood trauma reveals high associations between physical and sexual abuse and antisocial behaviors or violence

in boys and girls (Grella, Stein, & Greenwell, 2005; Gilbert et al., 2009), although physical trauma relates more to violence in girls (Gilbert et al., 2009). It has also been found that children who are abused physically or sexually are more likely to carry a weapon in adolescence than those who suffer neglect due to a perceived need for self protection (Gilbert et al., 2009). These individuals also impact society negatively through welfare dependence and homelessness (Grella et al., 2005; Messina et al., 2007; Stein, Leslie & Nyamathi, 2002).

Spiritual Psychotherapy Vs Traditional Psychotherapy

Meaning and Types of Psychotherapy

Psychotherapy is basically a repair work of an impaired human emotion (Kunst & Tan, 1996). When something about a human person is broken, their functioning could become abnormal or disordered, and may result in maladaptive ways of thinking, feeling or behaving (Kunst & Tan, 1996). It then becomes necessary to repair the impaired emotion with a form of psychotherapy (talking cure) with or without medication in order to reduce or remit the symptoms of the mental disabilities (Kunst & Tan, 1996; Corey, 2005).

There are many different theories about what psychotherapy is and how it helps people with their psychological difficulties. Beginning with Freud's pioneering work in psychoanalysis, numerous approaches to psychotherapy have emerged, which include: behavioral, cognitive, existential, psychodynamic, interpersonal, Gestalt, family, and spiritual approaches, among others (Kunst & Tan, 1996; Corey, 2005; Prochaska, &

Norcross, 2007). Each approach has its own set of assumptions about personality, psychopathology, and tools and processes of psychotherapy. In addition, each has a different way of understanding the goals of psychotherapy, from changing maladaptive behaviors to reducing psychiatric symptoms, and altering personality structure (Kunst & Tan, 1996; Corey, 2005; Prochaska, & Norcross, 2007).

Recent research findings show that the treatment of mental disabilities has been improved with the introduction of many medications and psychotherapies such as exposure therapies (a variation of cognitive behavioral therapy – CBT) of Stampfl, Foa and Shapiro (Hollon et al., 2005; Friedman et al., 2004; Fava et al., 2004; Prochaska & Norcross, 2007). For instance, in the study of Fava and colleagues (2004), the findings suggest that the sequential use of cognitive behavioral treatment after pharmacotherapy may improve the long-term outcome in recurrent depression. A significant proportion of patients with recurrent depression might be able to withdraw from medication successfully and stay well for at least 6 years with a focused course of psychotherapy. Hollon et al. (2005) agree with the findings of most research on the effectiveness of CBT in the treatment of depression. However, they remark that questions still remain about the efficacy of CBT on major or severe depression.

Spiritual Psychotherapy: Efficacy in Treatment

Lasting repair or healing of an individual with a psychiatric disability entails restoration of their psychobiological integrity with implication of their personal growth and a sense of renewal (Wilkinson, 2008; Cloninger, 2006). This kind of restoration or

recovery is holistic, and is produced by an integrative treatment approach which uses psychotherapy that considers the three dimensions of a human person, namely: the somatic, the mental and the spiritual (Frankl, 1954; Murphy, 1997; Cloninger, 2006). The psychotherapy that is spiritual, that is, it contains aspects of personal meaning or spirituality. It takes care of the spiritual dimension of a human person in its set of assumptions about human personality (Kunst & Tan, 1996; Frankl, 1954). An integrative treatment approach also uses medication to cure the resulting medical conditions caused by dysfunctional emotion (Anthony, 2008; Cloninger, 2006).

However, some spiritual psychotherapists do not always use medication in treatment. They use only their own patterns of spiritual psychotherapy to help patients to heal by simply assisting them (patients) to find personal meaning for their life issues (Lantz & Lantz, 1992; Karon & Widener, 1998). Their treatment philosophy asserts that the human mind can heal itself and the body naturally when it is helped to make sense of its issues (Karasu, 2009). It is the human mind or soul that is first impaired before the impairment or damage extends to the body (Sims, 2008; Vachss, 1994). Following the sequence, cure and healing would first start from the mind/soul and gradually extends to the body (Townsend, 1995). Spiritual psychotherapy is thus essential for the treatment of an impaired emotion, since human mind or soul is by nature spiritual, and can only be healed by a relevant spiritual or immaterial reality that shares its nature (Frankl, 1962). Personal meaning or spirituality thus enables psychotherapy to achieve its goals in the cure of persons with mental disabilities. These goals include: to help them: a) to find a way out of their mental, moral, emotional, and psychosocial problems; b) to find an

adequate and healthy attitude towards the world and themselves, and to increase their ability for reality testing, social coping behavior, and socio-emotional and moral behavior (Martens, 2003; Frankl, 1954).

Traditional Psychotherapy: Efficacy in Treatment

The current mental health system is a product of western science and uses only medication and traditional or conventional forms of psychotherapy in patient mental healthcare (Blanch, 2007). The western concept of mental healthcare emphasizes self-directedness and cooperativeness, and neglects the inclusion of crucial concept of spiritual awareness and meaning based on self-transcendent values in mental healthcare (Cloninger, 2006). The exclusion of the latter concept leaves the system with only medication and traditional or secular psychotherapies in patient care which may not sufficiently address the peculiar mental health issues associated with the symptoms of childhood trauma (Murphy, 1997; Cloninger, 2006). The omission of personal meaning or spirituality reduces the system to a giant who possesses a great power but has only one eye, and consequently lacks the full wisdom to understand that the human beings it cares for are a composite of body, mind and spirit (Blanch, 2007; Sullivan, 2009). Due to its inadequate notion of man, the current system removes the human beings out of the spiritual plane, and levels them down into the psychological plane (Frankl, 1962). This leveling entails a loss of a whole human dimension, and what is lost is the dimension that allows man to emerge and rise above the level of the biological and psychological foundations of his existence (Frankl, 1962). This is a very important issue for

transcending these foundations and thereby transcending oneself, and it is, in fact, the very act and essence of human existence (Frankl, 1962). Consequently, Frankl (1954) warns that a therapist who ignores the spiritual, and is thus forced to ignore the will-to-meaning, is giving one of his most valuable assets away, for it is this very will-to-meaning that psychotherapists should evoke and appeal (Frankl, 1954).

Corey (2005) gives a similar warning to the developers of psychotherapies. He instructs that any form of psychotherapy should have an integrative perspective, and insists that the developers of psychotherapies should think, holistically, in the process of creating them. To understand human functioning, it is important to account for the physical, emotional, mental, social, cultural, political, and spiritual dimensions of the human person. If any of these facets of human experience is neglected, a theory (of psychotherapy) is limited in explaining how we think, feel, and act (Corey, 2005). Unfortunately, most traditional psychotherapies hardly address sufficiently the issue of spirituality in treatment. This inadequacy or complete absence of spirituality in treatment may lower the quality of recovery in patients (Cloninger, 2006; Sperry, 2010; Murphy, 1997; Blanch, 2007; Byington, 2007).

In his study, Sperry (2010) creates an inventory which assesses the degree of efficacy or effectiveness of different psychotherapies. He measures this value by assessing the level of capacity for self-conscious awareness a given psychotherapy could produce in a patient during treatment. The author identifies four differing levels of self-conscious awareness, namely: little or no conscious awareness, minimal awareness,

moderate awareness and maximal awareness. These four levels of self-consciousness are described below along with their clinical correlates:

A. Levels of Spiritual Development and Consciousness

Ages/ways of Spiritual development	Levels of Consciousness
0. (None)	1. Little or no (conscious) awareness
1. Beginner/purgative	2. Minimal
2. Proficient/illuminative	3. Moderate awareness/metacognitive- meditative
3. Perfect/unitive	4. Maximal awareness/contemplative

B. Levels of Consciousness, GAF, and Duration of Distress Response

Consciousness	GAF	Duration of distress response
Level 0	<60	Several hours or days
Level 1	60—74	Hours
Level 2	75—89	Minutes to an hour
Level 3	90--100	Momentary

Note: GAF = Global Assessment of Functioning scale.

As regards the degree of effectiveness of traditional or conventional psychotherapies in patient care, Sperry (2010) observes that CBT and most conventional psychotherapy approaches appear to be primarily focused on Level 0 and Level 1 considerations. The situation creates a problem for two reasons: First, treatment end points might be limited to symptom reduction or prevention of relapse. These end points may be particularly problematic in long term, chronic conditions such as in recurrent depression where residual symptoms persist in the majority of patients on successful treatment of their mental disabilities. Second, when the goal of therapy is reduction of

symptoms and impairment, but not increased personal effectiveness and well-being, relapse is likely and perhaps even inevitable (Sperry, 2010).

Cloninger (2006) agrees with Sperry to some degree and provides findings of a study demonstrating that relapse could occur in a treatment of a major depression where a conventional approach is used. The findings show that major depression moderately responds to antidepressants or cognitive-behavior therapy (CBT). Substantial improvement occurs in about 50% or 65% of patients receiving active treatment, compared to 30% to 45% in controls. Relapse is rapid in those who drop-out of or prematurely discontinue treatment because the interventions are directed at symptoms and do not correct the underlying causes of the disability (Cloninger, 2006). In another randomized controlled trials of spiritual psychotherapies, Cloninger (2006) observes that patients show improvements in happiness and character strengths that increase treatment adherence and reduce relapse and recurrence rates when compared to cognitive-behavioral therapy or psychotropic medication alone (Cloninger, 2006).

In his first-person account of his experience while in treatment, Murphy (1997), a former patient of a psychiatric community, similarly remarks there is a decrease in quality of recovery when only medication and traditional or conventional psychotherapies are used in patient care. According to him,

It is not currently the fashion in the psychiatric community to search for the meaning of mental illness. The biochemical model of brain dysfunction dominates medical practice at this time, and medications are administered with great impact. With the aids of

drugs some persons improve dramatically, but there are others who continue to deteriorate. I have found that, although psychiatric medication aids in the management of some of my symptoms, it only treats part of the problem (Murphy, 1997, p. 541).

In the above remark, Murphy attributes poor level of recovery among patients in psychiatric communities to sole use of biochemical model and medication in patient care. He almost explicitly notes that meaning or spirituality is not sought and used in these communities. His remark is thus a call for an inclusion of spirituality in traditional treatment approach to make it integrative and more efficacious (Mohr et al. 2006; Corey, 2005; Stanard, Sandhu, & Painter, 2000). Individuals with mental disabilities extensively use spirituality to cope with their symptoms, and, for some of them, religious community is a precious social support (Mohr et al., 2007). Thus, a balanced and an effective treatment approach for that meet the therapeutic needs of these patients has to comprise psychotherapies with aspects of spirituality and medication. This approach considers all the aspects of the whole human person: body, mind/soul and spirit in care delivery (Wilkinson, 2008; DiNunno, 2000; Blanch, 2007; Frankl, 1954). However, when this integrative approach is not used in patient care, the degree or extent of recovery could be poor. Sperry (2010) assesses the degree of recovery from Levels 0 - 3 of conscious awareness in his recovery scale. At the Level 0 of consciousness,

... individuals experience very little or no awareness. Instead

they engage in emotional thinking, act in an egocentric fashion, seek immediate gratification, and display impulsivity and emotional instability. Their actions often seem “guided” by their severe personality disorders, substance dependence, or psychoses. When they experience distress and upset, it typically lasts for several hours or even a few days at a time until a sense of calm is reestablished. Their GAF scores tend to be under 60 (Sperry, 2010, p. 49).

While at the Level 1 of consciousness,

... individuals experience a minimal level of awareness. Accordingly, their actions are purposeful and although still somewhat egocentric, they have some impulse control and can delay gratifications relatively well in non-stressful situations, but poorly when under moderate stress during which they can exhibit a range of negative effects. The duration of their experience (of) distress and upset usually lasts for hours. Their GAF scores tend to be in the range of 60 to 74 (Sperry, 2010, p. 49).

At the Level 2 functioning or consciousness,

... individuals experience a moderate level of awareness. They are mature and aware of others’ needs as well as their own subconscious thinking. Their demeanor is characterized by

calmness and patience. They typically experience positive emotions and are able to observe themselves and others with little need to judge or blame. As a result, they deal reasonably well with conflicts and relationships. The duration of their experience of distress and upset usually lasts for minutes to an hour or so. Their GAF scores tend to be in the range of 75 to 90 (Sperry, 2010, pp. 49-50).

Lastly, at the Level 3 which is the peak of functioning,

... individuals experience a maximal level of awareness. Such awareness includes self-transcendence and a connection with a greater oneness or wholeness beyond the self. This translates to selfless calm, impartial awareness, creativity, and loving behavior. They are in touch with previously unconscious thoughts and motivations ... (they) possess a balanced outlook (in) life and no longer struggle with wishful thinking and conflicts. Consequently, their experience of distress and upset is very short-lived and momentary. Their GAF scores tend to be at the highest levels, that is, in the 90s (Sperry, 2010; p. 50).

This is indeed the optimal level of mental well-being and functioning that is achieved in patient care with well integrated treatment approach with aspects of spirituality or personal meaning. This level of recovery produces remission of symptoms

and impairments of mental disabilities, and not merely their reduction (Cloninger, 2006; Sperry, 2010).

Viktor Frankl's psychotherapy for adults abused in childhood, which is spiritually psychosocial in character, is an excellent example of an efficient treatment program that produces an optimal level of well-being and functioning in patient mental healthcare (Lantz & Lantz, 1992). The ideas of Frankl about the human will-to-meaning are central to this psychotherapy. They (ideas) are found to be very helpful in the care of patients in coping with traumatic experiences (Lantz & Lantz, 1992). His therapeutic approach to post-traumatic stress disorder (PTSD) is based on a belief in the core importance of helping the trauma client to perceive, discover and experience a sense of purpose and meaning in life (Lantz & Greenlee, 1990).

The use of this approach guards against trauma's disruption of search for meaning which can result in an existential or meaning vacuum, that is, an experience of inner emptiness, a total lack or loss of an ultimate meaning to one's existence that would make life worthwhile (Frankl, 1962). If the individual is not assisted to fill this existential vacuum with a developing sense of purpose and meaning in life, it will be filled instead by problems and symptoms such as some forms of depression, anxiety, substance abuse, emotional numbness, sexual problems, interpersonal difficulties, isolation and the like (Lantz & Greenlee, 1991; Chaikin & Prout, 2004). The use of this psychotherapy in the care of traumatized persons helps them to overcome their disruptions, shrink their

existential vacuum and limit their opportunity for symptom development (Lantz & Lantz, 1992).

The Franklian psychotherapy of consists of three treatment interventions, namely: network intervention, social skills training and existential reflection (Lantz & Lantz, 1992). Network intervention

... is used to increase the meaning opportunities in the trauma client's social situation and social environment. In many instances, the adult victim of child sexual abuse is isolated by people in his or her family and social network when the person begins to remember details of abuse as a child. Such isolating behavior occurs in reaction to the anxiety that is triggered in the family system and in the extended family network by the victim's memories of trauma and terror. This punishes the trauma victim for remembering the details of the abuse.... (Network is therefore) ... used to help the adult who was molested as a child to find and participate in a support group and/or support network that will treat him or her "with meaning," with acceptance, and as a person who deserves to be believed (Lantz & Lantz, 1992, p. 298).

Social skills training is another phase of intervention. It is

... used to help the client improve his or her ability to “make use” of the meaning opportunities and meaning potentials that do exist in the client’s social and family environment. In the social skills training, the therapist teaches the trauma client new interactional, communication, and problem-solving difficulties that have developed in reaction to the childhood trauma experiences (Lantz & Lantz, 1992, p. 298).

Lastly, existential reflection intervention

... uses questions, comments, empathy, interpretations, and sincere personal interest to help the trauma victim to bring repressed meanings and potentials out of the unconscious level of awareness and into the conscious level (Lantz & Lantz, 1992, p. 299).

