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## Church Hurt: A Therapeutic Approach for Treating Religious Trauma and Spiritual Bypass

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CHURCH HURT: A THERAPEUTIC APPROACH FOR TREATING RELIGIOUS  
TRAUMA AND SPIRITUAL BYPASS

By

MEGAN SUE THOMAS

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CHURCH HURT: A THERAPEUTIC APPROACH FOR TREATING RELIGIOUS  
TRAUMA AND SPIRITUAL BYPASS

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2023

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In approaching creating, I value the idea that we create what we think is missing or what we may need ourselves. In working on this project, I hope I have achieved this.

## **Abstract**

Religious trauma is a condition that may surface following religious abuse from clergy, religious communities, and family. These entities may use scripture to justify their actions, leading for individuals to face internal conflict about their religious affiliation. Additionally, the restrictive teachings of conservative fundamentalist Christian religions can establish a foundation for potential conflict and trauma down the line. While religious trauma is gaining in recognition, there is still limited research on how to treat this condition. Further, individuals may retreat into the avoidant coping strategy of spiritual bypass, in order to evade the unresolved psychological pain from their religiously traumatic experiences. Potential causes and impacts of religious trauma and spiritual bypass are reviewed. Special emphasis is placed on the unique religiously traumatic experiences of the LGBTQ community. Approaches to treatment for these conditions are considered. Recommendations for clinicians working with this population are then offered.

*Keywords:* religious trauma syndrome, religious trauma, religious abuse, spiritual bypass

## TABLE OF CONTENTS

I. Introduction .....	10
II. Religious Trauma and Religious Abuse.....	12
Background .....	12
Specific Religious Teachings .....	14
Attachment Figures: Mom, Dad, and God .....	15
Defining Religious Abuse .....	18
Religious Abuse by Caregivers .....	20
Impact of Abuse .....	22
Effects of Abuse by Clergy-Perpetrators.....	25
Effects of Religious Abuse by Caregivers.....	29
Impact in Those Who Leave Their Religion .....	30
Considerations for LGBTQ Populations.....	34
Levels of Trauma.....	35
Structural Trauma. ....	36
Interpersonal Trauma. ....	36
Intrapersonal Trauma. ....	38
Religious Reluctance .....	40
Navigating Religious Environments.....	41
III. Spiritual Bypass .....	44
Background .....	44
Potential Motives and Causes.....	45



Becoming Aware of Spiritual Bypass .....	46
Impact of Bypassing.....	47
Mechanism of Avoidance .....	50
Negative Outcomes.....	52
Positive Outcomes .....	53
IV. Current Interventions and Guidelines .....	55
Religious Trauma and Abuse .....	55
Winell’s (2007) Phases of Recovery .....	55
Issues in the Recovery Process .....	59
Psychotherapy Groups .....	63
Deconstructing Religion .....	64
Adapting Trauma-Focused Cognitive Behavior Therapy .....	66
Acknowledging Religious Abuse .....	70
Relational Family Therapy .....	72
For LGBTQ Populations .....	74
Spiritual Bypass.....	78
Using the Developmental Counseling and Therapy Model.....	79
In 12-Step Work and Using Motivational Interviewing.....	81
Importance of Prevention .....	83
V. Recommendations for Clinicians .....	85
Considerations Before Treatment.....	85
Assessing for Spiritual Bypass.....	87

Considerations for Treatment.....	88
References.....	96
Appendix A.....	102

# **Church Hurt: A Therapeutic Approach for Treating Religious Trauma and Spiritual Bypass**

## **I. Introduction**

In a review of research on religion, spirituality, and physical and mental health, religion is viewed as a significant source of support and comfort (Koenig, 2012). Engaging in prayer and rituals have all been used as coping strategies. Similarly, turning to leadership figures in church organizations for advice and spiritual guidance for various life challenges has also been standard practice for those in that culture (Koenig, 2012). While the benefits of religious practices and organizations are well established, what is less recognized is the potentiality of harm imposed by them. The assumption is that religion, as a whole, is beneficial at best and benign at worst (Winell, 2011). Additionally, the abuse that may be enacted by authority figures in the church or individuals who justify their actions based on scripture, can leave lasting impressions on those who are impacted. Depending on the level of abuse experienced, individuals enveloped in this may go on to exhibit trauma responses, akin to those seen in a posttraumatic stress disorder (PTSD) diagnosis (Winell, 2011). Further, rather than reconciling these trauma experiences, individuals may engage in the potentially harmful coping strategy of spiritual bypassing, often used to avoid processing unresolved psychological pain (Stone, 2013). This continues to be a developing area of research and treatment.

In this doctoral specialty project, I propose a set of guidelines for clinicians in addressing religious trauma and spiritual bypass in their clients. First, I review the literature pertaining to religious trauma, religious abuse, and spiritual bypass. Emphasis

will be placed on the known and documented impacts of religious trauma. Special consideration will be given to those populations in which religious trauma may be more prevalent, such as within the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community. Second, I review the current interventions and guidelines researchers and clinicians have crafted for this group of clients. Finally, I present a consolidated list of guidelines and therapeutic suggestions that clinicians may utilize to navigate their clinical work with this population.

## II. Religious Trauma and Religious Abuse

### Background

Marlene Winell (2011), a psychologist, coined the term “religious trauma syndrome” to better conceptualize and provide a label for the experiences of those who have been harmed by fundamentalist religious practices. Specifically, she defined this condition as the experience individuals face when they struggle to leave an authoritarian, dogmatic religion and to cope with the damage of indoctrination. This may also encapsulate the repeated, chronic abuses of harmful religious practices and the impact of disconnecting from one’s faith. Winell’s (2011) own experiences, as well as her clinical work with individuals from this population, has informed much of this framework. This work has centered around fundamentalist Christians who have made the decision to separate from their religion. Further, Winell (2011) explains that these restrictive religious teachings can be toxic and create lasting damage in numerous areas of someone’s life, such as cognitive, emotional, social, and physical. In other words, authoritarian and patriarchal religious groups may behoove themselves in fostering an environment in which abuse and subsequent trauma develop.

Stone (2013) expands upon Winell’s (2011) conceptualization of religious trauma syndrome and describes religious trauma as the pervasive psychological damage from religious messages, beliefs, and experiences. Not only does the process of leaving a fundamentalist religion create unique psychological harm (Winell, 2011), so does being entrenched in this environment. Oftentimes, individuals are born into specific belief systems in their families and their broader religious communities (Stone, 2013). These early experiences provide messages that may influence individuals’ ideas about

themselves and the world. Harmful messages may slowly accrue over time and will impact mental health. This repeated, long-term exposure may eventually develop into religious trauma (Stone, 2013).

There have been considerable efforts to conceptualize religious abuse (Novšak et al., 2012; Simonič et al., 2013; Super & Jacobson, 2011). Super and Jacobson (2011) define religious abuse as occurring when a religious leader or collective group use their power or position within the organization to oppress, manipulate, or harm an individual with their beliefs. The forefront example of this religious abuse is the decades-long sexual abuse perpetrated by clergy members of the Catholic Church (Farrell, 2009). Religious abuse has also been committed at the hands of parents and caregivers, wherein they use scripture and broader religious beliefs to justify their actions (Bottoms et al., 2003; Novšak et al., 2012; Simonič et al., 2013). Additionally, similar abuse is used against members of the LGBTQ community, whose very existence is used as a trigger for vitriol (Greene, 2013; Super & Jacobson, 2011). These ideas will be explored in detail later.

There is much overlap among the research on religious trauma syndrome, religious trauma, and religious abuse. Literature detailing the cause of religious trauma and religious trauma syndrome has its roots in religious abuse, and the symptoms exhibited within these conditions are similar. Due to this, the terms religious abuse, religious trauma, and religious trauma syndrome will be used interchangeably throughout this doctoral specialty project.

### *Specific Religious Teachings*

Looking further into how this condition may develop is important in understanding its unique features, as well as the symptoms that are similar to a posttraumatic stress disorder (PTSD) or complex posttraumatic stress disorder (C-PTSD) diagnosis. As mentioned, Winell (2011) posits that restrictive religious teachings can lead to negative effects in numerous realms of an individual's life. The foundation of many of these teachings lies in the doctrine of original sin, wherein every person shares a condition of sinfulness due to the actions of Adam and Eve (McKim, 2014). This resulted in the loss of Adam and Eve's perfect righteousness. Humans' ability to have a relationship with God, as they were created to do so, was also damaged because of this loss. Likewise, original sin leads to the hereditary corruption of all humanity (McKim, 2014). With these teachings in conservative Christianity, Winell (2011) describes followers are taught very early that they are unacceptable and subjected to conditional love. They are bathed in sin at birth and are told the essence of others are also sinful and cannot be inherently loved (Winell, 2011).

Stone (2013) and Russell-Kraft (2021) note there are several Bible verses that may leave a foundation of withholding emotional expression and not listening to one's body and instincts. For instance, "Let all bitterness, wrath, anger, clamor, and evil speaking be put away from you" (New King James Version Bible, 1982/1984, Ephesians 4:31) and "Pride goes before destruction and a haughty spirit before a fall" (New King James Version Bible, 1982/1984, Proverbs 16:18) ward off individuals from disclosing unpleasant, negative, or sinful emotions. Having these restrictions may lead individuals to suppress, compartmentalize, or release their emotions in unhelpful ways (Russell-Kraft,

2021; Stone, 2013). Another line, “The heart is deceitful above all things and desperately wicked; Who can know it?” (New King James Version Bible, 1982/1984, Jeremiah 17:9), suggests it is not advisable to listen to one’s heart and intuition, as it is inherently deceitful. This aligns with the doctrine of original sin (McKim, 2014), and if taken at its face as it may be taught, could lead to harmful consequences (Russell-Kraft, 2021; Stone, 2013).

### ***Attachment Figures: Mom, Dad, and God***

Attachment research has shown that an individual’s relationship with their parents can lead to notable impacts in various areas of their life (Stone, 2013). This can occur even if the parents are deceased, or the relationship has deteriorated or been fully removed. The templates provided by the caregiver-caregivee relationships inform how individuals interact with others in their life. These, as well as the caregiver’s values, beliefs, and attitudes, are frequently internalized, and individuals may be unaware that they are present. In this context, the early life relationships will shape future friendships and relationships (Stone, 2013).

Being raised in a religious environment may lead to many people characterizing God as a significant attachment figure (Stone, 2013). Much like attachment relationships with parents or caregivers, the attachment to God can be secure, anxious, dismissive-avoidant, or fearful-avoidant. Those who subscribe to a more angry, vengeful God may have more anxieties and self-doubt than believers who confide in a loving God (Stone, 2013). These problematic patterns of interaction that may arise from insecure attachments can foster distress in one’s life instead of satisfaction, and vulnerability instead of protection (McGriffith, 2010). For example, if an individual has a secure attachment



style, they know that God will be available when needed. If someone has an anxious attachment style, they may not believe God will be available when needed, even though they know He is capable. Therefore, this individual may feel inferior and undeserving of God's attention, or that God's love and attention are conditional. An individual with an avoidant attachment style, subtyped into dismissive or fearful, may only have their attachment behaviors triggered in extreme circumstances. Specifically, regarding a dismissive-avoidant style, someone may view God as emotionally distant or uninterested in aiding in times of need. They may go on to only rely upon themselves. With the fearful-avoidant style, the individual may avoid God, because they feel to be close with God is discomforting and will likewise only rely upon themselves (McGriffith, 2010).

As God can be characterized as a significant attachment figure, the individual's specific image of God can also be internalized (Stone, 2013). This relationship will serve as an additional template to guide future interactions. The values and attitudes they are taught that God possesses are assimilated into their own lives. Further, individuals may internalize similar features of important religious leaders who were involved in their early religious experiences (Stone, 2013). However, Griffith (2010) explains that attending a fundamentalist church does not inherently mean that a person may believe in a punishing, angry God; conversely, attending a more liberal congregation in which a loving God is typically preached does not inherently mean that an individual will believe in such a deity.

Freud (1910) discusses in psychoanalytic theory that God is viewed as an esteemed father figure, an extension of a parental complex. The internalization of an individual's ideas of their parents could drive the desire to become involved with

religion. Immersing the self into religious practices may appear to be a more acceptable, or safer, course of action. Overall, an individual, especially as a child, needs greater help in order to thrive, in whatever form that may take, from their parent or caregiver. The need for religion, then, may serve a similar purpose if they are unable to resolve this helplessness from their parent or caregiver (Freud, 1910). Further, when analyzing the severity of ruptures in attachment, it can be characterized as a betrayal trauma, or trauma inflicted by a person who provides care to another (Cashwell & Swindle, 2018; Maxwell, 2017). To achieve healthy development in childhood, there must be a significant attachment that the child can confide in to meet their survival needs and the desire to create these social contracts to pursue those needs. With an attachment rupture, the individual is left unsure who they can seek to have their needs met. Additionally, they may forgo adequate social contracts to still accept this attachment relationship. In other words, some of the behaviors that may surface can be adaptive (Maxwell, 2017). How these behaviors further develop as the individual ages and is removed from a potentially abusive situation should be considered, as well as their future adaptiveness.

Reflecting on the restrictive practices and teachings of more fundamentalist religions (Winell, 2011) and the significance of an insecure attachment style (McGriffith, 2010), the potentiality of harm can be seen. As mentioned, people with an insecure attachment with God are not comforted by the presence of Him. They are often more vulnerable to distressing situations and may be less capable to remove themselves from these situations by relying on this attachment relationship. An anxious attachment style may lead for an individual to fluctuate between angry attempts to establish that closeness and a near-obsessive drive to seek reassurance. A person who has an avoidant attachment

style may not pursue any attempts to foster relationships (McGriffith, 2010). Their attachment style and relationship with God is a significant factor to consider when examining religious abuse.

### ***Defining Religious Abuse***

Super and Jacobson (2011) discuss that defining religious abuse is a challenge, as there are ambiguous constructs, similar to the gray areas among physical and emotional abuse. For instance, there is the debate on when spanking becomes a physically abusive act. This definition may differ across bodies of people. Religious organizations may dispute that they are perpetrating abuse, due to them servicing a higher power (Super & Jacobson, 2011). This is, however, different from the blatant sexual abuse found in some religious institutions (Farrell, 2009).

It is important to recognize the similarities between religious abuse and other types of abuse. First, Bent-Goodley and Fowler (2006) describe that the abuser establishes an environment heavily founded on secrecy, using threats, intimidation, and manipulation to ensure it. These behaviors can harm the victim's thoughts, feelings, and spirituality (Bent-Goodley & Fowler, 2006). The goal of the abuser, therefore, is to obtain and also maintain this power and control, through the continued use of these strategies (Gubi & Jacobs, 2009). A significant difference among religious abuse and other types of abuse is the usage of religious doctrine and the church community's sanctioning of this belief system (Super & Jacobson, 2011). This abuse influences the values of the victim, distorts their view of themselves and the world, and resembles the ramifications of physical, emotional, and sexual abuse (Bent-Goodley & Fowler, 2006; Sherry et al., 2010).

Gubi and Jacobs (2009) characterize religious abuse as the manipulation and control of others perpetrated by an individual in a leadership or authority position in a religious organization. The authority figure would use doctrine to exploit the idea of a higher power to impose their own interpretations of scripture and values onto an individual or a group of people, often to fulfill their own interests (Gubi & Jacobs, 2009; Simonič et al., 2013). Cashwell and Swindle (2018) discussed three categories of religious abuse. It should be noted that religiously abusive experiences may take place across multiple categories. The first category is abuse perpetrated by religious leaders. Examples of this can include sexual abuse perpetrated by a clergy member or a leader manipulating a parishioner to donate more money to the church and community than they can reasonably afford (Cashwell & Swindle, 2018). The specific consequences of religious abuse perpetrated by these figures will be explored in detail later. The second category is abuse perpetrated by an individual's religious group (Cashwell & Swindle, 2018). An example of this is a religious group encouraging systemic racism, sexism, or homophobia. An individual acting on behalf of their religious group would also fall into this category. The last category is abuse with a religious or spiritual component and requires a direct connection of the abuse to religious beliefs. Examples of this include a pastor pressuring a woman to remain in an abusive marriage due to religious beliefs against divorce, a husband justifying sexual assault or domestic violence in his marriage based on scripture, or a parent or caregiver justifying child abuse with scripture. An example of religious abuse that falls into all three categories would be a religious community supporting a pastor who may refuse to marry a same-gender couple, due to his or her interpretation of scripture (Cashwell & Swindle, 2018).

### ***Religious Abuse by Caregivers***

Further attention needs to be paid to religious abuse not only perpetrated by religious authority figures and/or the church community, but by caregivers and parents in the home. In this circumstance, Simonič et al. (2013) characterizes religious abuse as occurring when certain religious beliefs, or religion as a whole, correlate with abuse. Actions are justified when incorrect interpretations are made about certain beliefs and faith. Simonič et al. (2013) consider religious abuse to be a form of emotional abuse, though physical abuse may certainly occur in this context. It should be noted that religion in a vacuum is not sufficient for abuse to occur, as there are many people who actively practice their faiths and do not perpetrate abuse in the name of it. The likelihood of religious abuse occurring, however, increases if the abusers have traumatic histories themselves or have features of personality disorders (Bottoms et al., 2003).