Viktor Frankl de-emphasizes the role of medication in his practice as a psychotherapist although his specialties are in neurology and psychiatry (Frankl, 1954). The central theme in his psychotherapy has always been an emphasis on the importance of helping trauma survivors to discover and make use of the unique and personal meaning opportunities in their worlds through self-transcendence in order to make sense of their memories of trauma and terror (Lantz & Lantz, 1992). A sound philosophy of life may be the most valuable asset a psychotherapist could rely on when they are treating a patient in ultimate despair (Frankl, 1962). The meaning of human existence and man’s will-to-

meaning are accessible only through an approach that goes beyond the plane of merely psychodynamic and psychogenetic data. This plane of existence is man's spiritual dimension of being. It is in this spiritual plane that a psychotherapist has to accompany a client to help them access the unique meaning of their life issues (Frankl, 1962). In this way, the pain of a traumatic experience can be transformed into meaning awareness rather than repressed and/or acted out (Lantz & Lantz, 1992).

In his psychotherapy for adults abused in childhood, Frankl identifies and deals directly with the source of their symptoms, and that source is repression (Lantz & Lantz, 1992). Repression is a double-edged process that keeps traumatized persons from directly experiencing painful memories of trauma, and, also, prevents them from experiencing the "meaning potentials" that are always embedded in the experience of trauma (Lantz & Lantz, 1992; Karon & Widener, 1998). The Franklian psychotherapy neutralizes the negative tendency of repression by assisting traumatized adults to remember their traumatic experiences, which helps them to recover and gain meaning potentials to consciousness that have been embedded in the unconscious memory of trauma. Experiencing flashbacks and intrusive memories is a means adults use to initiate a search for meaning potentials contained in the memories of trauma (Lantz & Lantz, 1992).

Karon (Karon & Widener, 1998) reports how he treated an adolescent or a young adult who had repression. The patient could not remember anything that happened in his life before his second year in high school. He and his family thought that the situation was normal until his psychological condition worsened and he was hospitalized. Many

psychiatrists diagnosed his mental condition as incurable schizophrenia, and recommended electro-convulsive treatment. The family was told that the treatment would probably not cure him, that it was the only hope he had. Luckily, a friend of the family whose specialty was in experimental psychology referred them to this psychiatrist. The patient was withdrawn from the hospital intensive care and taken to the psychiatrist's clinic. He then began treating patient of his repression without using medication. He reports that after years of hard work, the patient recovered and regained the memories of his childhood. According to Karon (Karon & Widener, 1998), the survivor currently has a distinguished career and a good marriage.

Karon and Frankl share a similar non-medication approach in the care of persons with repression. Their treatment approach is to locate first the sources of clients' emotional impairments and then help clients to find personal meaning for their trauma memories and to heal from them. Healing process begins first with the restoration of impaired emotion, and extends automatically to the physical domain of functioning (Stanard et al. 2000). A correct notion of a human person is thus very vital in providing an effective care for persons with mental disabilities. When a human being is understood from a mechanistic view of the physical universe, they are regarded and reduced to physical machines whose operations can be explained without reference to a Higher Power or God (O'Grady & Richards, 2010; Frankl, 1954).

There is, however, a growing awareness of the importance of spirituality in contemporary society, and it is becoming a vital topic of discourse in social and physical

sciences (Piedmont, 2001). This spiritual awakening is an indication of growing acceptance that human beings are not only physical but also spiritual beings, and that their problems or issues also have spiritual roots (Stanard et al., 2000). Encouraging clients, therefore, to engage in some spiritual activities helps them to address issues that pertain to their spiritual distress (Stanard et al., 2000). The spiritual exercises that could assist them to grow in awareness include: search for meaning through meditation, making a connection to a higher Being, Power or God, taking a yoga class, cultivating the ability to forgive, helping other people, worshipping with one's faith community, listening to a classical, sacred or any inspirational music, reading of the Bible, Torah, Koran, and other Holy Books; praying, and the like (Mascaro & Rosen, 2008; Hartog & Gow, 2005; Mascaro & Rosen, 2006, Royal College of Psychiatrists, 2010; Revheim & Greenberg, 2007).

Spirituality Impact on Childhood Trauma Outcomes

During the past decades, mental health researchers and professionals have shown frequent concerns over the role of spirituality/religion in the lives of individuals with severe psychiatric disabilities (Fallot, 2001). Some influential thinkers in the field of clinical psychology, such as Freud and Ellis, have associated religious beliefs and practices with mental illness manifested in hysteria, neurosis, and psychotic delusions (Newman & Pargament, 1990; Koenig, 2009). Freud construes religion as a universal obsession neurosis of humanity, and describes its teaching as neurotic relics (Koenig, 1999). On his part, Ellis (1980) refers to religion as an irrational thinking and emotional

disturbance. He holds that people largely disturb themselves by believing strongly in the absolutistic shoulds, oughts, and musts, and that most people who dogmatically believe in some religion believe in these health-sabotaging absolutes (Ellis, 1980).

However, recent research studies have clarified why persons with mental disabilities tend to show more negative responses and lesser positive ones toward spirituality or religion. Koenig (1999) observes that Freud may have based his negative opinion of religion on his own limited, somewhat negative personal experiences and his treatment of mentally ill persons, in whom religion is often distorted. He notes that if Freud had been treating older medical patients, his view of religion might have been different (Koenig, 1999). In his study on the role of spiritual coping in CSA adult survivors' responses to current life stressors, Gall's findings (2006) show the importance of making a distinction between negative and positive forms of spiritual coping when examining the role of spirituality in the current life functioning of adult survivors of childhood sexual abuse (Gall, 2006). The results acknowledge that spiritual coping behavior may play a negative role as well as a positive role in survivors' response to current life stress. This may especially be the case for those survivors who have suffered more severe forms of abuse and who have not personally confronted their abuse (Gall, 2006).

In a similar study by Gall, Basque, Damasceno-Scott & Vardy (2007), their findings indicate that a relationship with a benevolent God or higher power is related to the experience of less negative mood and a greater sense of personal growth and successful resolution of the abuse. Feinauer et al. (2003) and DeFrain et al. (2003) used

an existential approach in their studies on this subject. Feinauer and group (2003) observe that the goal of increasing existential well-being of client is focused on increasing respect for the uniqueness of the individual. It encourages survivor of traumatic experiences to gain a sense of commitment toward growth and a sense that there is meaning in their existence. The internal affirmation that the survivor has value in the face of terrible memories gives rise to hope. Hope is an essential element for healing and recovery (Feinauer et al., 2003). Their results seem to show that survivors with a higher sense of well-being experienced significantly less disturbance in terms of trauma symptom than those who did not have a sense that there was higher purpose in their lives (Feinauer et al. (2003). Whereas, DeFrain et al. (2003) suggest that human beings are capable of healing from traumatic experiences. However, the journey to health is a long and difficult one, and the early negative experiences appear to be internalized in the individual's very soul, perhaps for as long as the person is alive. As children and young adults, trauma survivors somehow manage to survive their traumatic time, which may last on average of 19 years; as adults they learn how to transcend their traumatic experiences (DeFrain et al., 2003).

These research studies have reasonably clarified most of the previously held damaging misconceptions of spirituality in the care of mentally ill patients, and have assisted in highlighting the truly great healing potential of spirituality (Gall, 2006; Gall et al., 2007; Feinauer et al., 2003; DeFrain et al., 2003; Fallot, 2001). Currently, there is a growing interest and recognition of the importance of spirituality in the healthcare system as a psychological and social resource in coping with stress (Koenig, 2009), and as a resource that improves physical and mental health (Fallot, 2001). These accruing health

benefits from spirituality have prompted its inclusion in patient care in many hospitals and mental healthcare centers (Wong-McDonald, 2007).

Today, many individuals with mental disabilities view spiritual exercises such as daily prayer, weekly religious worship, music therapy, and the like, as an integral part of their recovery process (Wong-McDonald, 2007; Young, 2010; Sullivan, 2009). A survey of patients (n=406) with persistent mental disabilities at a Los Angeles County mental health facility found that more than 80% of the population used religion to cope and most of them spent about half of their coping time in spiritual exercises such as prayer (Koenig, 2009). Repetitive prayer and nonreligious meditation have been found to have similar relaxation effects. However, repetitive prayer (that is, a prayer that is said all over again several times for an intention and relaxation, for instance, Catholic rosary) is found to be more comforting, emotionally. It slows down a person's heart and breathing rate, lowers the blood pressure, and even calms the brain waves without the use of drugs (Koenig, McConnell, & McConnell, 1999). McCullough (1995) suggests that prayer may involve in neuro-immunological, cardiovascular, and brain electrical changes. He argues that prayer may promote health through the induction of relaxation, which in turn may lead to decreased heart rate, lessened muscle tension, and slowed breathing (McCullough, 1995). Exercises in mindfulness meditation and somatic relaxation also produce similar health outcomes. In a study of Jain and colleagues (2007), the findings indicate that both mindfulness meditation and somatic or body relaxation are effective in reducing negative psychological states and in enhancing positive states of mind for

students experiencing significant distress. However, mindfulness meditation appears unique in reducing rumination and distraction compared with relaxation (Jain et al. 2007).

Music therapy is another aspect of spirituality that patients use as an effective resource to cope and recover from mental disabilities (Rio, 2005). Covington (2001) reports of a music therapy developed at a regional inpatient psychiatric hospital in Colorado for adolescents and adults using music as a means for psychological and emotional healing. The therapy offers a noninvasive approach to heal emotion, strengthen skills and effect a positive change in behavior. The music program is based on Rogers' theory of unitary human beings as its theoretical framework. According to Rogers (Covington, 2001), human beings and the environment are identified by characteristic patterns of energy. The human and environmental energy fields are integral, irreducible, and inseparable from one another. The process of life is thought to be dynamic and ever changing (Covington, 2001). Although the assessment and evaluation tools of the music program has not been validated or tested for reliability, patients

... felt that music helps "quite a bit" as a motivator and as a way to reduce anxiety, and physical and emotional pain. Patients felt that music's role in expressing feelings was only "minimal." Many participants viewed the benefit to self-esteem, socialization, and aid to goal accomplishment as "somewhat" helpful (Covington, 2001, p.66).

This program (Covington, 2001) reports how music positively impacted a 13-year-old male patient in a therapeutic music session, who was admitted to the inpatient unit of the hospital for treatment of depression. This teen patient was diagnosed with conduct

disorder and depression, and he seldom spoke during his time in the unit. During one music group session, however, he drew a magnificent eagle with only one wing flying through the air. He wanted to use the picture as a way of expressing his feelings. While processing this picture, he shared with the group how the eagle was a power symbol he used to express his desire for freedom from his parents and his depression (Covington, 2001).

Due to its numerous health benefits, many clients want their psychotherapists to be aware of their spiritual beliefs and needs, and to address these needs in therapy for their faster, holistic recovery and well-being (Cloninger, 2006; Wong-McDonald, 2007; Fallot, 2001). Literature has identified spirituality as an empowering reality which invites and enables human beings to attain transcendence as the path to the highest levels of well-being - to acquire personal, spiritual, existential or coherent meaning by which they connect with the world, and above all, with the unifying source of all life (Feinauer, Middleton & Hilton, 2003; Mascaro & Rosen, 2006; Grossman, Sorsoli & Kia-Keating, 2006; Cloninger, 2007). Getting help to make this connection can provide lasting meaning, hope, love, happiness, health, satisfaction (Cloninger, 2007; Mascaro & Rosen, 2006), and optimal emotional functioning in life even in the face of serious sickness and other life adversaries (Feinauer et al., 2003; Mascaro & Rosen, 2006).

The study of Baetz and colleagues (2004) suggests the extent psychiatric patients desire and want psychiatrists to be aware of their spiritual beliefs and needs, and to address these needs in therapy. It compares psychiatrists' and psychiatric patients' practice, attitudes, and expectations regarding spirituality and religion. The results of the

study show that psychiatrists had lower levels of beliefs and religious practices than did patients and the general population. In both groups, 47% felt there was “often or always” a place to include spirituality in psychiatric assessment, although the perceived importance differed. Among patients, 53% felt it was important to have this issue addressed, and 24% considered the psychiatrist’s spiritual interest important in their choice of psychiatrist (Baetz et al., 2004).

Although not strongly stressed, the findings of the above study (Baetz et al., 2004) emphasize the need for a deeper education of all psychiatrists and other mental health practitioners in the field of spirituality and religion so that they could be sufficiently informed in this field to be able to address the spiritual issues of their patients in order to accelerate their psychobiological recovery (Cloninger, 2007; Mohr, Gillieron, Borrás, Brandt, & Huguelet, 2007; Sullivan, 2009; Baetz et al., 2004). Individuals with mental disabilities often search for answers to questions about their existence and their failing health conditions, the meaning and purpose of life, sickness and suffering and happiness, although this quest is not always obvious (Cloninger, 2007). They urgently need help with satisfying answers to these existential questions from the mental health professionals who care for them (Cloninger, 2007). Offering adequate interventions in this crucial area of patient care and needs (personal meaning and spiritual solace), would save a good number of them from drowning in the mighty ocean of meaninglessness and despair resulting from the existential vacuum created in their lives by their mental disabilities (Cloninger, 2007; Fallot, 2001).

Spirituality and Depression

Depression is characterized predominately by one or more symptoms, including feelings of sadness or misery, unexplained tiredness and fatigue, the feeling that even the smallest tasks are almost impossible; a loss of appetite for food, sex, company or weight; excessive worry, feeling like a failure, unjustified feelings of guilt, feelings of worthlessness or hopelessness, lack of meaning or purpose in life, low self-esteem, sleep problems and physical symptoms such as back pain or stomach cramps; difficulty thinking, concentrating or making decisions; recurrent thoughts of death or suicidal ideation, plans, or attempts (DSM-IV-TR, 2000; Mental Health Foundation, 2006; Diner, Holcomb & Dykman, 1985).

Notwithstanding these disabling tendencies, literature has shown there is a convincing relationship between spirituality and prevention, coping and quick recovery from depression (Larson & Larson, 2003; Koenig et al., 1999; Covington, 2001; Mental Health Foundation, 2006). A review of more than 80 studies by McCullough & Larson (1999) published over the last 100 years finds spiritual activities are generally associated with decreased levels of depression. Individuals who took part in a religious group activity and who also highly valued their religious faith were at a substantially reduced risk of depressive disability, whereas those without any religious links might raise their relative risk of major depression by as much as 60%. Lack of organizational religious involvement was linked with a 20-60% increase in the odds of experiencing a major depressive episode. The researchers (McCullough & Larson, 1999) suggest that valuing

one's religious faith as centrally important and actively belonging to a religious group may give spiritual basis for meaning (McCullough & Larson, 1999; Mental Health Foundation, 2006) as well as receiving support from others. Such activities potentially provide hope and caring, which might also help in protecting against depression (McCullough & Larson, 1999).

Similar studies documented in Koenig (2009, 2007 & 1999) also identify spiritual/religious activities with lower rates of and faster recovery of the participants from depression. Another study of a general population of a racially diverse US sample of community-dwelling adults provides findings associating higher levels of spirituality with lower levels of depressive symptoms. Age and stress moderate the association. It suggests spirituality appears to be a psychosocial resource that may protect against depression, particularly in middle-aged adults and those who have experienced stressful life events (Mofidi, DeVellis, Blazer, DeVellis, Panter, & Jordan, 2006). In a situation of a chronic depressive disability which impairs the spiritual/religious involvement of a patient, Koenig (2007) suggests that their depression should be aggressively treated and the patient's prior religious activity encouraged. Once depression has been treated, religious activity and support may be the key to maintaining that patient in remission. He notes that physicians' failure to use this approach can cost them important information that may influence both patients' mental and physical health (Koenig, 2007; Alexander, Haugland, Ashenden, Knight, Isaac & Brown, 2009).