Simonič et al. (2013) identify two forms of religious abuse that occur in families. The first form recognizes that the abuser uses theological explanations and scripture for their justification in physically abusing their partner or punishing their children. Bottoms and colleagues (2003) provide specific Bible verses that have been used to justify child physical abuse. These include “He who spares his rod hates his son, but he who loves him disciplines him promptly” (New King James Version Bible, 1982/1984, Proverbs 13:24) and “Do not withhold correction from a child, for if you beat him with a rod, he will not die. You shall beat him with a rod and deliver his soul from hell” (New King James Version Bible, 1982/1984, Proverbs 23:13-14). Religious parents may, in fact, believe they are acting in good faith, as a vengeful God will punish their children if they engage in sinful, earthly pleasures. To combat this, they may use corporal punishment, in varying

degrees, as they view it is preferable to inflict temporary physical pain onto their children to save them from burning in eternal hell (Bottoms et al., 2003). The second form focuses on the emotional abuse that takes place wherein fear is spread using religious beliefs (Simonič et al., 2013). These will, in turn, trigger fear, guilt, and shame in those who are abused, consequently leaving them to feel worthless, neglected, or cursed. The thread that connects these two forms is the warped sense of self, others, and their relationships to others that the abused individual develops. This includes their relationship with God or any divine being with which they hold a significant relationship. Ways in which religious-related emotional abuse can occur include the distorted interpretations of religious writings, threats of divine punishment, improper interpretations of religious beliefs and dogma that children are unable to understand, denial of emotions as they can be sinful, perfectionism, literal interpretations of religious writings that may condemn a child's behavior as the machinations of an evil spirit, and the belief that it is the parents' responsibility to break a child's natural, evil will (original sin) (Simonič et al., 2013).

Oftentimes, religious-related emotional abuse happens simultaneously as religion-related physical abuse and is characterized as occurring "in the name of God" (Novšak et al., 2012; Simonič et al., 2013). Examples of this combination of abuse include spurning, terrorizing, isolating, exploiting, and denying emotional responsiveness. In its extremes, this behavior presents as deliberate, cruel, and sadistic (Simonič et al., 2013). The characteristic that differentiates religious-related emotional abuse is the victim's distorted view of their relationship with God or a divine being (Novšak et al., 2012). This relationship is distorted in such a way that it may be perceived as another abusive connection. Victims may believe they are trapped in this relationship with God, as they

are with their religiously abusive parents, and are unable to remove themselves from these relationships. Additionally, as this emotional and physical abuse is characterized as occurring in the name of God, the victim may fear being rejected by God if they speak out against the abuse (Novšak et al., 2012). This rejection may be more painful than the tangible abuse they are receiving.

### **Impact of Abuse**

Stone (2013) and Russell-Kraft (2021) both liken the symptoms of religious trauma to those of posttraumatic stress disorder (PTSD). For example, individuals who have religious trauma may avoid stimuli that remind them of their traumatic experiences. When they do encounter these stimuli, they may experience intense distress. Further, they are unable to tolerate any distress related to participating in organized religious activities, such as being near or in a religious environment, being around clergy or other religious individuals, or consuming reading material. Due to this inability to tolerate such distress, they may avoid these groups of people and activities. Additionally, these individuals may not mention their religious history in psychotherapy for years, perhaps uncertain whether their therapist is religious or how they would take this information. Disclosing a trauma history is a notable act in itself; however, disclosing a trauma stemmed from religious abuse may prove more challenging (Russell-Kraft, 2021; Stone, 2013). The concept of religious trauma syndrome is relatively new and suggesting religion is anything but helpful or neutral is taboo in Western society (Winell, 2011). This population will often remove themselves from religion. Although, they could be interested in spirituality and may find themselves in spiritual bypass (Stone, 2013). Spiritual bypass will be discussed in greater detail in the following chapter.

Winell (2011) describes several clusters of symptoms for religious trauma syndrome: cognitive, emotional, social, and cultural. Cognitive symptoms include negative beliefs about self-worth, black and white thinking, perfectionism, and difficulty with decision-making or critical thinking. Emotional symptoms are depression, anxiety, anger, grief, loneliness, and difficulty with experiencing pleasure or finding meaning. Social symptoms include the loss of a social network, family ruptures, and sexual difficulty. Finally, cultural symptoms are an unfamiliarity with a secular world, having difficulty with belonging, and information gaps in evolution, modern art, and music. Further, Winell (2011) explains that religious trauma syndrome can appear as other mental health disorders, emphasizing the importance of practicing clinicians to comprehensively assess for potential religious abuse and trauma. Some of the mental health disorders Winell (2011) lists as masks for religious trauma syndrome are PTSD, clinical depression, anxiety disorders, bipolar disorder, obsessive-compulsive disorder, borderline personality disorder, eating disorders, and substance use disorders. She includes extreme antisocial behavior, such as homicide, and also suicide as conditions that religious trauma syndrome can mimic.

While there may be an overlap between religious trauma symptoms and those of emotional, physical, or sexual abuse, the incorporation of a divine being, the sacred, is a critical factor (Cashwell & Swindle, 2018). Abuse that occurred in the name of God, such as religious-related abuse in the family, or by a representative of God, such as a member of the clergy, is extraordinarily significant. Depending on the relationship the victim may have with the abuser, they may believe their abuse was ordained by God. If these actions were decreed by Him, coming forward about this trauma could prove to be a challenge.



As mentioned, the fear of potential rejection by God may lead to sustained silence about the abuse. Victims experience feelings of betrayal, not only toward their abuser but also the broader religious community. They may blame their community for not recognizing the abuse or even failing to stop it, not supporting them, protecting the abuser, or participating in victim-blaming. This betrayal can extend to the sacred, religious system they believed would comfort, protect, and accept them (Cashwell & Swindle, 2018). This phenomenon is similar to what other trauma survivors experience, in that the world as they had known it has been shattered (Farrell, 2009). Individuals who have experienced religious trauma may be reluctant to disclose the abuse and feel significant guilt and confusion if they do not speak positively about their church community or God. They can feel abandoned by God Himself (Farrell, 2009). There may be nothing more damaging to a victim's spirituality and mental health than believing in a potentially omnipotent God.

It should be readdressed that there have been specific Bible verses that may contribute to an individual's traumatic stress symptoms (Russell-Kraft, 2021; Stone, 2013). For example, there are several verses that discourage the expression of emotions, as these may border on the edge of becoming sinful. These include "Let all bitterness, wrath, anger, clamor, and evil speaking be put away from you" (New King James Version Bible, 1982/1984, Ephesians 4:31) and "Pride goes before destruction and a haughty spirit before a fall" (New King James Version Bible, 1982/1984, Proverbs 16:18). Additionally, when it is taught that love is conditional, people may be reluctant in sharing unpleasant or negative emotions in fear that the love may be withdrawn. Individuals may feel guilt for experiencing a negative emotion and think they are a bad, condemnable person for experiencing such a human thing. Russell-Kraft (2021)

discusses a Biblical verse that discourages listening to one's heart and intuition, as they are deceitful and wicked, incurably sick: "The heart is deceitful above all things and desperately wicked; Who can know it?" (New King James Version Bible, 1982/1984, Jeremiah 17:9). Not only does this advise individuals to not listen to their bodily cues, but it may also create reluctance in coming forward about religious abuse (Russell-Kraft, 2013). Did they truly feel uncomfortable while the abuse occurred, or was that their deceitful heart? The survival instincts their body likely experienced during the abuse were potentially ignored if victims were taught and believed they could not trust what their body was telling them (Russell- Kraft, 2013). This can also impact recovery and treatment, as it is well established in trauma research that an individual's trauma can be held in the body for a significant amount of time (Van der Kolk, 2014). As victims may have been taught to not listen to their bodies, the process of resolving their abuse and trauma can be a difficult challenge.

### ***Effects of Abuse by Clergy-Perpetrators***

There have been several studies explaining the impacts of abuse perpetrated by religious authority figures. McGraw et al. (2019) identified themes in the research literature of the consequences of sexual abuse by members of a clergy. The first theme was that sexual abuse by Catholic clergy members was the most prevalent. They recognize that this may be due to the increased media attention and attempts at financial recompense by the Catholic Church. However, it has been argued that forced celibacy, an aspect of the Catholic Church, may foster an environment that contributes to sexual abuse. The second theme is the predominance of male victims of sexual abuse. McGraw et al. (2019) explains that this may be due to the demographics of Catholic individuals,

wherein there may be an increased likelihood of interactions between male priests and altar boys.