Spirituality and Suicide

Depression has been identified as one of the strongest predictors of suicide, especially when it is accompanied by hopelessness (Koenig (2007; Beck et al., 2006). People often commit suicide when they perceive that there is no way out of an intolerably painful situation, or when they see no purpose or meaning to a life of seemingly unending suffering. Impulsive and aggressive behaviors and alcohol abuse/dependence have also been found to be two independent predictors of suicide in major depression (Dumais, Lesage, Alda, Rouleau, Dumont, Chawky, Roy, Mann, Benkelfat & Turecki, 2005; Dervic, Oquendo, Grunebaum, Ellis, Burke, & Mann, 2004). The authors suggest that impulsive and aggressive behaviors seem to underlie these risk factors and are more prevalent among young adults aged 18 to 40.

As regards their relationship, convincing evidence demonstrates that spirituality may act as a potential safeguard against suicide (Larson & Larson, 2003). Spirituality is generally associated with positive mental health outcomes and high levels of well-being: access to social supports, resilience to stress, emotional calmness and stability, inner strength and empowerment, sense of well-being, and lower risk of suicide (Alexander et al, 2009). The study of Dervic and colleagues (2004) which investigated the relationship between religion and suicide attempts among depressed inpatients (N=371) shows that patients who had no religious affiliation or community had significantly more lifetime suicide attempts and more first-degree relatives who committed suicide than those who had a religious affiliation. Their findings reveal the religiously unaffiliated participants

were younger, often unmarried, less often had children, and had less contact with family members. They also perceived fewer reasons for living and thus had weak moral objections to suicide. These participants were clinically characterized by lifelong impulsivity and aggression, and had past substance use disability (Dervic et al, 2004).

The principal finding of the authors (Dervic et al, 2004) in the study has been that religion provides a positive force that counteracts suicidal ideation in the face of depression, hopelessness, and stressful events. The participants with religious affiliation in study reported less suicidal ideation at the time of evaluation, despite the fact they had comparable severity of depression, number of adverse life events, and severity of hopelessness with the participants of the opposite group. They also found that religious commitment promotes social ties and reduces alienation. Similar studies (Nisbet, Duberstein, Conwell, & Seidlitz, 2000; Stack, 1983) and literature review (Larson & Larson, 2003; Koenig, 2009) on the subject have also found that individuals who do not participate in religious activities have higher rates of committing suicide than those who frequently do. Spirituality (religion) is therefore in an inverse relationship to suicide. It (spirituality) counteracts hopelessness, isolation, and despair - all of which are closely associated with completed suicide (Alexander et al, 2009).

Spirituality and Anxiety

Positive outcomes have also been identified among individuals who use spiritual activities to cope with anxiety or stress (Koenig, 2009; Wong-McDonald, 2007; Koenig, 2007). The symptoms commonly associated with anxiety can be emotional, intellectual,

physical and/or social. They also include feelings of shame, grief or aloneness, difficulty concentrating or an inability to learn new details; increased breathing and pulse rate, difficulty sleeping and problems with eating, fearful/uneasy being with others (social apprehension), isolation or withdrawal and abnormal/excessive reaction, sensibility, anger, frustration or unusual levels of aggression (Mental Health Foundation, 2006).

In a study documented in Larson & Larson (2003), 62 Muslim patients with generalized anxiety disability were randomized to receive either: a traditional treatment of supportive psychotherapy with anxiolytic drugs or traditional treatment with medication plus psychotherapy with religious content, involving patient prayer and reading verses of the Holy Koran specific to the person's clinical condition. The study reports that patients receiving psychotherapy with religious content showed significantly more rapid improvement in anxiety symptoms than those receiving traditional therapy that did not have aspects of spirituality (Larson & Larson, 2003).

Similar studies documented in Mental Health Foundation (2006) show there is also a positive correlation between spirituality and anxiety. In one of them, heart transplant patients that attended church frequently reported less anxiety and had higher self-esteem than those who attended less frequently. Also, a similar study conducted by Pardinia and colleagues (2000) identify similar results. Another study explores whether spiritual involvement and beliefs and spiritual coping mechanisms could account for any of the variation in anxiety among women within one year's diagnosis of cervical cancer. It found higher levels of anxiety in those who did not use positive spiritual coping

mechanisms, and that this was especially true for younger women and those with more advanced stages of the disease (Mental Health Foundation, 2006).

Overall, literature has evidenced that persons who are frequently involved in spiritual/religious activities have reduced levels of anxiety or stress (Koenig, 2007; Wong-McDonald, 2007). Music, for example, has been documented to be effective in reducing anxiety and promoting relaxation, hope and joy (Covington, 2001). Religious beliefs and practices can also comfort persons who are fearful or anxious, increase sense of control, enhance feelings of security and increase self-confidence or confidence in Divine beings, although some of them may have the potential to induce guilt and fear that diminish the quality of life (Koenig, 2009). However, not all the studies exploring the association of spiritual or religious activities and anxiety show evidence of beneficial effect. It rather seems to depend, to some extent, on the way in which spirituality is expressed (Mental Health Foundation, 2006).

Spirituality and Substance Abuse

Substance abuse or dependence is a disabling habit of an individual whereby they persistently prefer the use of alcohol or other drugs in place of their previous priorities, relationships and values, despite the problems that result from the dependence (Miller, & Bogenschutz, 2007). This habit may lock the affected individuals in their own narrow worlds of emotional pain, interpersonal difficulties, insecurity, defensiveness, and low self-esteem. Burdened under the weight of their perceived failings, and unable to find

escape from their faults and pain, they may despair and live in their very narrow and limited worlds (Piedmont, 2004).

Recovery from substance dependence is a slow process that involves rebuilding one's isolated, psychopathological world into a healthier and more fulfilling one (Prezioso, 1987). Spirituality is an effective tool the substance abusers need to reconstruct their lives. The former (spirituality) helps alcoholics shift from their impaired limited self-perception to a broader perception of the dimensions of their lives in connection with other realities (Piedmont, 2004). The recovery process entails involvement in spiritual activities such as prayer, meditation, self-acceptance and the ability to move toward greater authentic relationship with fellow human beings, and God or Higher Power. The spiritual exercises gradually infuse creative energy in the affected persons, allowing them to experience once again a sense of renewal and enthusiasm for living, and a growing belief that there is a larger purpose for their lives, a reason for being in the world (Prezioso, 1987; Wilkinson, 2008; Cloninger, 2006). Thus, spirituality reintroduces substance abusers as meaningful and valuable members of the larger human family. Spirituality stresses the value of people despite their brokenness; it emphasizes the importance of each person's life in maintaining the integrity of the fabric of human experience (Piedmont, 2004).

A documented review (Larson & Larson, 2003) of 86 studies examined spiritual or religious commitment and alcohol use. Some 88% of them found lower alcohol use/abuse among the more religious, including the high risk group of adolescents and young adults. Persons lacking a strong religious commitment were more at risk to abuse alcohol. Risk

for alcohol dependency was 60% higher among drinkers with no religious affiliation compared to members of conservative denominations in another documented study (Larson & Larson, 2003). Furthermore, the findings of the study by Pardini and colleagues (2000) show positive mental health benefits when religious faith and spirituality were incorporated in substance abuse recovery. Here, higher religious faith and spirituality were associated with increased coping, greater resilience to stress, an optimistic life orientation, greater perceived social support, and lower levels of anxiety. Even after controlling for social desirability, the associations between religious faith, spirituality, and positive mental health remained (Pardini, Planteb, Shermanc, Jamie & Stumpd, 2000). Spirituality is thus in an inverse relationship to alcohol/drug abuse and its associated problems (Miller, & Bogenschutz, 2007).

Spirituality and Schizophrenia

Schizophrenia is a chronic and debilitating psychiatric disability characterized by multiple psychological processes, such as: perception ideation (hallucinations), reality testing (delusions), thought processes/loose associations, feelings (flatness, inappropriate affect), behavior (catatonia, disorganization), attention, concentration, motivation (impaired intention and planning) and judgment. These characteristics are associated with impairments in multiple domains of functioning such as learning, self-care, working, interpersonal relationships and living skills (Mohr & Huguelet 2004).

There is evidence that spirituality is highly prevalent and vital to many individuals suffering from schizophrenia (Mohr, Branddt, Borrás, Gillieron & Huguelet, 2006). For

them, spirituality/religion plays a central role in the processes of reconstructing a sense of self and recovery (Mohr & Huguelet 2004). In other words, spirituality restores their psychobiological integrity disintegrated by its disruption of their cognition, perception and emotion (Mental Health Foundation, 2006; Mohr & Huguelet, 2004; Wilkinson, 2008; Cloninger, 2006). In a first-person account of schizophrenia, Murphy (1997) reports how he made a substantial recovery from schizophrenia when he returned to religion. According to him,

By turning back to religion, my impulsivity ... diminished. I found orderliness in my thinking and respect for authority. The chaos of my schizophrenic behavior is nearly gone for I find I like to obey rules and feel the “anything goes” philosophy I once had is self-destructive. Once in a while I still have setbacks, but in general, I’m doing much better. I have a lot more motivation and not so many negative symptoms or depression. When I relied only upon medication my condition was still poor. Drugs could only do so much, and something was lacking. ...I now see that much of depression was a nihilistic crisis. ..., nihilism is a general rejection of customary beliefs in morality, religion, and the like. It is the belief that there is no meaning or purpose in existence. This kind of crisis affects many in our materialistic Western culture. I denied the existence of any knowledge or truth. This is something that still creeps into my life almost daily.

The problem of not finding meaning made me feel like a boat without a rudder and a ship without a captain. After all, if there is no purpose, why get up in the morning? And if there is no absolute basis for knowledge, why believe anything at all? This was quite depressing! My current belief system has aided me with these problems, and I no longer need medication for depression (Murphy, 1997; p. 543).

Finding meaning and purpose in life is indeed therapeutic. Little wonder so many individuals suffering from schizophrenia use spirituality/religion to cope (Mohr & Huguelet, 2004). Incorporating spirituality in caring for the affected individuals helps to reduce psychopathologies, enhance coping and foster recovery (Mohr & Huguelet, 2004). However, some studies suggest that religion does not always offer health benefits to schizophrenic patients. It rather presents them with some negative outcomes of difficulties (Koenig, 2009; Mohr et al., 2006; Sullivan, 2009). Religion may become part of the problem as well as part of the recovery. Some patients are helped by their faith community, uplifted by spiritual activities, comforted and strengthened by their beliefs (Mohr & Huguelet, 2004).

In view of its (religion's) partial disabling outcomes in the treatment of schizophrenia, Mohr & Huguelet, (2004) observe that most studies tend to research on religion and schizophrenia mainly at the acute phase of the disability when there is a high prevalence of religious delusions among patients. Only a few studies examine patients in remitted states when they could assess the function of spirituality in their recovery. They

instruct that even if the spirituality of patients is distorted at certain times, this doesn't mean that their spiritual experience is always illegitimate or the product of distorted thinking (Mohr & Huguelet, 2004). Religious delusions are but a product of a patient's culture (Koenig, 2009; Sullivan, 2009; Mohr & Huguelet, 2004).

Mohr, Branddt, Borrás, Gillieron, & Huguelet, (2006) demonstrate from the results of their study that the health benefits of spirituality/religion are far greater than its negative outcomes when incorporated in the treatment of the schizophrenic population. Their study findings show that,

For some patients, religion instilled hope, purpose, and meaning in their lives (71%), whereas for others, it induced spiritual despair (14%). Patients also reported that religion lessened (54%) or increased (10%) psychotic and general symptoms. Religion was also reported to increase social integration (28%) or social isolation (3%). It may reduce (33%) or increase (10%) the risk of suicide attempts, reduce (14%) or increase (3%) substance use, and foster adherence to (16%) or be in opposition to (15%) psychiatric treatment (Mohr, Branddt, Borrás, Gillieron, & Huguelet, 2006; p.1952).

Based on the clinical significance of religion in their study, Mohr and colleagues (2006) recommend that spirituality be integrated into the psychosocial dimension of care for individuals with schizophrenia. They also suggest that mental health professionals be

highly sensitive and particular in their approach to each unique story of the affected individuals due to the complexity of the relationship between religion and schizophrenia.

CHAPTER 3 METHODS

The purpose of this study was to examine whether adults who had experienced childhood trauma, and who had a higher sense of personal meaning or spirituality, would have better mental health and lower trauma symptoms. This may inform if a higher sense of personal meaning or spirituality is related to improved mental health and lower trauma symptoms.

Statistical Hypotheses

The following null hypotheses were tested:

1. There was no statistically significant relationship between achievement, relationship, religion, self-transcendence, self-acceptance, intimacy, fair treatment and good mental health condition.
2. There was no statistically significant relationship between these predictor variables and good physical health condition.
3. There was no statistically significant relationship between these predictor variables and good condition of general well-being.
4. There was no statistically significant relationship between dissociation, anxiety, depression, SATI (Sexual Abuse Trauma Index), sleep disturbance, sexual problems and good mental health condition.

5. There was no statistically significant relationship between these predictor variables and good physical health condition.
6. There was no statistically significant relationship between these predictor variables and good condition of general well-being.

Participants

The sample consisted of $N = 115$ participants who were randomly selected from the Detroit Rescue Mission Ministries (DRMM), The Salvation Army Eastern Michigan Division, Harbor Light System, Detroit, and Ypsilanti Medical and Drug Rehabilitation Clinic, Ypsilanti. They are all located in the southeastern region of the State of Michigan of the United States. Letters of request were written to the administrators of these mental health facilities and others in the region to authorize the use of their centers to test the survey questionnaires of this study. The above mentioned administrators granted the request but could not allow the testing of the study measures until the study was approved by the Institutional Review Board of Wayne State University. Upon its approval on July 06, 2011, they were contacted. The administrator of DRMM provided three mental health centers, designated as: DE, DW and DS; while the other two administrators provided one center each, DSA and Y, for the study test.

DE, DW, DS and DSA are inpatient/residential treatment centers and had similar psycho-spiritual and medical treatment programs consisting of medication, community project, group therapy, individual therapy, housework skills group therapy, spiritual life classes, prayer, worship, 12-steps/spiritual journey or AA and NA meeting, male gender

group/women's ministry, women's NA meeting/men's fellowship, meditation, men of integrity session/bible study, choir rehearsal, and others. However, some differences were observed in the qualities and quantities of their integrated treatment programs and these also reflected on the behavioral health of their respective consumers who were participants in this study. Whereas, Y is an outpatient treatment center which provides an outpatient treatment to its consumers comprising more of medications and a few spiritual activities. It is open to consumers Monday through Saturday, from 9:00 a.m. to 12:00 p.m.

The majority of the population of participants was male (83%), while the female population was only 17%. The criteria for their selection for this study included: an experience of one or multiple childhood abuses or traumas, namely - physical abuse, sexual abuse, verbal/emotional abuse, child neglect or cumulative trauma. The other criteria were: The participants had to be in treatment as at the time of this study, and should be between the ages of 18 and 60 years old. The consumers who did not meet all these criteria were excluded from the study.

Procedures

The testing of participants took place from July 22, 2011 through August 9, 2011. A common procedure was used in the testing of participants from DE, DW and DS mental health centers. They assembled together in a hall or chapel on their respective scheduled dates for testing. Then, they were first clearly informed about the purpose and procedure of the study, and the reason they were being asked to be in a research study that was

examining whether adults who had experienced childhood trauma and who had a higher sense of personal meaning or spirituality, would have better mental health and lower trauma symptoms (mental disabilities) such as depression, anxiety, low self-esteem, difficulties in relationship, self-harm, suicide, obesity, heart disease, liver disease, lung disease, and many others. The participants were told that they might not directly benefit from taking part in this research study; however, the information from it might benefit other people now or in the future. They were also told that the study was approved by the Institutional Review Board of Wayne State University, Detroit, Michigan; and that participation in the study was voluntary and that they were free at any time of their choice to stop taking part in the study. The participants were also assured of the confidentiality of their personal information. After passing out all these vital pieces of information about the study, the survey packages were distributed among participants. Those who you agreed to take part in the study were given a survey package each. They then read and signed the informed consent form, filled out a demographic questionnaire, and two survey questionnaires, namely: Personal Meaning Profile (PMP) which measures mental health well-being, and Trauma Symptom Checklist-40 (TSC-40) which measures trauma symptoms or mental disabilities. It took them about 40 minutes to finish the three questionnaires.

Different procedures were used to test participants from DSA and Y mental health centers. At DSA, the survey packages were given to the administrator who in turn distributed them to her residential consumers who agreed to take part in the study. She collected later the copies of completed and blank survey packages from the participants

and then indicated they were ready for collection, and they were promptly collected from her by the principal investigator of this study. Whereas at the Y center a day was assigned to test its consumers who would agree to take part in the study. The principal investigator came in the morning at about 9:30 a.m. and informed the consumers about the study as they came in to refill their medications or go for counseling. Those who agreed to participate were given a survey package. They read it and signed the informed consent form, and filled out the demographic questionnaire and the two survey instruments, PMP and TSC-40. No monetary incentive was given to participants who took part in this study.

Clinical Measures

Demographic Questionnaire: Participants filled out a demographic questionnaire (Appendix B) developed for this study which measured variables such as gender, age, education, marital status, employment, mental health condition, physical health condition and general health condition.

Personal Meaning Profile (PMP): Participants also completed a 57-item, self-report version of the Personal Meaning Profile of Wong, 1998 (Appendix B) which measures the extent to which individuals correspond to the attitudes and behaviors that are normatively judged as comprising a meaningful life, incorporating concepts of commitment, pursuit of personal projects and life tasks which have personal significance (Wong, 1998; Mascaro & Rosen, 2008). PMP is an interval scale of measurement and consists of seven subscales or factors, namely: Subscale 1 = Achievement (16 items), Subscale 2 = Relationship (9 items), Subscale 3 = Religion (9 items), Subscale 4 = Self-

transcendence (8 items), Subscale 5 = Self-acceptance (6 items), Subscale 6 = Intimacy (5 items), and Subscale 7 = Fair treatment (4 items).

The following are the examples of the items in the sub-scales: *I strive to do my best in whatever I am doing* (achievement), *I care about other people* (relationship), *I am at peace with God* (religion), *I strive to make this world a better place* (self-transcendence), *I accept my limitations* (self-acceptance), *I have someone to share intimate feelings with* (intimacy), and *I have received my fair share of opportunities and rewards* (fair treatment). Participants indicate their degree of agreement with each item on a 7-point scale (Mascaro & Rosen, 2008). The higher the value of an item they indicated, the higher their mental, physical and general well-being conditions it reported, and vice versa (Wong, 1998).

PMP Reliability and Validity: Studies have demonstrated the reliability and validity of the current version of PMP. One of them (Wong, 1998) reports an overall Cronbach alpha coefficient of .93 and subscale alpha values of: Self-acceptance .54, Fair treatment .54, Intimacy .78, Relationship .81, Self-transcendence .84, Religion .89, and achievement .91. Other studies have also shown good 3-week test-retest reliability of .85 for the instrument and significant correlations with a number of other meaning and well-being inventories (Wong, 1998).

Trauma Symptom Checklist-40 (TSC-40): Participants also completed a 40-item self-report inventory of Trauma Symptom Checklist-40 (Briere and Runtz, 1989) (Appendix B) which measures symptoms in adults associated with childhood or adult traumatic

experiences. It is an interval scale of measurement which consists of six subscales: Subscale 1 = Dissociation (6 items), Subscale 2 = Anxiety (9 items), Subscale 3 = Depression (9 items), Subscale 4 = SATI (Sexual Abuse Trauma Index, 7 items), Subscale 5 = Sleep Disturbance (6 items), and Subscale 6 = Sexual Problems (8 items). Each symptom-item is rated according to its frequency of occurrence over the prior two months, using a four-point scale ranging from 0 ("never") to 3 ("often"). A symptom-item with a higher frequency of occurrence represents a higher degree of psychopathology or psychopathologies associated with that symptom, and vice versa.

TSC-40 Reliability and Validity: Studies have shown that the instrument has a relatively reliable measure with subscale alphas ranging from .66 to .77 and internally consistent alphas for the full scale averaging between .89 and .91 (Briere and Runtz, 1989).

Data Analyses

The data were analyzed using the IBM Statistical Package for Social Sciences 19 (IBM SPSS Statistic 19). Multinomial logistic regression (MLR) was used to analyze the group categories of participants with their sex, age, marital status, education and employment to obtain their demographic characteristics. Multinomial logistic regression was also used to analyze the predictor or categorical variables of Personal Meaning Profile (PMP) and those of the TSC-40 with the dependent variable (group) in order to compare or identify how the different possible outcomes of the categories of dependent variable - group (DE, DW, DS, DSA and Y) were associated with these predictor variables (PMP and TSC-40), respectively.

Ordinary Least Squares linear regression statistic was used to analyze respectively: a) the self-reported categories of mental health condition - MHC, b) physical health condition - PHC and c) general health condition – GHC of participants as dependent variables and group categories (DE, DW, DS, DSA and Y) as case labels, using PMP as independent variables to produce three graphs showing the levels and relationships in the mental, physical and general health conditions of participants with regard to their well-being. The same method was also used for the predictor variables of TSC-40 to produce three graphs of the levels and relationships in the mental, physical and general health conditions of participants with regard to their disability.

The Custom/Stepwise option of multinomial logistic regression was selected to specify predictor variables for fixed factor box or covariate box for interactions terms (Chan, 2005). Two statistical tests were used to measure the statistical significance of the hypotheses of this study as stated above using multinomial logistic regression. The tests were: a) Chi-square statistic (χ^2) -- to assess if predictor variables of personal meaning profile (PMP) and trauma symptom checklist-40 (TSC-40) would significantly have an overall effect on the dependent variables, respectively (Kerlinger & Lee 2000); and b) The test of Goodness-of-Fit – to assess the overall significance of the model.

All analysis tests conducted were performed at an alpha level of 0.05. All confidence intervals were set to the 0.95%.

CHAPTER 4 RESULTS

The descriptive characteristics of participants in this study are shown in Table 1. The participants had five subpopulations of: DE 23.2% (n = 26, 1 person missing), DW 23.2% (n = 26, 1 person missing), DS 25.0% (n = 28, 1 person was missing), DSA 15.2% (n = 17) and Y13.4% (n = 15). The subpopulations summed up to the total population of 115, with a mean age of 40.7 years old. The participants were primarily male (83.0%), while the female population was only 17.0%. Sixty-four point three percent (64.3%) of participants were single, 17.9% were either divorced or separated, while 84.8% were unemployed.

Table 2 presents the types of trauma experienced in childhood by participants, showing their numbers and percents according to their subgroups. The participants from the treatment subgroup DW had the greatest counts (61) in all the forms of trauma experienced by the population and experienced mostly multiple abuses (29.4%) and cumulative trauma (28.8%). They were followed by participants from the treatment subgroup DE whose traumatic experiences were mostly child neglect (33.3%) and cumulative trauma (22.7%). Of all the participants, participants from Y subgroup had the highest experiences of sexual abuse (33.3%) and multiple abuses (35.3%).

Table 1: Demographic Characteristics

		N	Marginal Percentage
Grp	DE	26	23.2%
	DW	26	23.2%
	DS	28	25.0%
	DSA	17	15.2%
	Y	15	13.4%
Sex	Male	93	83.0%
	Female	19	17.0%
Age	21 - 30 years old	23	20.5%
	31 - 40 years old	23	20.5%
	41 - 50 years old	38	33.9%
	51 - 60 years old	28	25.0%
Education	Less than 8th Grade	4	3.6%
	Completed 8th Grade	5	4.5%
	Some High School	25	22.3%
	High School Graduation	20	17.9%
	Some College	25	22.3%
	College Graduation	9	8.0%
	Other*	24	21.4%
Marital Status	Single	72	64.3%
	Living with a Partner	9	8.0%
	Married	7	6.3%
	Divorced/Separated	20	17.9%
	Widowed	4	3.6%
Employment	Employed	13	11.6%
	Unemployed	95	84.8%
	Never employed	4	3.6%
Valid		112	100.0%
Missing		3	
Total		115	
Subpopulation		73 ^a	
a. The dependent variable has only one value observed in 57 (78.1%) subpopulations.			
b. Other* includes GED, specialized career trainings, and the like.			

Grp		Verbal/Emotional Abuse	Physical Abuse	Neglect	Sexual Abuse	Multiple Abuses	Cumulative Trauma
DE	N	14	8	17	2	3	15
	% of Total N	22.2%	21.6%	33.3%	13.3%	17.6%	22.7%
DW	N	16	7	10	4	5	19
	% of Total N	25.4%	18.9%	19.6%	26.7%	29.4%	28.8%
DS	N	12	9	15	1	2	20
	% of Total N	19.0%	24.3%	29.4%	6.7%	11.8%	30.3%
DSA	N	11	5	3	3	1	4
	% of Total N	17.5%	13.5%	5.9%	20.0%	5.9%	6.1%
Y	N	10	8	6	5	6	8
	% of Total N	15.9%	21.6%	11.8%	33.3%	35.3%	12.1%
Total	N	63	37	51	15	17	66
	% of Total N	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Cumulative Trauma* includes constant exposure to family, relationship, school and street violence; wars, earthquakes, car accidents and the like.

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
	Verbal/Emotional * Grp	63	54.8%	52	45.2%	115
Physical Abuse * Grp	37	32.2%	78	67.8%	115	100.0%
Neglect * Grp	51	44.3%	64	55.7%	115	100.0%
Sexual Abuse * Grp	15	13.0%	100	87.0%	115	100.0%
Multiple Abuses * Grp	17	14.8%	98	85.2%	115	100.0%
Cumulative Trauma * Grp	66	57.4%	49	42.6%	115	100.0%

Testing the Overall Significance of PMP Model Using Chi-square and Goodness-of-Fit Tests

Chi-square Test

Table 4 shows the model fitting information for the clinical measure of personal meaning profile (PMP) and the group categories (DE, DW, DS, DSA and Y), indicating the parameters of the model from which the model fit was calculated. The chi-square (χ^2) test is a likelihood ratio test which assesses the significance of the difference between the -2 log likelihood of the final model (Table 4) minus the -2 log likelihood ratio for a reduced model (Table 5): $[-2LL(\text{final model}) - (-2LL(\text{reduced model}))]$. The chi-square was: $7.906 - 7.906 = 0$. The reduced model was equivalent to the final model, and was formed by omitting an effect from the final model. The null hypothesis is all parameters of that effect are 0. The chi-square test of this model (PMP and group categories) was thus statistically significant ($p < 0.05$). Therefore,

1. There was a statistically significant relationship between achievement, relationship, religion, self-transcendence, self-acceptance, intimacy, fair treatment and good mental health condition.
2. There was a statistically significant relationship between these predictor variables and good physical health condition.
3. There was a statistically significant relationship between these predictor variables and good condition of general well-being.

Table 4: Model Fitting Information: PMP + Group Categories

Model	Model Fitting Criteria	Likelihood Ratio Tests		
	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	267.724			
Final	7.906	259.818	252	.354

Table 5. Likelihood Ratio Tests: Independent Variables of PMP and Group Categories

Effect	Model Fitting Criteria	Likelihood Ratio Tests		
	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	7.906 ^a	.000	0	.
P57	7.906 ^b	.000	4	1.000
P55	7.906 ^b	.000	8	1.000
P53	7.906 ^b	.000	4	1.000
P51	7.906 ^b	.000	4	1.000
P49	7.906 ^b	.000	4	1.000
P47	7.906 ^b	.000	4	1.000
P45	7.906 ^b	.000	4	1.000
P43	13.313 ^b	5.407	4	.248
P41	7.907 ^b	.001	4	1.000
P39	7.906 ^b	.000	4	1.000
P37	7.906 ^b	.000	4	1.000
P35	7.906 ^b	.000	4	1.000
P33	7.906 ^b	.000	4	1.000
P31	7.906 ^b	.000	4	1.000
P29	7.907 ^b	.001	4	1.000
P27	7.906 ^b	.000	4	1.000
P25	101.396 ^c	93.490	4	.000
P23	7.906 ^b	.000	4	1.000
P21	7.906 ^b	.000	4	1.000
P19	10.540 ^b	2.634	4	.621
P17	7.906 ^b	.000	4	1.000
P15	7.906 ^b	.000	4	1.000
P13	7.906 ^b	.000	4	1.000
P11	7.906 ^b	.000	4	1.000
P9	85.784 ^c	77.878	4	.000
P7	7.906 ^b	.	4	.
P5	70.685 ^c	62.779	4	.000
P3	7.906 ^b	.000	8	1.000
P1	9.011 ^b	1.105	4	.894
P2	7.906 ^b	.	4	.
P4	7.907 ^b	.001	4	1.000
P6	7.906 ^b	.000	4	1.000
P8	1639.445 ^b	1631.538	4	.000
P10	7.906 ^b	.000	4	1.000
P12	7.907 ^b	.000	4	1.000
P14	7.906 ^b	.000	4	1.000
P16	7.906 ^b	.000	4	1.000
P18	7.906 ^b	.000	4	1.000
P20	7.906 ^b	.000	4	1.000
P22	7.906 ^b	.000	4	1.000

P24	158.694 ^c	150.788	4	.000
P26	7.906 ^b	.	4	.
P28	88.066 ^c	80.160	4	.000
P30	7.906 ^b	.000	4	1.000
P32	7.906 ^b	.	4	.
P34	7.906 ^b	.000	4	1.000
P36	7.906 ^b	.000	4	1.000
P38	7.906 ^b	.000	4	1.000
P40	36.366 ^c	28.460	8	.000
P42	7.907 ^b	.001	4	1.000
P44	35.996 ^c	28.090	4	.000
P46	7.906 ^b	.000	4	1.000
P48	7.906 ^b	.000	4	1.000
P50	183.291 ^c	175.385	8	.000
P52	8.814 ^b	.908	8	.999
P54	7.906 ^b	.000	4	1.000
P56	7.906 ^b	.000	8	1.000

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

b. Unexpected singularities in the Hessian matrix are encountered. This indicates that either some predictor variables should be excluded or some categories should be merged.

c. The log-likelihood value cannot be further increased after maximum number of step-halving.

Goodness-of-Fit Test

The goodness-of-fit test for the overall significance of a model in multinomial logistic regression is assessed by the existence of two similar overall model fit tests, and its adequate fit corresponds to a finding of non-significance for these tests. In the case of this research study, these conditions were met as shown in Table 6. The chi-squares and the degrees of freedom for Pearson and Deviance tests were the same and both tests were non-significant. Therefore, this model (PMP and group) of this study was statistically significant ($p < 0.05$), having met the conditions for the goodness-of-fit test.

	Chi-Square	df	Sig.
Pearson	.000	80	1.000
Deviance	.000	80	1.000

The three hypotheses of this model (PMP and group) were also statistically significant ($p < 0.05$) based on the positive outcomes of its goodness-of-fit test (Table 6).

Graphs for PMP Model

These three normal P-P Plots (that is, Probability Plots) show there was a significant relationship between personal meaning or spirituality and the mental, physical and general health conditions of participants in the PMP model.