The third theme identified was PTSD being the prototypical disorder following the sexual abuse (McGraw et al., 2019). Clergy-perpetrated sexual abuse may repeatedly occur in several congregational settings over time. The length of time in which the abuse occurred, the severity of the abuse, and whether penetration occurred, have all been found to relate to the likelihood of a PTSD diagnosis (McGraw et al., 2019). Additionally, there is a frequent pattern in the development of symptoms in regard to sexual abuse (Fogler et al., 2008). First, the victim may feel specially chosen by the clergy member. As they are ordained by God, that must reflect something about the victim's religiosity. However, while the abuse is occurring, this reaction will turn to confusion, anger, betrayal, and isolation (Fogler et al., 2008). It is also common to see symptoms similar to the presentation of complex PTSD: depression, isolation, anxiety, fear, poor self-esteem, anger, self-destructive behaviors, substance abuse, vulnerability to being revictimized, sexual difficulties, and difficulty in trusting people (McGraw et al., 2019). Further, there are differences in symptom presentation compared to traditional trauma symptoms, including the type and depth of guilt experienced and spiritual confusion. While common preceding events for a trauma may include fear or threat to their life, many victims of clergy-perpetrated sexual abuse are groomed over time. Although, there may be overt threat or coercion that takes place in order for the abuse to occur, these gradual tactics can create confusion and shame instead of fear. Because of this, for these individuals, the typical PTSD symptoms may not be the presenting concerns (McGraw et al., 2019).

The fourth theme was disbelief by the family and secrecy by the church and these often play a role in the chronicity of abuse and the late disclosure of the abuse (McGraw et al., 2019). It was discussed earlier that the fear of rejection by God is a powerful motivator in keeping victims silent. This fear can also extend to the individual's family if the family has a strong religious faith. The family may possess an absolute trust of the Church and the clergy because these figures and the organization are representatives of God. Victims may wait years to disclose their trauma to family due to these attitudes, as they do not want to rupture the family's ties with the Church. Following disclosure, family members who are exceptionally devout may encourage the victim to forgive the clergy-perpetrator or that they forgive the clergy member themselves. Victim-blaming may occur, especially if the perpetrator or the Church suggests that the victim had a part to play in the abuse (McGraw et al., 2019). This example of religious abuse extends to all three categories Cashwell and Swindle (2018) have identified.

McGraw and colleagues' (2019) fifth and sixth themes are that victims often have feelings of betrayal, mistrust, shame, depression, and helplessness. Betrayal and mistrust are common features of sexual abuse; however, clergy-perpetrated sexual abuse includes an additional level. As mentioned, as the clergy can be seen as a representative of God, there may be no greater indicator of trustworthiness. This breach in trust from the abuse could transcend to other authority figures and could impact psychotherapy in the future, if that is a course the victim would want to pursue. These individuals can also report having negative self-image, engaging in social isolation and self-sabotage, and possessing an inability to connect with other people. These may persist for years after the abuse has occurred. Victims can also experience shame because of their past and may view

themselves as damaged or unlovable. Should there be a shroud of secrecy surrounding the sexual abuse, victims' feelings of shame may exacerbate, in addition to experiencing depression and learned helplessness. Victims may begin to question their sexual identities, if they are the same gender as their perpetrators. With religions that reject same-gender attraction or behavior, this can be an additional stressor. They may blame themselves for the abuse occurring, in that they had led the clergy member toward sin. This thought process may even be encouraged and exploited by the clergy-perpetrator to rid themselves of their own guilt (McGraw et al., 2019).

Another significant theme McGraw and colleagues (2019) have found was the change in faith following the clergy-perpetrated sexual abuse. They describe that a decrease in a victim's religiosity or spirituality happens because their relationship and view of God had been changed. This is noteworthy, as they may have viewed the clergy member who had abused them as a direct representative of God and questioned why He allowed for this abuse to occur. Additionally, the loss of faith may be contributed by the contradiction between the religious teachings and the clergy-perpetrator's behavior. For instance, in some religious sects, same-gender sexual behavior is considered to be mortally sinful, though the victim may have been abused by a clergy member of the same gender as them. Further, Catholic individuals are instructed to seek absolution from their sins by a priest through penance or confession. This process has, unfortunately, been exploited by clergy-perpetrators to prolong the religious abuse (McGraw et al., 2019). Victims may question if the sacrament of confession they had received was sacred and holy, because their abuser had given it to them (Farrell, 2009). They also question that if their God was truly a forgiving God, would they meet their abuser in Heaven should they

repent. It may be too painful to reconcile these discrepancies, so victims may lose their faith (Farrell, 2009). However, there are some survivors who continue to engage in some form of spirituality (McGraw et al., 2019). Their beliefs may shift to an “interpersonal God,” a spiritual being, or to a higher presence that is connected to the survivor’s present experience instead of an organized religion (McGraw et al., 2019).

### ***Effects of Religious Abuse by Caregivers***

There has also been research examining the impact of religious abuse occurring in families. Religious parents likely feel an obligation to promote moral and positive behaviors in their children and often do so by following directives posed by scripture and other religious teachings (Bottoms et al., 2003). It should be recognized again that being religious and following these practices does not inherently make one abusive. What makes these actions religiously abusive is the pairing of scripture and beliefs to the physical and emotional abuse (Bottoms et al., 2003). Nelsen and Kroliczak (1984) conducted a study and found that children who had parents use the threat “God will punish you” during discipline were more likely to experience self-blame but were also more obedient. Children who have been abused using scripture will not only experience betrayal from their parent but also betrayal from God (Bottoms et al., 2003). Similar to how victims of clergy-perpetrated abuse may believe their abuse was sanctioned by God or the Church, children can view the parental abuse as justified based on doctrine. Victims may feel emotionally distant from their parents following the abuse and as if they do not have a secure attachment with their parents or God (Bottoms et al., 2003).

Overall, Bottoms and colleagues (2003) explain that individuals who have experienced religious-related physical abuse could have fewer coping resources and may

eventually lose their religion, spirituality, or church as a significant social support. They also have significantly more negative prospects for their long-term psychological well-being. Children who experience this type of abuse may develop symptoms of depression, including suicidal ideation, phobias, social withdrawal, aggression, psychoticism, and dissociative disorders (Bottoms et al., 2003).

### ***Impact in Those Who Leave Their Religion***

For fundamentalist Christian beliefs, the belief that all events are predetermined and inevitable, and instilling fear played a significant part in keeping followers in line (Ineichen, 2019). The world is also looked at in black-and-white terms, in which people and events are either good or evil, never both, and the concept of conditional love loomed high. The impact of religious trauma does not only occur while an individual is still immersed in a religious environment or identifies with a religion. Symptoms may persist even after someone exits (Ineichen, 2019). Individuals who merely consider leaving their religion, though ultimately stay, frequently have poorer mental health over time than those who are more consistent in their religious or nonreligious identities (Nica, 2019). In other words, those who never considered leaving in the first place or those who committed on leaving their religion fared better (Nica, 2019).

Survivors of religious trauma do not make the decision to exit their religion lightly, as there are significant costs in doing so. Religion has been established to be a wellspring of social resources for those that may find that to be helpful (Nica, 2019). Congregations can be tight-knit groups that offer social support. When choosing to exit, these individuals are losing that social support, whether that be from their friends or from the larger group. It should be noted that the significance of these relational losses on the

exiter's well-being may depend on the perceived quality of the relationship. For example, if certain relationships were not considered to have high value, then the loss of them from exiting a religion would not have much of an impact on an individual's well-being. Conversely, if those relationships were of value, there would be a greater impact. When relationships were lost, they were due to no longer sharing a common thread among friends: religious ideology. The loss of social support also occurred if an individual was excommunicated from the church and their family, as a result of them pursuing an exit (Nica, 2019).

Experiencing these losses make it difficult for exiters to navigate society (Nica, 2019). As they were potentially sheltered by the religious community and their family, this may be the first time these individuals truly experience the world. Due to these relational losses, they may have also lost financial support from their families. This creates challenges in seeking education and career changes. Exiters have to pursue replacements to provide these supports (Nica, 2019).

While the losses accrued may be on the forefront, there can also be gains in leaving a religion that should be considered. In replacing these social supports, exiters may find that they develop stronger relationships with these individuals (Nica, 2019). Relationship can feel more authentic, as they are no longer only held together by a shared religious ideology. Social supports can be more equivalent, in that an individual can "take" as well as "give" in the relationship, compared to mostly "giving" in their religious community. These new relationships may also provide emotional, informational, and instrumental support, often without the exiter fearing judgment (Nica, 2019).



Additional lingering impacts of religious trauma after leaving a religion can be particularly seen among ex-Mormons and ex-Evangelicals (Brooks, 2020; Russell-Kraft, 2021). Instead of framing the thought patterns and emotions had after leaving the Mormon faith as trauma, Brooks (2020) labeled these experiences religious disenchantment. In Mormonism, to deny that the church is true is considered an unforgiveable sin and those who commit this sin are deemed apostates. Family members and friends will frequently shun these individuals because it was their personal choice to commit this sin. In fact, those individuals who later decided to exit the Mormon faith, did so after studying scripture and seeking to find the church's truth. They were unable to reconcile the discrepancies and to tolerate the distress that now accompanied their religious environment and chose to leave (Brooks, 2020).