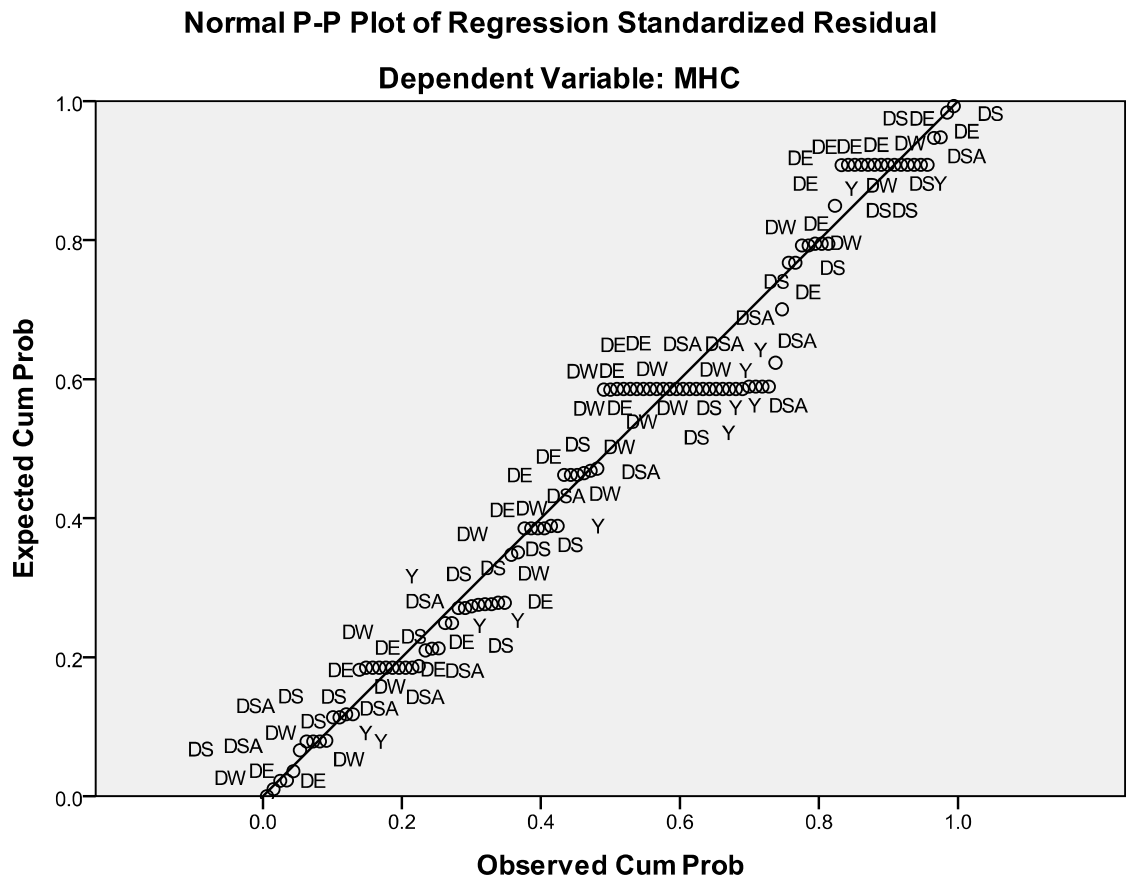


Table 7: Ordinal Scale measuring MHC values in PMP Model on both of the Expected and Observed Axes:

- 1) 0.0 – 0.2 = Very Poor;
- 2) 0.2 – 0.4 = Poor;
- 3) 0.4 – 0.6 = Fair
- 4) 0.6 – 0.8 = Good;
- and 5) 0.8 – 1.0 = Very Good

The Graph/plot of Table 7 shows the well-being levels of the mental health conditions (MHC) of participants according to their subgroups in this model (PMP and group). The

higher a subgroup rose on the graph slope, the better their mental health conditions, and vice versa.

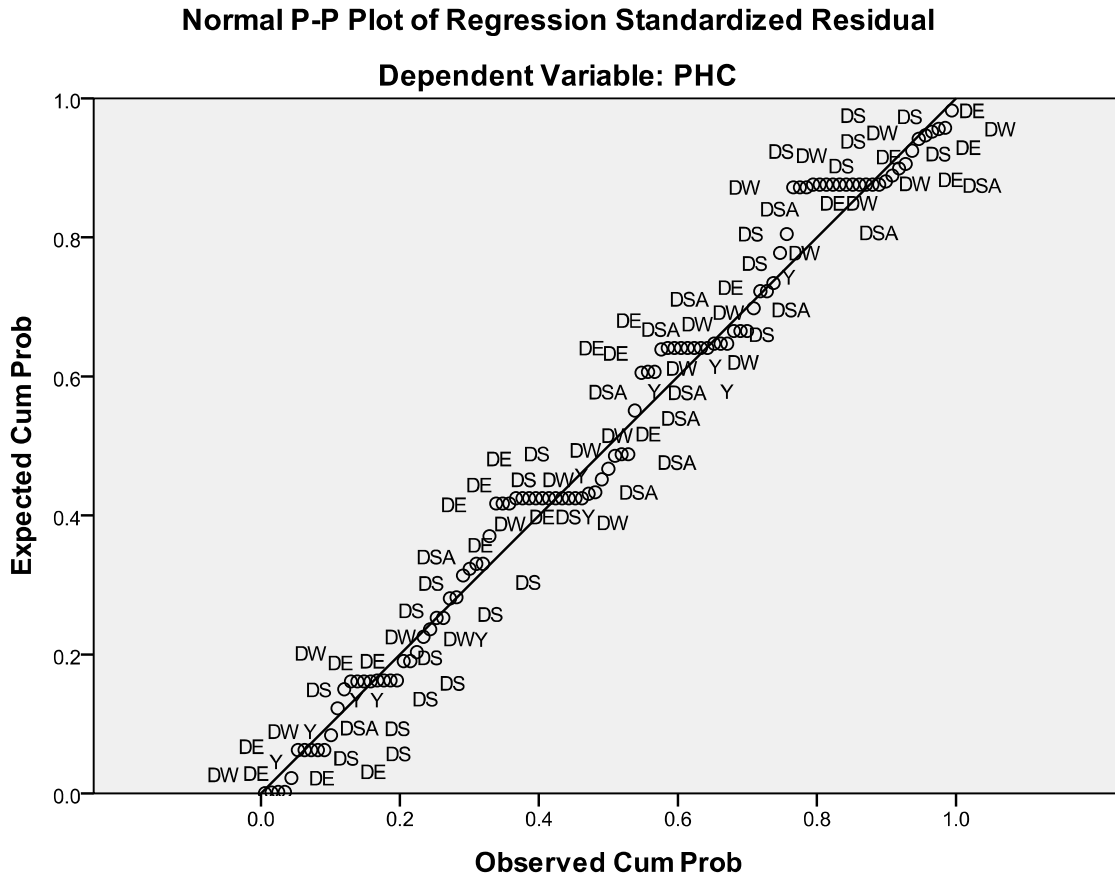


Table 8: Ordinal Scale measuring PHC values in PMP Model on both of the Expected and Observed Axes:

- 1) 0.0 – 0.2 = Very Poor; 2) 0.2 – 0.4 = Poor; 3) 0.4 – 0.6 = Fair
- 4) 0.6 – 0.8 = Good; and 5) 0.8 – 1.0 = Very Good

The Graph/plot of Table 8 shows the well-being levels of the physical health conditions (PHC) of participants according to their subgroups in this model (PMP and group). The higher a subgroup rose on the graph slope, the better their physical health conditions, and vice versa.

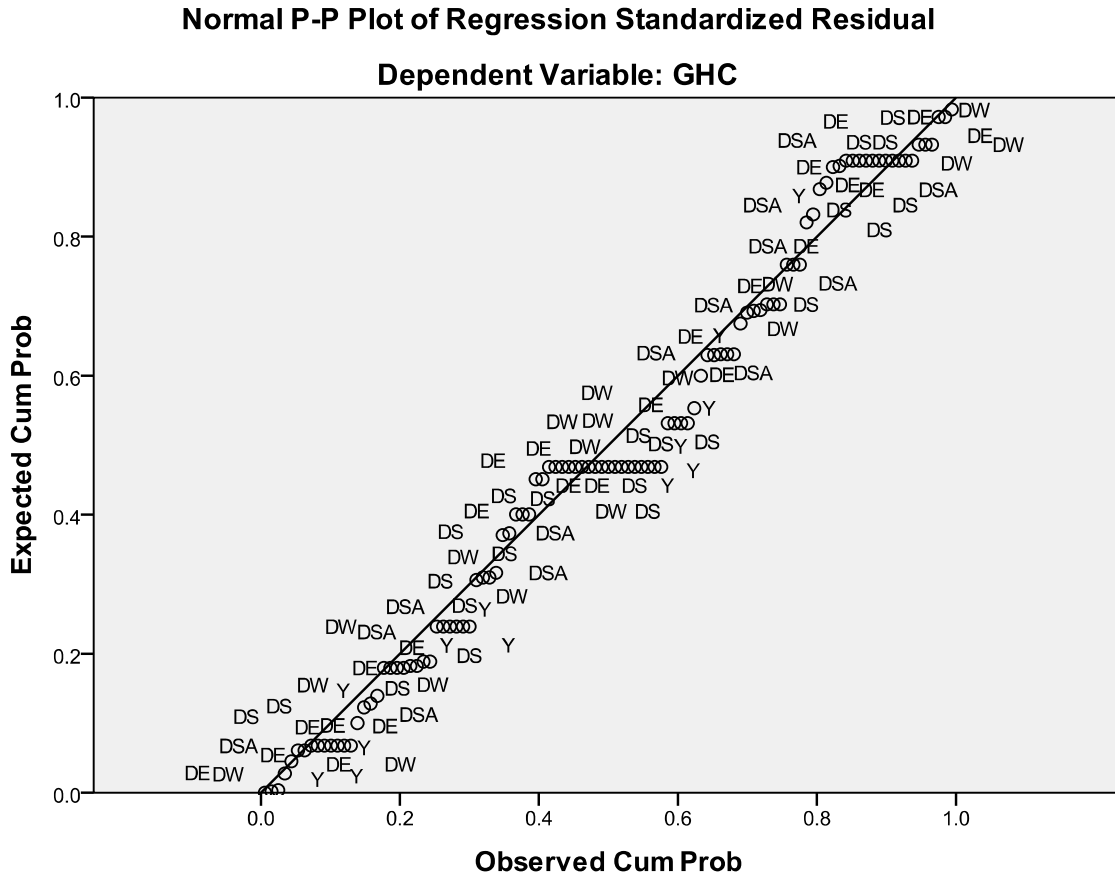


Table 9: Ordinal Scale measuring GHC values in PMP Model on both the Expected and Observed Axes:

- 1) 0.0 – 0.2 = Very Poor; 2) 0.2 – 0.4 = Poor; 3) 0.4 – 0.6 = Fair
4) 0.6 – 0.8 = Good; and 5) 0.8 – 1.0 = Very Good

The Graph/plot of Table 9 shows the well-being levels of the general health conditions (GHC) of participants according to their subgroups in this model (PMP and group). The higher a subgroup rose on the graph slope, the better their general health conditions, and vice versa.

Testing the Overall Significance of the TSC-40 Model Using Chi-square and Goodness-of-Fit Tests

Chi-square Test

Table 10 shows the model fitting information for the clinical measure of Trauma Symptom Checklist-40 (TSC-40) and the group categories (DE, DW, DS, DSA and Y), indicating the parameters of the model from which the model fit was calculated. The chi-square (χ^2) test is a likelihood ratio test which assesses the significance of the difference between the -2 log likelihood of the final model (Table 10) minus the -2 log likelihood ratio for a reduced model (Table 11): $[-2LL(\text{final model}) - (-2LL(\text{reduced model}))]$. The chi-square was: $18.773 - 18.773 = 0$. The reduced model was equivalent to the final model, and was formed by omitting an effect from the final model. The null hypothesis is all parameters of that effect are 0. The chi-square test of this model (TSC-40 and group categories) was thus statistically significant ($p < 0.05$). Therefore,

1. There was a statistically significant relationship between dissociation, anxiety, depression, SATI (Sexual Abuse Trauma Index), sleep disturbance, sexual problems and good mental health condition.
2. There was a statistically significant relationship between these predictor variables and good physical health condition.
3. There was a statistically significant relationship between these predictor variables and good condition of general well-being.

Table 10: Model Fitting Information: TSC-40 and Group Categories

Model	Model Fitting Criteria	Likelihood Ratio Tests		
	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	263.444			
Final	18.773	244.671	168	.000

Table 11. Likelihood Ratio Tests: TSC-40 and Group Categories

Effect	Model Fitting Criteria	Likelihood Ratio Tests		
	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	18.773 ^a	.000	0	.
T40	18.777 ^b	.004	4	1.000
T38	18.772 ^b	.	4	.
T36	18.778 ^b	.005	4	1.000
T34	21.377 ^b	2.604	4	.626
T32	18.771 ^b	.	4	.
T30	18.771 ^b	.	4	.
T28	19.717 ^b	.944	8	.999
T26	18.771 ^b	.	4	.
T24	82.190 ^c	63.416	4	.000
T22	24.123 ^b	5.350	4	.253
T20	49.774 ^c	31.001	4	.000
T18	23.479 ^b	4.706	4	.319
T16	18.771 ^b	.	4	.
T14	78.454 ^c	59.681	4	.000
T12	23.581 ^b	4.807	4	.308
T10	18.772 ^b	.	4	.
T8	24.367 ^b	5.594	4	.232
T6	24.223 ^b	5.450	4	.244
T4	19.717 ^b	.944	4	.918
T2	21.374 ^b	2.601	4	.627
T1	18.774 ^b	.001	4	1.000
T3	18.776 ^b	.002	4	1.000
T5	18.776 ^b	.003	4	1.000
T7	27.285 ^b	8.512	4	.075
T9	21.547 ^b	2.774	4	.596
T11	26.355 ^b	7.582	4	.108
T13	18.772 ^b	.	4	.
T15	18.773 ^b	.	8	.
T17	25.406 ^b	6.633	4	.157
T19	24.316 ^b	5.543	4	.236
T21	18.786 ^b	.013	4	1.000
T23	19.917 ^b	1.144	4	.887
T25	19.922 ^b	1.148	4	.887
T27	18.771 ^b	.	4	.
T29	18.775 ^b	.002	4	1.000
T31	18.820 ^b	.047	4	1.000
T33	18.772 ^b	.	4	.
T35	18.771 ^b	.	4	.
T37	18.772 ^b	.	4	.

T39	23.883 ^p	5.110	4	.276
The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.				
a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.				
b. Unexpected singularities in the Hessian matrix are encountered. This indicates that either some predictor variables should be excluded or some categories should be merged.				
c. The log-likelihood value cannot be further increased after maximum number of step-halving.				

Goodness-of-Fit Test

The goodness-of-fit test for the overall significance of a model in multinomial logistic regression is assessed by the existence of two similar overall model fit tests, and an adequate fit that corresponds to a finding of non-significance for these tests. In the case of this research study, these conditions were met as shown in Table 12. The chi-squares and the degrees of freedom for Pearson and Deviance tests were the same and both tests were non-significant. Therefore, the TSC-40-and-group was statistically significant ($p < 0.05$), having met the conditions for the goodness-of-fit test.

	Chi-Square	df	Sig.
Pearson	4.002	124	1.000
Deviance	5.548	124	1.000

The three hypotheses of this model (TSC-40 and group) were also statistically significant ($p < 0.05$) based on the positive outcomes of its goodness-of-fit test (Table 12).

Graphs for TSC-40 Model

The three normal P-P Plots (that is, Probability Plots) show there was a significant relationship between personal meaning or spirituality and the mental, physical and general health conditions of participants in TSC-40 model.

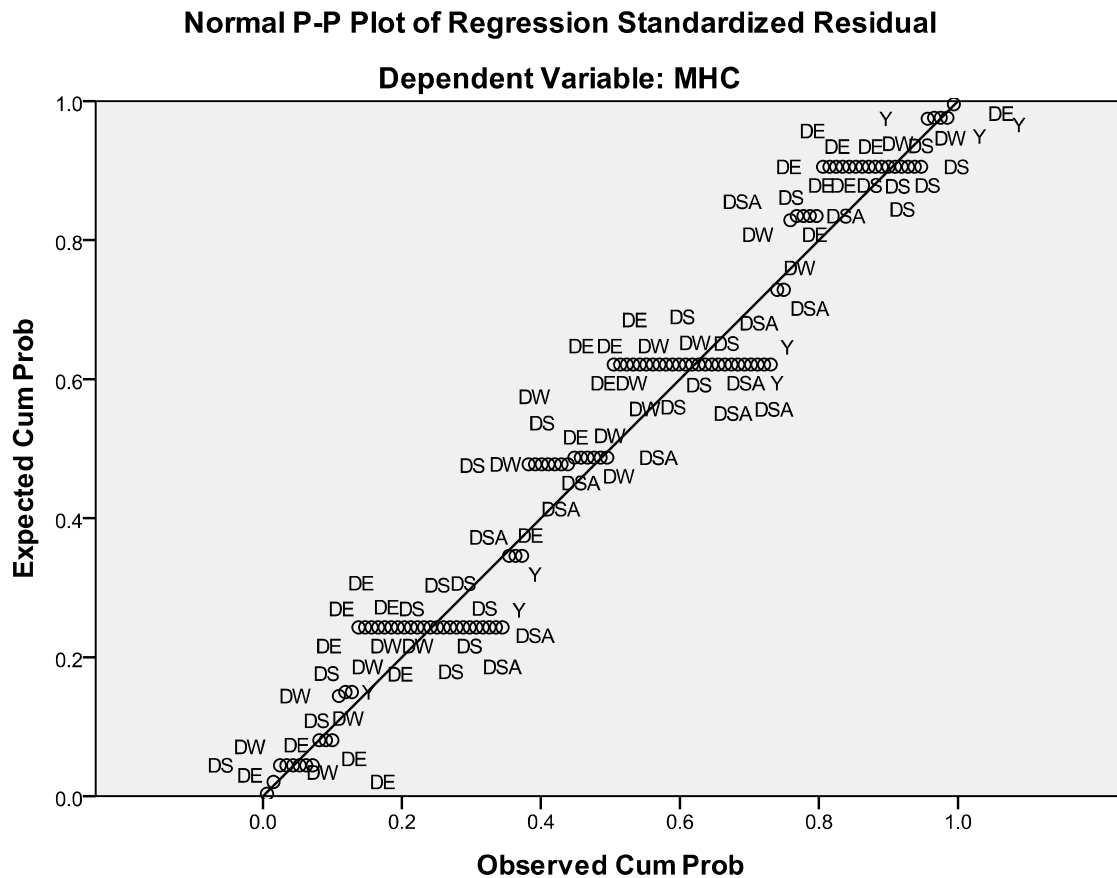


Table 13: Ordinal Scale measuring MHC values in TSC-40 model on both the Expected and Observed Axes:

- 1) 0.0 – 0.2 = Very Good;
- 2) 0.2 – 0.4 = Good;
- 3) 0.4 – 0.6 = Fair
- 4) 0.6 – 0.8 = Poor; and
- 5) 0.8 – 1.0 = Very Poor

The Graph/plot shows the trauma symptom levels of the mental health conditions (MHC) of participants according to their subgroups in this model (TSC-40 and group). The

higher a subgroup rose on the graph slope, the lower their mental health conditions, and vice versa.

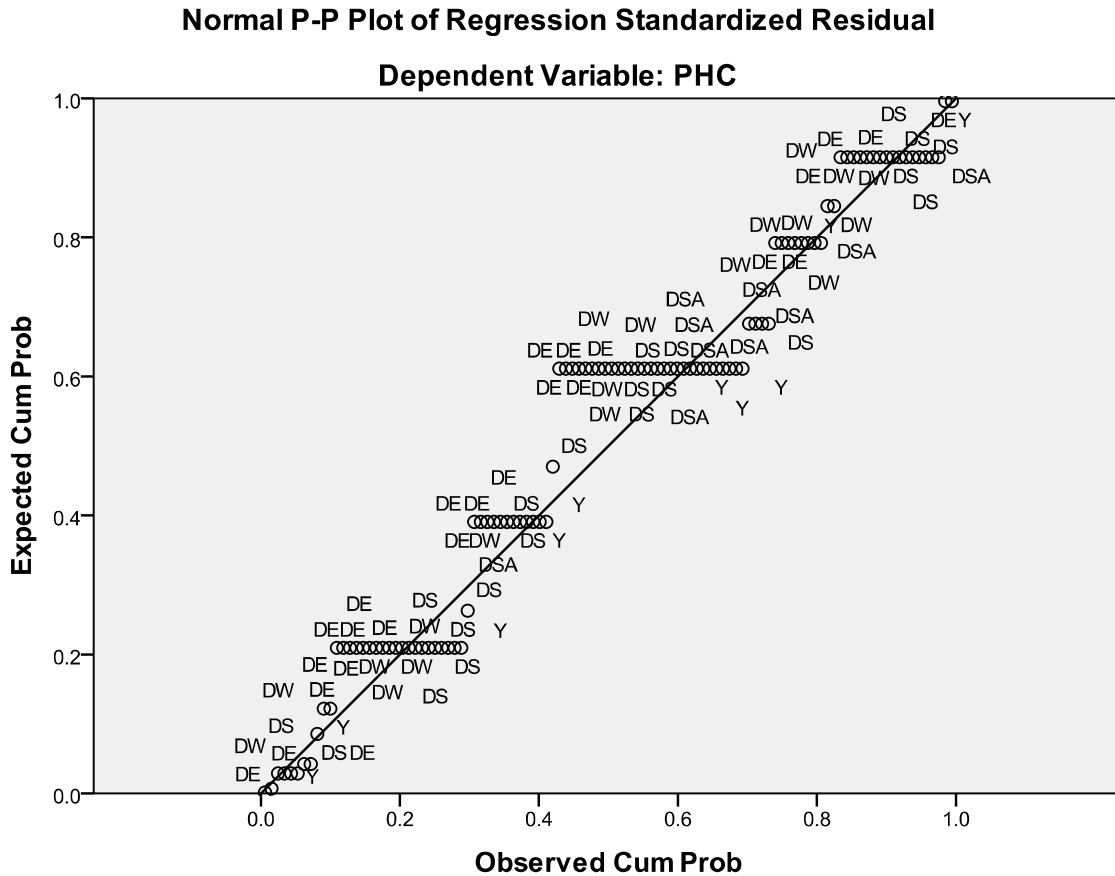


Table 14: Ordinal Scale measuring PHC values in TSC-40 Model on both the Expected and Observed Axes:

- 1) 0.0 – 0.2 = Very Good;
- 2) 0.2 – 0.4 = Good;
- 3) 0.4 – 0.6 = Fair
- 4) 0.6 – 0.8 = Poor; and
- 5) 0.8 – 1.0 = Very Poor

The Graph/plot shows the trauma symptom levels of the physical health conditions (PHC) of participants according to their subgroups in this model (TSC-40 and group).

The higher a subgroup rose on the graph slope, the lower their physical health conditions, and vice versa.

Normal P-P Plot of Regression Standardized Residual

Dependent Variable: GHC

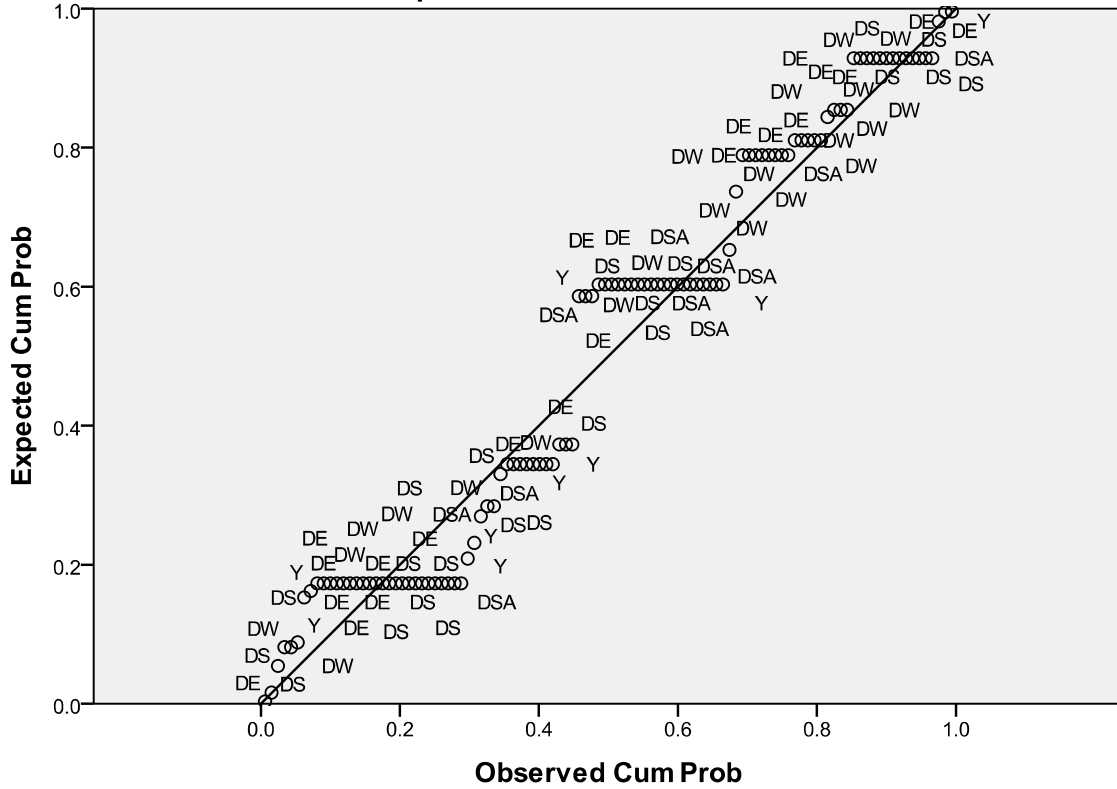


Table 15: Ordinal Scale measuring GHC values in TSC-40 Model on both the Expected and Observed Axes:

- 1) 0.0 – 0.2 = Very Good; 2) 0.2 – 0.4 = Good; 3) 0.4 – 0.6 = Fair
- 4) 0.6 – 0.8 = Poor; and 5) 0.8 – 1.0 = Very Poor

The Graph/plot shows the trauma symptom levels of the general health conditions (GHC) of participants according to their subgroups in this model (TSC-40 and group). The higher a subgroup rose on the graph slope, the lower their general health conditions, and vice versa.

CHAPTER 5 DISCUSSION

The findings of the study showed that adults who had experienced childhood trauma and who were treated in a supervised environment with medication and adequate personal meaning or spirituality; had better mental, physical and general health conditions and lower trauma symptoms than those treated in an unsupervised environment. The term “adequate personal meaning or spirituality” used here refers to spiritual activities such as 12-steps/spiritual journey, prayer, worship, spiritual life classes, women’s ministry, men’s fellowship, women’s support group, choir rehearsal, Sunday school, domestic and community training, Sunday School, reading of the Bible/Torah/Qur’an/other Holy Books, meditation, and the like.

The participants from DE, DW, DS and DSA subgroups or mental health centers had had more of these therapeutic advantages in their treatment than those from Y subgroup or mental health center. They (the former) received a residential treatment which combined medication with adequate aspects of spirituality. They resided in their mental health centers in the course of their treatment where clinicians and other health professionals always taught and supervised their spiritual activities and also ensured they took their medications according to prescriptions. Hence, they had improved or better mental, physical and general health conditions and lower trauma symptoms (Tables 7, 8 and 9; Tables 13, 14 and 15). Whereas participants from Y center received an outpatient treatment which concentrated more on medication and less on personal meaning or spiritual activities. They came from their private homes to the mental health center in the

course of their treatment to primarily refill their medications and occasionally had either individual or group counseling with their therapists. They were given the prescriptions of their medications but no health professionals supervised the way they took them in a residential setting. They also had little or no group spiritual activities such as prayer, worship, spiritual life classes, men's fellowship, choir rehearsal, Sunday school, domestic and community training, Sunday school, and others that were supervised by their clinicians. Their clinic operates from morning to noon, Monday through Saturday. Hence, these participants had poorer mental, physical and general health conditions and higher trauma symptoms than others due to their poorer treatment contents, insufficient treatment time and absence of supervision (Tables 7, 8 and 9; Tables 13, 14 and 15). Thus, integrating spirituality or personal meaning in the treatment programs of persons with mental disabilities spirituality is efficacious in accelerating their psychobiological or holistic recovery when it is adequately incorporated in treatment in a supervised environment (Wong-McDonald, 2007; Grossman, Sorsoli & Kia-Keating, 2006; Cloninger, 2007; Young, 2010; Sullivan, 2009; Rio, 2005).

Limitations of the Study

This study has a number of limitations. First, there was no specification of the length of time participants would be in treatment before they could qualify to take part in the study. New consumers or patients were tested along with those who had been in treatment for a long time. Although participants might be in the same mental health center, receiving the same treatment for the same or similar psychiatric disabilities, the

healing impact and the results of their recovery might not be the same. Healing or recovery occurs in a slow process. Thus, the individuals who had been in treatment for a longer period of time were more likely to experience more recovery than those who had been newly accepted for treatment in the same subgroup at the time this test was conducted. This limitation may have accounted for the reason a good number of the subgroups (DE, DW, DS and DSA) which had participants with better mental, physical and general health condition was found almost evenly distributed at the upper, middle and lower levels of well-being in the ordinal scale (Tables 7, 8 & 9). This reason may also apply to the linear regression analyses for TSC-40 model (Tables 13, 14 & 15).

Secondly, the study was fairly broad in its scope of investigation. It could have been narrowed to an investigation on the impact of spirituality on a gender or both who had experienced a minimum of one childhood trauma (for example, physical abuse, sexual abuse, verbal abuse or child neglect). The topic could even be made narrower.

The third limitation borders on the measurement of spirituality. Although research on spirituality is rapidly growing, it is difficult to measure spiritual constructs such as well-being. Some of these existing spiritual measures which are currently in use may have some validity errors. Therefore, it is difficult to find psychometric measures of spirituality that do not have some limitations (Piedmont, 2001).

Fourthly, the study may have some limitations in its internal and external validities. The use of self-report instruments in the study may create some limitations in its internal validity. Some participants may have responded to the surveys in a manner they perceived as being socially desirable. The external validity of generalization may also be

limited in this study due to the factors related to its sample composition of 93% male and 95% unemployed. Readers should use caution when generalizing the findings to other groups, for example, females.

Some Study Implications for Rehabilitation Counseling

Clinical Implications

The participants of this study were mostly exposed to cumulative trauma (66%), verbal/emotional abuse (63%) and child neglect (51%) rather than other forms of trauma (Table 2). From a clinical perspective, therefore, over 50% of this population would need treatment for the following mental disabilities: low self-esteem, anxiety, depression, anger, cognitive dysfunction, self-blame, hopelessness, expectations of rejection or abandonment, social withdrawal, alcohol and substance abuse, self-destructive behaviors, suicide, impulsivity, posttraumatic stress disorder (PTSD) and the like (Briere & Jordan, 2009; Chaikin & Prout, 2004; Chartier, Walker & Naimark, 2009; De Bellis, 2001; Gilbert et al., 2009; Hildyard & Wolfe, 2002). Their demographic characteristics (Table 1) also strongly suggested that this population may have dissociative or interpersonal difficulties. Here 64.3% of the population (with a mean age of 40.7 years old) was single, and 17.9% was either divorced or separated.

Educational Implications

Educationally, the population is more likely to have learning difficulties and lower academic achievements since learning dysfunction was one of the mental disabilities that the clinical perspective has shown to be more prevalent among the greater percentage of

this population (Chaikin & Prout, 2004; Chartier, Walker & Naimark, 2009; De Bellis, 2001). Also, most of the members are more likely to have had a lower school attendance, and to have received more special education (Gilbert et al., 2009).