These individuals' system of meaning, of which their self-concept had been built, no longer brought comfort (Brooks, 2020). Instead, they felt as if their world had collapsed, as if they were floating, or that nothing appeared real. There was a sense of despair and meaninglessness. At its most extreme, these ex-Mormons experienced a total dissolution of their personality. However, even when their lives seemed to be shattered and they wished to be removed from any semblance of their faith, they were often haunted by embodied memories, anxiety, and fear, as if they had never left. Some symptoms experienced were sexual deficiencies, oscillations between panic and detachment, and sensations of "feeling the spirit." Engaging in daily routines could even beckon memories and reminders of their Mormon faith, despite those beliefs and practices not being incorporated into their lives for years. Ex-Mormons considered these to be traumatic experiences, as they were triggered by the abuse and the restrictive

religious environment in which they grew up and because they would not leave.

Seemingly unique to this population, the abusive events they endured presented as a form of psychosomatic trauma (Brooks, 2020).

Ex-Mormon cisgender women also encounter distinctive posttraumatic symptoms related to their religion's views on women (Brooks, 2020). Women experienced a consistent expectation to "build eternal families," while also warding away from sexual temptations. There is resentment toward the Mormon church in allowing them to "lose" their bodies to the service of childbearing. These groups of women were not able to "know" their bodies or even acknowledge them outside of motherhood. Achieving sexual gratification with a partner or by themselves was a challenge, as talk about those subjects was sinful. These thoughts lingered once exiting the Mormon faith, specifically with the idea that God was still ever present during intimate moments. The teachings of Mormonism could hook into women, presenting almost as a tangible entity, to further encourage the women's idea of themselves as possessing a sacred spirit within a tainted body. This could be increasingly frustrating when ex-Mormon women were able to go through their daily routines and not have those thoughts triggered (Brooks, 2020). Additionally, ex-Evangelical women have also experienced shame and guilt due to their gender (Russell-Kraft, 2021). These women were taught that their bodies never belonged to them; instead, they belonged to God, then their father, and then their husband. They also experienced similar guilt after engaging in sexual intercourse. Though they recognized that their behavior was not a sin, as they did not subscribe to those beliefs anymore, that internal conflict remained. The consequence of hell was so emphasized that indulging in these behaviors could still produce a trauma response (Russell-Kraft, 2021).

Ex-Mormons grapple with the challenge of now constructing their own meaning to life (Brooks, 2020). While being active in their faith, there was an understanding that any question or concern would one day be answered or addressed by God. Having this safety net could allow Mormons to persist through life even in the most difficult of circumstances. Upon leaving, there were new concerns about their own mortality, their existence, that they now had to find answers for. They may have prolonged periods of self-reflection. Two distinctive times of their life are formed: when they were in the church and since they left the church. While being in the church, they were engaged in an interval of religious enchantment. Their thoughts, beliefs, and actions were developed and fostered by the church. Since they have left the church, they are faced with the reality of the origin of their thoughts, beliefs, and actions, and may attempt to disown the “deluded” person they once were. Creating such a distinct divide between these two states allows for ex-Mormons to grow as more self-aware and autonomous individuals. However, this realization could produce distress, as it is at the behest of an internally divided, incongruent individual. An ex-Mormon described that he had to intentionally remind himself of the things he cared about, to stop from devolving into an apathetic state. Further, he reported he had to force himself to keep on living, despite not understanding what that meant now (Brooks, 2020).

### **Considerations for LGBTQ Populations**

Special attention needs to be paid in regard to religious trauma in the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community. The traditional family is at the core of conservative Christianity and Judeo-Christian values, and the existence of the LGBTQ community inherently threatens this (Morrow, 2003; Super & Jacobson, 2011).

Specifically, in Judeo-Christian religions, sexism is ingrained in the patriarchal context of scripture. Women are seen as inferior to men, and maleness has been used to describe the presence of God, or God the Father (Morrow, 2003). Further, maleness has been established as superior in forming significant social institutions, such as religion, families, and politics, among others. Embedded in these religious beliefs is the concept of heterosexism, which is the belief that a heterosexual orientation is superior to other sexual orientations. Organized religion has been a driving force in encouraging heterosexist ideals and the oppression of LGBTQ individuals for decades (Morrow, 2003). Biblical verses have been selected in order to promote this agenda (Greene, 2013). One such verse includes “For this reason God gave them up to vile passions. For even their women exchanged the natural use for what is against nature. Likewise also the men, leaving the natural use of the woman, burned in their lust for one another, men with men committing what is shameful, and receiving in themselves the penalty of their error which was due” (New King James Version Bible, 1982/1984, Romans 1:26-27). Further, for those who had this debased mind and engaged in these acts, among others, “are deserving of death” (New King James Version Bible, 1982/1984, Romans 1:28-32). It should be noted that select Bible verses have been used throughout history to justify racial segregation, slavery, genocide, the Holocaust, and the forced sterilization of people labeled as mentally and morally defective (Greene, 2013). This practice is, unfortunately, not new.

### ***Levels of Trauma***

The LGBTQ community can experience religious trauma on three levels: structural, interpersonal, and intrapersonal (Lefevor et al., 2020). These experiences are

often influenced by the heterosexism, and, to an extent, sexism, that is embedded in some Judeo-Christian values (Morrow, 2003). Further, these belief systems can shape policies and interactions within a church community and lead for an individual in the LGBTQ community to internalize damaging messages and develop self-loathing because of this part of their identity.

**Structural Trauma.** The first is structural, which occurs as the result of societal and institutional discriminatory policies. Many religious institutions may prevent their clergy from officiating same-gender marriages or neglect to honor the names and pronouns of transgender individuals. They may prohibit sharing the identities of their LGBTQ members of the congregation, due to not agreeing with it. Some institutions may also prevent LGBTQ individuals to be members of the clergy (Lefevor et al., 2020). Clergy could preach sermons that directly target members of the community, providing encouragement to the “othering” of these individuals (Cashwell & Swindle, 2018). Additionally, religious institutions may support and encourage LGBTQ individuals to pursue sexual orientation change efforts, such as conversion therapy, to manage their same-gender attraction (Lefevor et al., 2020). Due to the position of power the clergy has, religious LGBTQ individuals may engage in these efforts, which is a trauma by its very nature, as sexual orientation does not frequently, if at all, change (Lefevor et al., 2020).

**Interpersonal Trauma.** The second level is interpersonal, which occurs with negative interactions with other individuals (Lefevor et al, 2020). Interpersonal trauma can take the form of rejection, stigma, closeting, invisibility, and violence. Rejection is the most recognizable form of trauma LGBTQ individuals face. Certain religious communities and family members may prefer for an LGBTQ individual to not display

any same-gender attraction at all, instead electing them to present as having no attraction to others. Similarly, they may discourage transgender individuals from expressing their gender how they so choose. These negative reactions and nonacceptance can lead LGBTQ individuals to be isolated. Additionally, rejection can also occur if the religious community enforces the use of discriminatory practices. Stigma can contribute to rejection, as well as disapproval, condemnation, and discrimination. This may be expressed in overt or covert messaging, but the overall effect makes LGBTQ individuals feel singled out while being in a religious environment. They could feel pressured to dress or act a certain way in order to appear as heterosexual or cisgender to avoid any negative reactions. Likewise, LGBTQ individuals may feel compelled to hide parts of their sexual orientation or gender identity to ward away disapproval from their religious community or family. Being closeted may be traumatic in of itself. Having to conceal their identity prevents LGBTQ individuals from obtaining resources that might be beneficial for them in navigating their intersecting identities. There are also numerous positive outcomes for LGBTQ individuals who feel safe in coming out. With the pressure to remain closeted, they are often forced to go without these benefits and the trauma they are experiencing may persist (Lefevor et al., 2020).

Another form of interpersonal trauma in religious communities is invisibility (Lefevor et al., 2020). LGBTQ identities are not formally recognized in many conservative religions, leading LGBTQ individuals to navigate their religious community with little to no guidance. They may feel like there is no community for them. The heterosexist ideals at the core of conservative religions, as well as in Judeo-Christian values, are a significant force behind this invisibility. Misgendering transgender

individuals, as well as identifying same-gender partners of congregation members as only their “friend,” contributes to invisibility. It should be noted that LGBTQ individuals who are public with their identity can still experience this trauma. This can occur when they may have to repeatedly disclose their identity to those who they have already come out to, or the repeated correcting of people who misgender them. Additionally, feelings of invisibility can occur when individuals they may have considered to be supportive silently stand by when discrimination or violence is taking place. If this should happen repeatedly in a religious community, LGBTQ individuals are likely to feel that they are not understood, valued, or truly supported (Lefevor et al., 2020).