The demographic questionnaire survey presents a good picture of the cognitive difficulties and academic deficits of this population (Table 1). According to the information from this table, the number of members/participants who dropped out high school (22.3%) was more than those who completed high school (17.9%), and there were more who had some college (22.3%) than those who completed college (9%). This information demonstrates there is a prevalence of lower educational achievements in this population.

Research Implications of the Study

There is ample literature for this research study. Its clinical tests involved minimal risks and no money was paid to the participants for taking part in the tests. However, some problems were encountered in the course of this study. The major problem was the unwillingness of the managements of many mental health centers to permit the principal investigator of this study to test its clinical measures on their consumers or patients. Most administrators refused to permit the test in their facilities on an account of the government laws which disallow such a test and also for fear that the test could have harmful effects on their consumers. These latter factors made the conduction of this research study very frustrating and time-consuming.

Conclusion

Notwithstanding its limitations, this research study nonetheless has a number of strengths. Firstly, it raises the awareness of the public on the danger of childhood trauma. It has been found that every form of the trauma, namely: physical abuse, sexual abuse, emotional/psychological/verbal abuse or child neglect has the potential and tendency to destroy human emotion which is the foundation in the construction of the self and a key determinant of self-organization (Greenberg, 2004; Messina et al. 2007). The goal or target of childhood trauma, regardless of its particular type or nature, is to cause a life-long, emotional dysfunction, pain and a profound damage to the sense of self of the affected individual (Anderson & Hiersteiner, 2007; Chaikin & Prout, 2004; Sims, 2008; Vachss, 1994).

Secondly, among the findings of this study, the hypotheses of Personal Meaning Profile (PMP) were shown to be statistically significant ($p < 0.05$) to better mental, physical, general health condition. The findings of the study strongly suggest, in association with the findings of similar research studies, that integrating adequate spirituality in mental healthcare delivery is an efficient and dependable treatment option for the care of adults with mental disabilities resulting childhood trauma or other traumas experienced in later life. Again, research studies do not only demonstrate that a treatment option or approach with aspects of spirituality powerfully restores the mental, physical and overall health conditions of the affected individuals, they also show that the cost of

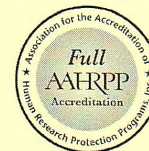
this treatment option is inexpensive (Cloninger, 2006; Martens, 2003; Sperry, 2010; Wilkinson, 2008).

APPENDIX A

WAYNE STATE UNIVERSITY IRB APPROVAL FOR THE STUDY

WAYNE STATE
UNIVERSITY

IRB Administration Office
87 East Canfield, Second Floor
Detroit, Michigan 48201
Phone: (313) 577-1628
FAX: (313) 993-7122
<http://irb.wayne.edu>



NOTICE OF EXPEDITED APPROVAL

To: Chijioke Chigbo
College of Education

From: Dr. Scott Millis *N. Nahan*
Chairperson, Behavioral Institutional Review Board (B3) */pm*

Date: July 06, 2011

RE: IRB #: 058811B3E
Protocol Title: The Impact of Spirituality on the Self-Reported Recovery of Adults Who Experienced Childhood Trauma
Funding Source:
Protocol #: 1106009782

Expiration Date: July 05, 2012

Risk Level / Category: Research not involving greater than minimal risk

The above-referenced protocol and items listed below (if applicable) were **APPROVED** following *Expedited Review* Category (#7)* by the Chairperson/designee for the Wayne State University Institutional Review Board (B3) for the period of 07/06/2011 through 07/05/2012. This approval does not replace any departmental or other approvals that may be required.

- Protocol Summary Form (revised 6-14-11 and again 6-23-11)
- Notice/Flyer (revised)
- Research Information Sheet (revised 6-14-11).
- Dissertation Proposal, 2011.

- Federal regulations require that all research be reviewed at least annually. You may receive a "Continuation Renewal Reminder" approximately two months prior to the expiration date; however, it is the Principal Investigator's responsibility to obtain review and continued approval **before** the expiration date. Data collected during a period of lapsed approval is unapproved research and can never be reported or published as research data.
- All changes or amendments to the above-referenced protocol require review and approval by the IRB **BEFORE** implementation.
- Adverse Reactions/Unexpected Events (AR/UE) must be submitted on the appropriate form within the timeframe specified in the IRB Administration Office Policy (<http://www.irb.wayne.edu/policies-human-research.php>).

NOTE:

1. Upon notification of an impending regulatory site visit, hold notification, and/or external audit the IRB Administration Office must be contacted immediately.
2. Forms should be downloaded from the IRB website at **each** use.

*Based on the Expedited Review List, revised November 1998

The Impact of Spirituality on the Self-reported Recovery of Adults Who Experienced Childhood Trauma

Research Information Sheet

The Impact of Spirituality on the Self-reported Recovery of
Adults Who Experienced Childhood Trauma

Principal Investigator (PI): Chijioke Alphonsus Chigbo
Counselor Education Department
313 - 577 - 1613

Purpose

You are being asked to be in a research study that is examining whether adults who have experienced childhood trauma and who have a higher sense of personal meaning or spirituality, would have better mental health and lower trauma symptoms; because you have been abused as a child and have been to treatment. This study is being conducted at: The Salvation Army Harbor Light System, Detroit; Detroit Rescue Mission Ministries, Detroit, and Ypsilanti Medical & Drug Rehabilitation Clinic, Ypsilanti. These sites are located in southeast Michigan. The estimated number of study participants to be enrolled at the proposed sites is about 150.

Study Procedures

If you take part in the study, you will be asked to read this Information Sheet, fill out a demographic questionnaire, and two survey questionnaires, namely: Personal Meaning Profile (PMP) and Trauma Symptom Checklist-40 (TSC-40).

All participants will be asked to complete the following:

1. The study will take one visit and one session, and will take about 40 minutes to complete all the tasks.
2. The demographic questionnaire will ask questions such as: "Have you been to treatment? What type of treatment have you had?" and so on. The Personal Meaning profile (PMP) survey will measure the extent each of its items such as "I relate well with others, I am at peace with God" and so on, characterizes your own life in a scale of 1 to 7. Finally, Trauma Symptom Checklist-40 (TSC-40) survey will measure symptoms in adults associated with childhood or adult traumatic experiences. Participants will be asked to indicate in a scale of 0 to 3 how often they have experienced each of the survey's items such as headaches, weight loss (without diet), stomach problems and sexual problems in the last two months (: 0 =Never; 1 = Seldom; 2 = Periodically; 3 = Often).
3. Participants are not allowed to print their names on any documents in order to protect their identities. Also, all answers will be grouped for analysis and therefore will not be identified as coming from any one individual. A participant can remain in the study if he does not want to answer some of the questions.

Revision Date: 6/14/11
Protocol Version #: 1106009782

Page 1 of 3

HIC Date: 5/08

The Impact of Spirituality on the Self-reported Recovery of Adults Who Experienced Childhood Trauma

Benefits

As a participant in this research study, there may be no direct benefit for you; however, information from this study may benefit other people now or in the future.

Risks

By taking part in this study, you may experience sadness or anxiety as some resources are provided for you at the end of this Information Sheet.

Alternatives

None

Study Costs

- Participation in this study will be of no cost to you.

Compensation

You will not be paid for taking part in this study.

Confidentiality

- All information collected about you during the course of this study will be kept without any identifiers.

Voluntary Participation /Withdrawal:

Taking part in this study is voluntary. You may choose not to take part in this study, or if you decide to take part, you can change your mind later and withdraw from the study. You are free to not answer any questions or withdraw at any time. Your decision will not change any present or future relationships with Wayne State University or its affiliates, or this agency.

Questions

If you have any questions about this study now or in the future, you may contact Chijioke A. Chigbo at the following phone number 734-604-7111. If you have questions or concerns about your rights as a research participant, the Chair of the Human Investigation Committee can be contacted at (313) 577-1628. If you are unable to contact the research staff, or if you want to talk to someone other than the research staff, you may also call (313) 577-1628 to ask questions or voice concerns or complaints.

The Impact of Spirituality on the Self-reported Recovery of Adults Who Experienced Childhood Trauma

Participation

By completing the survey questionnaires, you are agreeing to participate in this study.

Resources

Inner City Alano Club, Inc., 18600 Wyoming St., Detroit, Phone: (313) 862-2121

Southwest Alano Club, Inc., 8065 W. Vernor Hwy., Detroit, Phone: (313) 842-1433

Washtenaw Alano Club Inc., 995 N. Maple Rd., Ann Arbor, Phone: (734) 668-8138

New Center Community Mental Health
2051 W. Grand Boulevard, Detroit, MI 48208, Phone: (313)-961-3200

Hope Network Insight Recovery Center
3031 West Grand Blvd, Suite 423, Detroit, MI 48202, Phone: (313) 872-2520

Washtenaw County Community Support and Treatment Services
2140 East Ellsworth Road, Ann Arbor MI 48108, Phone: (734) 971-2282

Catholic Social Services
4925 Packard Road, Ann Arbor, MI 48108, Phone: (734) 926-0155

APPROVAL PERIOD

JUL 06 '11 JUL 05 '12

WAYNE STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

Revision Date: 6/14/11
Protocol Version #: 1106009782

Page 3 of 3

HIC Date: 5/08

RECRUITMENT FLYER

RECRUITMENT OF VOLUNTEERS FOR RESEARCH PROJECT

TITLE: THE IMPACT OF SIRITUALITY ON THE SELF-
REPORTED RECOVERY OF ADULTS WHO
EXPERIENCED CHILDHOOD TRAUMA

PARTICIPANT'S INVOLVEMENT: You will be provided with an Information Sheet
that describes the purpose of the research and
your responsibilities

BASIC PROCEDURES: You will be required to complete the following
forms:

- Demographic Questionnaire
- Personal Meaning Profile (PMP) Survey
- Trauma Symptom Checklist-40 Survey

TIME COMMITMENT: Approximately 40 minutes of your time will be
asked

CONTACT PERSON: Chijioke Al Chigbo, 734-604-7111

PARTICIPATION IN THIS STUDY IS VOLUNTARY AND ALL INFORMATION IS KEPT

CONFIDENTIAL

APPROVAL PERIOD

JUL 06 '11

JUL 05 '12

WAYNE STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

APPENDIX B**INSTRUMENTS****DEMOGRAPHIC QUESTIONNAIRE**

Please indicate your answer by a mark of an “X” in the space provided the response that is appropriate to you or filling in the information in the space. Thank you.

General:

Gender/Sex: Male Female

Age: _____ years old

Education:

Please indicate with an X the Highest Level of Education you completed:

Less than 8th Grade Completed 8th Grade Some High School

High School Graduation Some College College Graduation

Other, please specify _____

Marital Status:

Please indicate with an X the state that best describes your marital status:

Single Living with a Partner Married

Divorced/Separated Widowed

Employment:

Please indicate your employment status:

_____ Employed _____ Unemployed _____ Never Employed Before

Type of Childhood Abuse/Trauma

Please indicate the type of abuse/trauma you experienced:

_____ Verbal/Emotional Abuse _____ Physical Abuse _____ Neglect

_____ Sexual Abuse _____ Multiple Abuses

_____ Cumulative Trauma (that is, Constant Exposure to Family/Relationship/School/

Street Violence, Wars, Earthquakes, Car Accidents, and so on)

When Abused:

Please indicate at the age you were abused:

_____ 1 – 6 years old _____ 6 – 12 years old _____ 12 – 17 years old

_____ 17 – before the age of 18

Treatment:

Have you been in treatment?

_____ Yes _____ No

If your answer is: Yes, please indicate how long you have been in treatment?

_____ Less than 1 year _____ 1 – 3 years _____ 3 – 6 years

_____ 6 – 9 years _____ 9 – 12 years _____ Over 12 years

Type of Treatment:

What type of treatment have you had?

_____ Individual _____ Group _____ Family

Please check all of the things below you have received or done while in treatment:

_____ Medication _____ Group Therapy/Counseling

_____ Individual Therapy _____ Prayer

_____ 12-steps/Spiritual Journey _____ Women's Ministry

_____ Spiritual Life Classes _____ Reading of the Bible/Torah/Qur'an or
other Holy Books

_____ Men's Fellowship _____ Yoga

_____ Sunday School _____ Choir Rehearsal

_____ Meditation _____ Listening to Spiritual/Classical Music

_____ AA/NA Meeting _____ Women's Support Group

_____ Other. Please specify _____

Mental Health Condition:

How would you rate your mental health condition?

_____ Very Poor _____ Poor _____ Fair _____ Good _____ Very Good

Physical Health Condition:

How would you rate your physical health condition?

_____ Very poor _____ Poor _____ Fair _____ Good _____ Very Good

General Health Condition:

How would you rate your general health condition?

_____ Very poor _____ Poor _____ Fair _____ Good _____ Very Good

Personal Meaning Profile (PMP): What are your sources of meaning?

The following statements describe potential sources of a meaningful life. Please read each carefully. Indicate to what extent each item characterizes your own life by circling one of the seven numbers to the right of the statement according to the following scale:

Not at all		Moderately			A Great Deal	
1	2	3	4	5	6	7

For example, if going to parties does not contribute to your sense of personal meaning, you may circle 1 or 2. If taking part in volunteer work contributes quite a bit to the meaning in your life, you may circle 5 or 6.

It is important you answer honestly on the basis of your own experience and beliefs.

1. I have a good family life. 1 2 3 4 5 6 7
2. I believe I can make a difference in the world. 1 2 3 4 5 6 7
3. I am at peace with God. 1 2 3 4 5 6 7
4. I have learned that setbacks and disappointments are
an inevitable part of life. 1 2 3 4 5 6 7
5. I believe that has an ultimate purpose and meaning. ...1 2 3 4 5 6 7
6. I engage in creative work. 1 2 3 4 5 6 7
7. I am successful in achieving my aspirations.1 2 3 4 5 6 7
8. I pursue worthwhile objectives. 1 2 3 4 5 6 7
9. I strive to achieve my life goals. 1 2 3 4 5 6 7
10. I care about other people.1 2 3 4 5 6 7
11. I have someone to share intimate feelings with. 1 2 3 4 5 6 7
12. I believe in the values of my pursuits. 1 2 3 4 5 6 7

13. I seek to actualize my potentials. 1 2 3 4 5 6 7
14. I have found that there is rough justice in this world. 1 2 3 4 5 6 7
15. I strive to make this world a better place. 1 2 3 4 5 6 7
16. I am at peace with myself. 1 2 3 4 5 6 7
17. I have confidants to give me emotional support.1 2 3 4 5 6 7
18. I relate well to others. 1 2 3 4 5 6 7
19. I have a sense of mission or calling.1 2 3 4 5 6 7
20. I seek to do God's will. 1 2 3 4 5 6 7
21. I like challenge.1 2 3 4 5 6 7
22. I believe that human life is governed by moral laws. 1 2 3 4 5 6 7
23. It is important to dedicate my life to a cause. 1 2 3 4 5 6 7
24. I take initiative.1 2 3 4 5 6 7
25. I am able to make full use of my abilities. 1 2 3 4 5 6 7
26. I strive to do my best in whatever I am doing. 1 2 3 4 5 6 7
27. I have a number of good friends.1 2 3 4 5 6 7
28. I am trusted by others. 1 2 3 4 5 6 7
29. I am committed to my work. 1 2 3 4 5 6 7
30. I have a purpose and direction in life. 1 2 3 4 5 6 7
31. I seek higher values – values that transcend self-interests. 1 2 3 4 5 6 7
32. I am highly regarded by others. 1 2 3 4 5 6 7
33. I seek to glorify God. 1 2 3 4 5 6 7
34. I am enthusiastic about what I do. 1 2 3 4 5 6 7

35. Life has treated me fairly. 1 2 3 4 5 6 7
36. I accept my limitations. 1 2 3 4 5 6 7
37. I am at peace with my past. 1 2 3 4 5 6 7
38. I have a mutually satisfying loving relationship. ... 1 2 3 4 5 6 7
39. I have a sense of coherence and continuity in my life. 1 2 3 4 5 6 7
40. I do not give up when I encounter setbacks or obstacles. 1 2 3 4 5 6 7
41. I am altruistic and helpful. 1 2 3 4 5 6 7
42. I am liked by others. 1 2 3 4 5 6 7
43. I have found someone I love deeply. 1 2 3 4 5 6 7
44. I strive toward personal growth. 1 2 3 4 5 6 7
45. I bring happiness to others. 1 2 3 4 5 6 7
46. I accept what cannot be changed.1 2 3 4 5 6 7
47. I am persistent and resourceful in attaining my goals. 1 2 3 4 5 6 7
48. I value my work. 1 2 3 4 5 6 7
49. I make a significant contribution to society.1 2 3 4 5 6 7
50. I contribute to the well-being of others. 1 2 3 4 5 6 7
51. I believe in after-life.1 2 3 4 5 6 7
52. I believe that one can have a personal relationship with God. 1 2 3 4 5 6 7
53. I attempt to leave behind a good and lasting legacy. 1 2 3 4 5 6 7
54. I believe that there is order and purpose in the universe. 1 2 3 4 5 6 7
55. I am treated fairly by others. 1 2 3 4 5 6 7
56. I have received my fair share of opportunities and rewards. 1 2 3 4 5 6 7

57. I have learned to live with suffering and make the best of it. 1 2 3 4 5 6 7

Trauma Symptom Checklist-40 (TSC-40)

How often have you experienced each of the following in the last two months?

0 = Never; 1 = Seldom; 2 = Periodically; 3 = Often

Please encircle the option that best describes your condition in each of the 40 enquiries.

1. Headaches	0	1	2	3
2. Insomnia (trouble getting/staying asleep)	0	1	2	3
3. Weight loss (without dieting)	0	1	2	3
4. Stomach problems	0	1	2	3
5. Sexual problems	0	1	2	3
6. Feeling isolated from others	0	1	2	3
7. "Flashbacks" (sudden, vivid, distracting memories)	0	1	2	3
8. Restless sleep	0	1	2	3
9. Low sex drive	0	1	2	3
10. Anxiety attacks	0	1	2	3
11. Sexual over-activity	0	1	2	3
12. Loneliness	0	1	2	3
13. Nightmares	0	1	2	3
14. "Spacing out" (going away in your mind)	0	1	2	3

15. Sadness	0	1	2	3
16. Dizziness	0	1	2	3
17. Not feeling satisfied with your sex life	0	1	2	3
18. Trouble controlling your temper	0	1	2	3
19. Waking up early in the morning and can't get back to sleep	0	1	2	3
20. Uncontrollable crying	0	1	2	3
21. Fear of men	0	1	2	3
22. Not feeling rested in the morning	0	1	2	3
23. Having sex that you didn't enjoy	0	1	2	3
24. Trouble getting along with others	0	1	2	3
25. Memory problems	0	1	2	3
26. Desire to physically hurt yourself	0	1	2	3
27. Fear of women	0	1	2	3
28. Waking up in the middle of the night	0	1	2	3
29. Bad thoughts or feelings during sex	0	1	2	3
30. Passing out	0	1	2	3
31. Feeling that things are "unreal"	0	1	2	3
32. Unnecessary or over-frequent washing	0	1	2	3
33. Feelings of inferiority	0	1	2	3
34. Feeling tense all the time	0	1	2	3
35. Being confused about your sexual feelings	0	1	2	3
36. Desire to physically hurt others	0	1	2	3

37. Feelings of guilt	0	1	2	3
38. Feelings that you are not always in your body	0	1	2	3
39. Having trouble breathing	0	1	2	3
40. Sexual feelings when you shouldn't have them	0	1	2	3

APPENDIX C

LETTERS OF REQUEST

March 02, 2011

Chief Operating Officer
Detroit Rescue Mission Ministries
PO Box 312087
Detroit, MI 48231 - 2087

Dear Ms. Willis,

My name is Mr. C. Al Chigbo, a doctoral candidate in the Counselor Education program with a specialty in rehabilitation counseling at Wayne State University, Detroit, Michigan. I am requesting to complete a research project as part of my dissertation at Detroit Rescue Mission Ministries. This study project will investigate the degree or level of recovery that is had when adult individuals who are mentally ill due to childhood trauma are treated separately with: i) a traditional treatment program without aspects of spirituality, and ii) an integrated treatment program with aspects of spirituality. This is a very important and contemporary topic in the field of mental health. Abundant research overwhelmingly indicates that a treatment program with aspects of spirituality assists affected persons to achieve a better recovery from mental disabilities.

This research project will involve administering: i) a demographic questionnaire, ii) a 57-item instrument that measures psychological well-being, and iii) a 40-item instrument which measures trauma symptom. It will take about 35 minutes to complete them and can be done individually or in a small group. The questionnaires are voluntary and confidential. Participants will be able to stop at any time during the survey if they feel uncomfortable answering any of the questions. All answers will be grouped for analysis and therefore will not be identified as coming from any one individual.

Finally, all participants must sign an informed consent form in order to take part in the study and identify the methods by which anonymity is assured. If you have any question about the study, please call or e-mail my advisor, Dr. G. P. Parris, at 313-577-1619 or gparris@wayne.edu. Thank you so much in advance for considering granting me this permission.

Sincerely,

Chijioke Al Chigbo
Doctoral Candidate Researcher

March 02, 2011

Program Director/Addiction Counselor
Ypsilanti Medical & Drug Rehabilitation Clinic
880 N Ford Blvd
Ypsilanti, MI 48198

Dear Ms. Dennis,

My name is Mr. C. Al Chigbo, a doctoral candidate in the Counselor Education program with a specialty in rehabilitation counseling at Wayne State University, Detroit, Michigan. I am requesting to complete a research project as part of my dissertation at Ypsilanti Medical & Drug Rehabilitation Club, Ypsilanti. This study project will investigate the degree or level of recovery that is had when adult individuals who are mentally ill due to childhood trauma are treated separately with: i) a traditional treatment program without aspects of spirituality, and ii) an integrated treatment program with aspects of spirituality. This is a very important and contemporary topic in the field of mental health. Abundant research overwhelmingly indicates that a treatment program with aspects of spirituality assists affected persons to achieve a better recovery from mental disabilities.

This research project will involve administering: i). a demographic questionnaire, ii). a 57-item instrument that measures psychological well-being, and iii). a 40-item instrument which measures trauma symptom. It will take about 35 minutes to complete them and can be done individually or in a small group. The questionnaires are voluntary and confidential. Participants will be able to stop at any during the survey if they feel uncomfortable answering any of the questions. All answers will be grouped for analysis and therefore will not be identified as coming from any one individual.

Finally, all participants must sign an informed consent form in order to take part in the study and identify the methods by which anonymity is assured. If you have any question about the study, please call or e-mail my advisor, Dr. G. P. Parris, at 313-577-1619 or gparris@wayne.edu. Thank you so much in advance for considering granting me this permission.

Sincerely,

Chijioke Al Chigbo
Doctoral Candidate Researcher

March 02, 2011

Site Administrator
The Salvation Army Harbor Light System
3737 Lawton
Detroit, MI 48208

Dear Ms. Powell-Berry,

My name is Mr. C. Al Chigbo, a doctoral candidate in the Counselor Education program with a specialty in rehabilitation counseling at Wayne State University, Detroit, Michigan. I am requesting permission to complete a research project as part of my doctoral dissertation at The Salvation Army Harbor Light, Detroit. This study project will investigate the degree or level of recovery that is had when adult individuals who are mentally ill due to childhood trauma are treated separately with: i) a traditional treatment program without aspects of spirituality, and ii) an integrated treatment program with aspects of spirituality. This is a very important and contemporary topic in the field of mental health. Abundant research overwhelmingly indicates that a treatment program with aspects of spirituality assists affected persons to achieve a better recovery from mental disabilities.

This research project will involve administering: i) a demographic questionnaire, ii) a 57-item instrument that measures psychological well-being, and iii) a 40-item instrument which measures trauma symptom. It will take about 35 minutes to complete them and can be done individually or in a small group. The questionnaires are voluntary and confidential. Participants will be able to stop at any during the survey if they feel uncomfortable answering any of the questions. All answers will be grouped for analysis and therefore will not be identified as coming from any one individual.

Finally, all participants must sign an informed consent form in order to take part in the study and identify the methods by which anonymity is assured. If you have any question about the study, please call or e-mail my advisor, Dr. G. P. Parris, at 313-577-1619 or gparris@wayne.edu. Thank you so much in advance for considering granting me this permission.

Sincerely,

Chijioke Al Chigbo
Doctoral Candidate Researcher

LETTERS OF AUTHORIZATION

The Salvation Army Harbor Light System, Detroit Center

Shaw Clifton
General

Barry C. Swanson
Territorial Commander

Major Norman S. Marshall
Divisional Commander



THE SALVATION ARMY
Founded in 1865 by William and Catherine Booth

Eastern Michigan Division
Harbor Light System
Detroit Center

Major Edward Rowland
Director

Major Sandra Rowland
Pastoral Care
and
Women's Ministries
Director

March 29, 2011

Mr. Chijioke Al Chigbo
P.O. Box 980366
Ypsilanti, MI 48198

Dear Mr. Chigbo:

This letter is to officially inform you of The Salvation Army Harbor Light Program Executive Board decision regarding your research. The Executive Board has reviewed your request and a decision has been made under the following conditions:

1) Surveys must be brought into the facility and submitted to the office of Linda Powell-Berry, 2) Surveys will be provided only to those clients who are willing to participate, 3) Schedule pick up on the last Friday of each month.

This letter will also serve as a notification to Wayne State University and the Counseling Education Program of this decision.

If you have any questions, please give me a call at (313) 361-6136 Ext. 237.

Sincerely,

Linda Powell-Berry
Linda Powell-Berry LMSW, CAADC
Site Administrator



SUBSTANCE ABUSE SERVICES
3737 Lawton • Detroit, Michigan 48208
(313) 361-6136
Fax: (313) 361-6211



Detroit Rescue Mission Ministries, Detroit



150 Stimson ° P.O. Box 312087 ° Detroit, MI 48231-2087 ° (313) 993-4700 ° Fax (313) 831-2299

April 4, 2011

Mr. Chijioke Al Chigbo
P.O. Box 980366
Ypsilanti, MI 48198

Re: Wayne State University Research Survey

Mr. Chigbo,

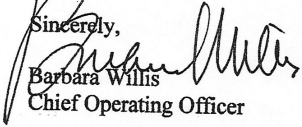
This letter is to confirm our conversation regarding the distribution of mental health surveys at our facility. Before we begin the survey, we need a letter from Wayne State University confirming your participation in the Counselor Education doctoral program for our files.

As we discussed, the identity of our clients must not be disclosed on the survey. We will discuss guidelines for conducting the survey upon receipt of the letter.

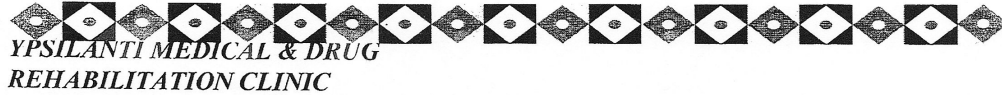
We look forward to working with you.

Feel free to contact me if you have any questions.

Sincerely,


Barbara Willis
Chief Operating Officer

Ypsilanti Medical and Drug Rehabilitation Clinic



880 North Ford Blvd. Phone: 734-483-9900
Ypsilanti, MI 48198 Fax: 734-483-9903
Email:
NWYPSIREHAB@SBCGLOBAL.NET

Mr. Chijioke Alphonsus Chigbo

P.O. Box 980366

Ypsilanti, Mi 48198

Mr. Chigbo,

I am please to inform you that the Program Director has approved your request to conduct a survey here at The Ypsilanti Medical and Drug Rehabilitation Clinic, 880 N. Ford Blvd., Ypsilanti, Mi 48198.

The conditions are as we discussed on Tuesday, March 22, 2011. You are to have a "Memo of Understanding from the University that you are attending, Wayne State University. Additionally, you are to bring sign-in sheets, where as the interested clients can sign in. The sign-in sheets must indicate that the clients will remain anonymous. The clients will also understand that they will not lose their place in line and there is no pressure to participate in survey.

Once these conditions have been met, we can schedule your survey on a day that I am here. If it is not one of my scheduled days, I am happy to alter my schedule to assist you.

Sincerely,

Tiwanna D. Palm

Recipient Rights Advisor

Human Resources, Administrative Assistant

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ABSTRACT**THE IMPACT OF SPIRITUALITY ON THE SELF-REPORTED RECOVERY
OF ADULTS WHO EXPERIENCED CHILDHOOD TRAUMA**

by

CHIJOKE ALPHONSUS CHIGBO**May, 2012****Advisor:** Dr. George P. Parris**Major:** Counseling**Degree:** Doctor of Philosophy

Objective: To examine whether adults who had experienced childhood trauma, and who had a higher sense of personal meaning or spirituality, would have improved mental health and lower trauma symptoms such as depression, lower self-esteem, anxiety, dissociative disabilities, PTSD, and the like.

Method: 115 participants were randomly selected from five mental health centers in the southeast of the State of Michigan of the United States. Each participant had an experience of one or multiple childhood abuses, namely: physical abuse, sexual abuse, verbal/emotional abuse, child neglect or cumulative trauma. They had also been to treatment, and were between 18 and 60 years old. A demographic questionnaire, Personal Meaning Profile (PMP) and Trauma Symptom Checklist-40 (TSC-40) surveys were used as clinical measures. A multinomial logistic regression statistic was used for data analyses.

Results: Each set of the hypotheses for PMP-and-Group and TSC-40-and-Group models were assessed for their overall significance using chi-square and goodness-of-fit tests, and both were statistically significant ($p<0.05$) in both tests, respectively.

Conclusion: The results suggest that adults who had experienced childhood trauma, and who had a higher sense of personal meaning or spirituality, would have better mental, physical and general health conditions, and lower trauma symptoms. Many research studies also indicate that this treatment option powerfully restores mental, physical and overall health conditions of the affected adults, and that the cost is usually inexpensive.

AUTOBIOGRAPHICAL STATEMENT

I was born in a southeastern city of Nigeria called Aba. It is a big town with a large population, many schools, churches, hospitals and other modern infrastructures. My siblings and I were all born and raised here by our parents. They (our parents) took advantage of the available schools in our city and provided us with formal education.

My informal education started almost simultaneously at home and our local Catholic Church community under the guidance of my parents and the parish staff, respectively. I was very comfortable and faithful to this early formation. I got my vocation to the Catholic priesthood from this early upbringing.

I began formal education in 1971 after the Nigerian civil war, and completed it in 1991 with two certificates and two bachelor degrees, one in philosophy and the other in theology. I was ordained a Catholic priest for the Catholic Diocese of Awka in Nigeria, on August 17, 1991.

After about nine years of pastoral ministry, I left Nigeria in 2000 for the United States to further my studies with the full permission of my bishop. I have ever since been with the Roman Catholic Diocese of Lansing, Michigan, assisting part-time with pastoral ministry as I pursued graduate education. I successfully defended my doctoral dissertation on December 12, 2011, and the degree (in counseling program) was awarded in May, 2012.

Table 17. Educational Career

Periods	Levels of Education	Certificates/Degrees
1971-1976	Primary School (Nigeria)	First School Leaving Certificate
1976-1981	High School/Junior Seminary (Nigeria)	General Certificate of Education
1982-1986	Undergraduate Study: Philosophy (Nigeria)	B.Phil. (Bachelor in Philosophy)
1987-1991	Undergraduate Study: Theology (Nigeria)	B.D. (Bachelor in Divinity)
2001-2004	Grad. Study: Educational Leadership	M.S.A. –Madonna Univ., Livonia
2004-2008	Grad. Study: Rehabilitation Counseling	M.A. – WSU, Detroit, MI
2004-2011	Grad. Study: Ph.D. Counseling Program	Ph.D. - WSU, Detroit, MI