The last form of interpersonal trauma is violence (Lefevor et al., 2020). This includes sexual abuse committed by religious leaders and physical assaults perpetrated by members of the congregation. LGBTQ individuals who are aggressed against and banned from the church and even their homes are also experiencing interpersonal violence (Sherry et al., 2010). Lefevor and colleagues (2020) note that the most frequent form of violence, however, is emotional manipulation and verbal abuse. These tactics are used to shame LGBTQ individuals because of who they are. This may lead them to feel worthless, helpless, and “othered.” Religious communities can exploit these fears of violence to control LGBTQ congregation members to make them appear heterosexual or cisgender. LGBTQ individuals who have experienced interpersonal violence are often hypervigilant, most often in the environment in which the violence happened (Lefevor et al., 2020).

**Intrapersonal Trauma.** The third and final level is intrapersonal, which takes place following frequent exposure to homophobic and transphobic interactions and

interpersonal discrimination (Lefevor et al., 2020). Examples of these fall under the structural and interpersonal forms of trauma detailed earlier. This repeated exposure contributes to the internalized negative beliefs and attitudes LGBTQ individuals may have about themselves. Intrapersonal trauma can present as crises of sexuality and gender identity, crises of faith, internalized homophobia or transphobia, and internalized spirituonegativity. As conservative Christianity and Judeo-Christian religions condemn same-gender attraction and displays of gender nonconformity, many LGBTQ individuals in these environments initially repress their attraction and gender dysphoria. Becoming aware of this attraction and discomfort with their assigned gender at birth can be traumatic for LGBTQ individuals, as it goes directly against what they may have been taught. This confusion about their identity can persist and contribute to feelings of low self-worth and as if they do not belong in their religious community (Lefevor et al., 2020).

An additional crisis that can occur is a crisis of faith (Lefevor et al., 2020). As they know they are experiencing same-gender attraction and/or gender dysphoria, which puts them at odds with the teachings of their religious community, they may experience a crisis of faith. This additional crisis can lead LGBTQ individuals to further question their sense of self and have them question their place in the community. They may also now grapple with how to make meaning out of their world. Crises of faith can occur on three levels: with God, with religious institutions, or with their religious worldview. How this crisis is resolved ultimately depends on how the LGBTQ individuals decide to engage with their religious community (Lefevor et al., 2020). This will be discussed in more detail later.



The next forms of intrapersonal trauma are internalized homophobia, transphobia, and spirituonegativity (Lefevor et al., 2020). LGBTQ individuals who have experienced repeated instances of violence and discrimination may begin to believe the negative thoughts and attitudes that have been directed at them or the community. Even when the specific direct stressors that have contributed to this internalization of negative beliefs are no longer present, LGBTQ individuals may still feel the effects of that discrimination and violence. They may feel as if they are rejecting who they are, that they are unworthy, or that they are deceiving the people in their religious community by still being a part of it. Internalized homophobia and transphobia are connected to increased shame and decreased perceptions of social support (Lefevor et al., 2020).

### ***Religious Reluctance***

Similarly, LGBTQ individuals who are religious may also internalize negative beliefs about religion and spirituality (Lefevor et al., 2020). These attitudes can arise from the perceived rejection of LGBTQ individuals from religion. Internalized spirituonegativity can present as questioning whether they are able to identify with a religion, feeling divided from non-religious LGBTQ individuals, and perceiving themselves as unwelcome in the LGBTQ community. While the LGBTQ community has every right to be wary of organized religion and religious communities, considering the long history of discrimination and violence, some LGBTQ individuals choose to participate in a religion. This may prevent them from becoming involved with the broader LGBTQ community, in fear of rejection from them or feeling compelled to inauthentically reject their religious identity to feel accepted. Experiencing isolation from both the religious community and the LGBTQ community, as a religious LGBTQ

individual, can leave them with no social support system and an inability to relate to either community (Lefevor et al., 2020).

### *Navigating Religious Environments*

Considering the multitude of ways LGBTQ individuals can experience religious trauma, Rodriquez and Ouellette (2000) discuss four ways members of the community may navigate the internal conflicts that arise from being in these environments. The first way is to reject their religious identity. Recognizing that the values of their religious community can lead to direct harm to their person or that they have already endured said harm, LGBTQ individuals may choose to completely remove themselves from the religious community. Formal steps can be taken to achieve this, but it can also be a more subtle removal, wherein LGBTQ individuals may slowly fade out from the services at their church. The second way is to reject their LGBTQ identity. This can be achieved by engaging in sexual orientation change efforts, such as “reparative” or conversion therapy. It can also include “praying away” their same-gender attraction, suppressing that part of their identity, or remaining abstinent. There are some religions that encourage LGBTQ individuals to not engage in behavior that affirms their same-gender attraction, because that would make them more acceptable. The third way is to compartmentalize their religious and LGBTQ identity. In other words, they may decide to keep their LGBTQ identity separate from their religious identity. Keeping those two areas of their lives fully separate may address some of the internal conflict present. For example, a lesbian woman may be open about her sexual orientation among her supportive friends; however, while at church, she may conceal that part of her identity and present as a heterosexual woman. The last way is integrating the identities. Rodriquez and Ouellette (2000) posit that

internal conflict in regard to potentially contrasting identities can be ameliorated when LGBTQ individuals are able to integrate their sexual orientation and gender identity and their religious beliefs into a new, workable understanding of themselves. As a result, they would have a positive LGBTQ identity, a positive religious identity, and no identity conflict. This is different from compartmentalization, because while LGBTQ individuals may be fully out in certain areas of their life, they still keep their LGBTQ identity separate from other areas. An integrated individual will have these two aspects of their identity unified in all areas of their life (Rodriquez & Ouellette, 2000).

Lefevor and colleagues (2020) explain that some LGBTQ individuals may navigate religious environments without experiencing trauma. This may occur for several reasons. First, while an LGBTQ individual's family may be religious, they may not be actively practicing and the usual dogma, discrimination, and violence may not be readily present. Conversely, the LGBTQ individual's family could be actively engaged in the religious community, but the LGBTQ individual is not. Because of this, they may not fully experience the impact that a religious LGBTQ individual may. Additionally, LGBTQ individuals and their families may be involved with an affirming congregation, in which the vitriol is not apparent in their teachings and service. Even if the religious community does engage in discrimination and violence, LGBTQ individuals may study the scripture on their own and discover their own interpretations of the text that could lead for them to feel affirmed of their sexual orientation or gender identity. They may even identify their non-affirming religious community as imperfect, whereas God is perfect, which results in less of an impact on potential trauma. However, it should also be noted that while LGBTQ individuals may report they do not experience religious trauma,

they may, in fact, be experiencing potentially traumatic events. Not recognizing the severity of the religious trauma experienced is often a byproduct of repeated invalidation of their experiences. Further, choosing to report a traumatic experience may require them to disclose their sexual orientation or gender identity, which could be particularly unsafe in conservative Christian and Judeo-Christian environments (Lefevor et al., 2020).

### **III. Spiritual Bypass**

#### **Background**

For individuals who have experienced religious trauma, they may engage in a coping strategy called spiritual bypassing (Stone, 2013). Welwood (1984) created this term to describe the tendency to avoid or prematurely transcend basic human needs, feelings, and developmental tasks. Spiritual bypass is a process an individual chooses, either consciously or unconsciously, to go through to avoid unresolved psychological pain. In other words, there is a desire to rise above their unresolved concerns and emotions and to be released from structures, physical and mental, that may hold them back. Welwood (1984) described some of these structures as karma, conditioning, the body, form, matter, and personality. In wanting this release, an individual may indulge in spiritual practice and “bypass” important work. In many spiritual teachings, there is an assumption that individuals have already worked through the basic developmental stages. However, those who engage in spiritual bypass are often not at this level, and still want to use spiritual practice to have their needs met or their identity established. Welwood (1984) explained that this does not work. To fully receive the advantages of spiritual practice, the individual must first have a stable self-structure (Welwood, 1984).

Further, those who engage in spiritual bypass may be avoiding psychological or emotional pain (Fox et al., 2020). They may push this, often important, religious trauma integration work aside. As a result, emotional development may stagnate, and greater psychological suffering may surface (Fox et al., 2020). Cashwell and colleagues (2004) also suggest that this commonly occurs when people think that certain issues are not important, and aspects of their daily life, such as relationships, receive less attention. It

may resemble a cutoff of crucial unfinished business that is too painful to acknowledge (Cashwell et al., 2004). Spiritual bypassing has also been identified in the substance use disorder recovery literature, wherein individuals in recovery similarly avoid—or bypass—critical psychological work on their addiction by heading straight for spirituality (Picciotto et al., 2018).

### ***Potential Motives and Causes***

Picciotto and colleagues (2018) researched the development of spiritual bypass and some of its potential causes. They discovered three motives for what made an individual encounter spirituality/religion and “engage in a search for the sacred” (p. 342). The first motive was to search for answers for existential questions, such as answering what God is and where did humans come from. The second motive was to suppress or to relieve their pain from existential emptiness. Some individuals believed that religion and spirituality could help guide them through their pain. Last, the third motive was due to their family’s current beliefs and practices. Individuals’ perception of their closeness to spirituality or religion was dependent on their family’s relationship to these concepts (Picciotto et al., 2018).

Additionally, Picciotto and colleagues (2018) explored the reasons why individuals engaged in spiritual bypass. There were four causes identified. The first cause was to escape. Individuals desired to escape reality and flee into spirituality. Day-to-day life seemed to be meaningless, and spirituality corrected this. The second cause was to avoid pain. Given that spiritual bypassing is often an avoidance coping strategy, seeking a way to dilute possible pain is a powerful motivator. The third cause was to cope with difficult familial history or other social contexts. This goes further than avoiding pain.

Individuals may experience hardships in their family and broader environments, whether that be childhood abuse or even religious trauma. Finding themselves in spiritual bypass to cope with the challenges they faced in their lives appears to be a common cause.

Lastly, the fourth reason why individuals engaged in spiritual bypass was because of the negligent practices by their spiritual or religious leaders and community. The way these leaders interpreted scripture and spread their messages had helped foster the usage of spiritual bypass (Picciotto et al., 2018).

Some individuals believed that going through spiritual bypass was necessary for their spiritual growth (Picciotto et al., 2018). Further, this process may even be seen as an inevitable part of this growth (Masters, 2010). However, still others believed that it only served as a short-term coping strategy, in that it helped them navigate distressing situations for as long as they needed it (Picciotto et al., 2018). This stance appears to be the most common throughout the spiritual bypass literature, though the amount of time that an individual is in this state differs. While this may be an adaptive coping skill in the short term, spiritual bypass persisting and developing into an avoidance strategy should be kept in mind (Picciotto et al., 2018).

### ***Becoming Aware of Spiritual Bypass***

The general public may not be aware of what spiritual bypass is, and as a result, individuals in prolonged periods of spiritual bypass may not realize they are in it (Picciotto et al., 2018). Picciotto and colleagues (2018) found there were several factors as to how people in spiritual bypass become aware of this state. The first factor was angst, in which individuals experienced a profound feeling of existential crisis that prompted them to seek further support. In other words, their current engagement with

spirituality was not enough to address their distress. The second factor was feedback, where other people in their lives realized that their behavior or spirituality had changed or become stronger for the worse. The third factor was concrete experiences, or when individuals engaged in other activities, nonspiritual in nature, and recognized how exaggerated their spiritual practices had become in comparison. The fourth factor was relational conflict, in which individuals began to experience increased conflict in their relationships that stemmed from them being unable to maintain the image that they were doing well and were spiritually healthy. The last factor was individuals becoming educated about spiritual bypass. By obtaining more information about spiritual bypass through books, articles, and other materials, their awareness of their experiences was increased. Individuals with greater awareness are able to then reflect on how engaging in spiritual bypass has affected their well-being (Picciotto et al., 2018).

### **Impact of Bypassing**

There are several ways how spiritual bypass may manifest. These include 1) isolation, 2) reluctance to have relationships with unspiritual people, 3) disconnectedness from the body, 4) spiritual narcissism and spiritual materialism, 5) blind following, 6) compulsive goodness, and 7) avoidance (Cashwell et al., 2007; Cashwell et al., 2010; Cashwell et al., 2004; Fox et al., 2017; Picciotto et al., 2018).

The first is the intentional isolation from other people and the world (Picciotto et al., 2018). Individuals may choose to remain isolated and engage in pray, bible study, or similar activities. Further, they may also choose to cease contact with people who they consider to be unspiritual or even spiritually disruptive. This can include family members and other loved ones. Spiritual bypass can lead to some individuals refusing to be open to



new relationships or pursuing relationships with unspiritual people, which results in difficulty in starting them or even deepening current relationships. Related, these individuals can idealize themselves to such a level to where they believe they are above the basic human need for relationships (Picciotto et al., 2018).

Another symptom of spiritual bypass is being disconnected from the body (Picciotto et al., 2018). Not only was there a mere disconnection to the body, but the individual was wholly disregarding their body and its cues. This neglect can also leave the individual with only some of the information to properly and fully navigate their world. This physical disconnect may be connected to religious abuse an individual has experienced, or from scripture in which they were taught that they could not trust their bodily cues or their heart (Picciotto et al., 2018). Listening to their body was not important, if it was inherently deceitful (Russell-Kraft, 2013).

Spiritual bypass can also present as spiritual narcissism (Cashwell et al., 2007; Cashwell et al., 2010; Cashwell et al., 2004; Fox et al., 2017; Picciotto et al., 2018). Spiritual narcissism is a process where an individual believes and behaves as though they are spiritually superior to other people. They position themselves as the authority of reason and the source for all answers. In other words, they feel as if they are the enlightened ones and the other people in their lives are not. This may occur when an individual has high ego needs or when narcissistic individuals participate in spiritual practice in order to feel superior to others (Cashwell et al., 2007; Cashwell et al., 2010; Cashwell et al., 2004; Fox et al., 2017; Picciotto et al., 2018). Given the religious trauma literature, this group of individuals may not fall into the latter category, but the first. Additionally, those in spiritual bypass may show spiritual materialism, or that they

engage in spiritual practice for material gain (Cashwell et al., 2004; Fox et al., 2017). Those who may fall into the latter category, more narcissism than high ego needs, may present with this symptom, as well.

Another symptom of spiritual bypass is blind following (Cashwell et al., 2007; Cashwell et al., 2004; Fox et al., 2017; Picciotto et al., 2018). Individuals engaged in this process often follow charismatic, spiritual leaders without question. They have a blind faith, and fully believe and trust what these leaders are telling them. This symptom is noteworthy in the context of religious trauma. Individuals may have chosen to leave their religion because of the abusive behaviors and restrictive teachings they had experienced. In leaving, they may have then chosen to engage more with spirituality, and inadvertently found themselves in a similar situation with those leaders (Cashwell et al., 2007; Cashwell et al., 2004; Fox et al., 2017; Picciotto et al., 2018). Further, knowing how significant attachment styles are to religious trauma (McGriffith, 2010; Stone, 2013), it would not be unreasonable for individuals to be drawn to spiritual leaders who resemble former faith leaders or caregivers.

Cashwell and colleagues (2004; 2007) discuss that individuals engaging in spiritual bypass participate in compulsive goodness. Individuals who are compulsively good behave this way because they may have difficulty asserting themselves and respecting their own thoughts and feelings. They are good because they know they cannot express anger, know what they want, ask for what they want, refuse what is asked of them, assert themselves, trust in their own instincts and perceptions, or express any self-interest. This compulsive goodness compensates for feeling worthless and functions to protect them from criticism or being disliked. There is a fear of connecting to and truly

being themselves. In behaving as a “good” person, they may be avoiding addressing any underlying concerns they may have due to the abuse they had experienced. They are not allowed to seek support, because they are a good person, and they are not allowed to—they are not worth it (Cashwell et al., 2004; Cashwell et al., 2007).

### ***Mechanism of Avoidance***

There are several ways in which spiritual bypass may serve as an avoidance strategy (Picciotto et al., 2018). These include 1) avoidance of confrontation, 2) unrealistic living, 3) emotional dissociation, 4) exaggerated optimism and shadow side, and 5) rationalization (Cashwell et al., 2007; Cashwell et al., 2010; Cashwell et al., 2004; Fox et al., 2017, Picciotto et al., 2018).

Picciotto and colleagues (2018) discovered that spiritual bypass can present as an avoidance of confrontation. Individuals may refuse to create appropriate boundaries to avoid disappointing other people. This fits into the broader picture of what spiritual bypass is, which is ultimately an avoidance (or bypassing) strategy. Additional avoidance symptoms include unrealistic living, emotional dissociation, exaggerated optimism, and rationalization (Picciotto et al., 2018).

Unrealistic living captures an individual’s tendency to avoid responsibilities and potentially turning that responsibility over to others (Cashwell et al., 2007; Cashwell et al., 2010; Cashwell et al., 2004; Fox et al., 2017). This may include responsibilities related to work and money, in which they refuse to join a professional career or make long-term financial plans (Cashwell et al., 2007; Cashwell et al., 2010; Cashwell et al., 2004; Fox et al., 2017). Conversely, another way in which spiritual bypass may manifest is through individuals having a strong need to control other people and themselves

(Clarke et al., 2013; Fox et al., 2017). As with most trauma survivors, they desire to have control over their situation because they were frequently in circumstances that denied them that control. Considering religious trauma and the restrictive teachings that can lead to it, these individuals have been under control for most of their life. Some may desire to reclaim that control, and that is why when they are in spiritual bypass, they extend that control to others, almost as an overcorrection. Similarly, those who instead prefer to abdicate responsibilities and avoid them, may fear this decision-making process. Further, even when they recognize the harm that religion has caused them, they are still hesitant to seize the reins of their life and thus retreat into the avoidance spiritual bypass brings (Clarke et al., 2013; Fox et al., 2017).

Emotional dissociation is avoiding emotions that the individual perceives to be difficult (Picciotto et al., 2018). They may also repress these emotions to stifle their intensity (Cashwell et al., 2007; Cashwell et al., 2010; Cashwell et al., 2004). These symptoms align with the function of avoiding unresolved spiritual or emotional pain (Cashwell et al., 2007; Cashwell et al., 2010; Cashwell et al., 2004). Relatedly, individuals' spiritual bypass may manifest as being anger-phobic (Picciotto et al., 2018). They may believe that anger is an inappropriate emotion for spiritually advanced people to feel (Picciotto et al., 2018). When reflecting on the religious teachings these individuals may have had, the expression of certain emotions was discouraged, as these emotions, anger being one of them, were too reminiscent of sin (Stone, 2013). Exaggerated optimism is a similar avoidance symptom of spiritual bypass, wherein the individual overly focuses on the bright side of situations (Picciotto et al., 2018); however, this leads to them being unrealistic and not viewing the whole picture. A narrower

symptom is shadow side, in which an individual refuses to recognize the “darker” parts of their personality or history. Like exaggerated optimism, the individual is cherry-picking which aspects of their situation or themselves they want to acknowledge. Again, as the function of spiritual bypass is to avoid these unresolved psychological concerns, symptoms that serve to prolong this underlying avoidance will manifest. Specifically in regard to the negligence of acknowledging the “darker” parts of their history, this will create an immense obstacle for resolving religious trauma. It is difficult to reconcile with something that is not recognized (Picciotto et al., 2018).

Rationalization is an additional avoidance symptom of spiritual bypass (Picciotto et al., 2018). This occurs when an individual places an overemphasis on reason, solely focusing on objective facts and logic. This can be related to emotional dissociation and repression, in that the individual does not acknowledge the emotions they are currently feeling in favor of emphasizing the logic of the situation. Again, however, this does not allow them to capture the full picture and can lead them to operate in situations with only half of the needed information, as emotions play critical roles in social interactions (Picciotto et al., 2018).

### ***Negative Outcomes***

Picciotto and colleagues (2018) identified specific negative outcomes of spiritual bypass. They include developmental arrest, familial obligations, depression, anxiety, social disconnection, and loss of self-love. Developmental arrest refers to the stagnation and potential regression an individual may feel because of their intense focus on spirituality (Picciotto et al., 2018). Welwood (1984) noted that spiritual growth could only be possible when individuals had an existing self-structure. Those engaging in

spiritual bypass often do not, and as a result, do not experience any true spiritual growth. Instead, they feel this stagnation (Welwood, 1984). Another negative consequence is familial obligations, which refers to an individual not being able to earn enough money to support their family or fulfill their responsibilities in their family, either as a spouse or parent (Picciotto et al., 2018). This is tied to the spiritual bypass symptoms of abdication of personal responsibility and unrealistic living (Cashwell et al., 2007; Cashwell et al., 2010; Cashwell et al., 2004; Clarke et al., 2013; Fox et al., 2017; Picciotto et al., 2018). By refusing to make strides in their professional careers or avoiding responsibilities, their daily functioning can suffer (Picciotto et al., 2018). The negative outcomes of depression and anxiety are the pathological consequences of spiritual bypass, in which all the discussed symptoms may lead to these conditions surfacing. Blindness refers to the inability to see the full picture or understand themselves on a deeper level. Social disconnection includes challenges in connecting and empathizing with the people in their lives, often feeling alienated. Individuals may experience this disconnection with others because of presenting with spiritual narcissism and having that sense of spiritual superiority. Lastly, the negative outcome of loss of self-love captured when individuals ultimately feel no compassion for themselves because of the spirituality indulgence and the avoidance in which they immerse themselves (Picciotto et al., 2018).

### ***Positive Outcomes***

It should be noted that there are some positive benefits to spiritual bypass, as well (Picciotto et al., 2018). These factors encouraged individuals to continue to engage in this process. The first positive effect was superiority. Individuals believed they were more important or advanced compared to people who did not participate in spiritual practice.

The second factor was pain relief. Individuals specifically identified spiritual bypass as a significant coping mechanism. Finally, universality was a motivator, wherein they believed that spiritual bypassing alleviated their anxieties and fear around their existential crises of meaning. These crises likely surfaced following their exit from their religion, and when they were solely responsible for crafting meaning for their lives. While these positive effects should be recognized, some of these factors may contribute to the negative outcomes that arise. Namely, the superiority and pain relief factors could potentially lead into the symptoms of spiritual narcissism and overall avoidance that gave spiritual bypass its name (Picciotto et al., 2018).

## **IV. Current Interventions and Guidelines**

### **Religious Trauma and Abuse**

For being the pioneer of coining religious trauma syndrome, Winell's (2007) phases of recovery from rigid religion should first be explored when considering what could be applicable to clinical work with this population. Winell (2007) likens these phases to other stages of life. However, these can be influential in all areas of an individual's life. Importantly, Winell (2007) does not present these phases as discrete, in that one must complete one stage to go to the next. There is significant overlap across phases, and an individual may find themselves in more than one at a time. These phases are separation, confusion, avoidance, feeling, and rebuilding (Winell, 2007).

### ***Winell's (2007) Phases of Recovery***

The separation phase is marked by a period wherein an individual begins to have questions and doubts about their current religious affiliation (Winell, 2007). Before these questions and doubts surface, there may have been moments where the individual was satisfied with being a part of their religious community. They may have felt as if their needs were being met and they were valued. The teachings they received and current beliefs were congruent. Although, because of a multitude of factors, they may start to question what they are being told and to examine their beliefs and attitudes. Oftentimes, this is due to the religious abuse they have experienced. They may have difficulties reconciling the abuse with what they believe is morally correct. Individuals may start to have challenges with believing in the doctrine of original sin and what that means in the context of their life. The specific circumstance will depend on the individual, but each result in them doubting if they can remain in their current religion. Individuals begin to



realize that their life experiences do not fit with the dogma they have been taught. However, individuals in this phase may not exit their religion as soon as these doubts emerge. Instead, they may choose to continue in their faith, deny their skepticism, and make rationalizations in order to answer their questions. Further, they may devote themselves and delve deeper into their religious community. A threshold will eventually be hit and push the individual to fully begin to exit their religion. This also depends on the individual, as it may be a quick transition for some, while others may take months and years (Winell, 2007).

The second phase is confusion (Winell, 2007). This arises when the individual makes the firm decision to leave their religion, regardless of the speed of the transition. It will be a significant life change, as for some people, their religious background has defined their whole life. The structure they had for the world is no longer applicable. In this stage, individuals may feel adrift or disconnected or a sense of existential angst. The devices they had in place to instill meaning in their lives are no longer trustworthy. They will have to create their own answers for the basic questions of life. Their restrictive religious teachings instilled deep fear into them, and even though they may begin to question the truth of these teachings, the anxieties are still present. Individuals may fear that they will go to Hell because they are questioning their faith and may ultimately not believe in God anymore. They may think the very act of questioning will damn them for eternity (Winell, 2007). Individuals could have difficulty grappling with the intense emotions they may be feeling, because they were taught that certain emotions amounted to sin (Stone, 2013). Considering the anxieties they may have, individuals may think it would be better if they returned to the church (Winell, 2007). Despite the potentially

difficult emotions likely occurring during this phase, it can also be a moment of liberation. For perhaps the first time, individuals can think, feel, and experience themselves more fully. They may feel capable of taking control of their lives, because they view the world as a hopeful, welcoming place (Winell, 2007).

Avoidance is the third phase of recovery (Winell, 2007). As the name suggests, the individual does not engage in any religious or spiritual practice. They do not attend religious services or participate in conversations centered on God. Those who have experienced religious abuse will want to have little to no contact with their religious community and may avoid settings that remind them of their traumatic experiences, such as the church building. Some of these avoidance strategies may flock to the extreme end, in that they are completely cutting this part of their life out. However, Winell (2007) notes that these strategies may be essential parts of recovery from rigid religion and are forms of self-protection. In order to create this new life for themselves, individuals will have to have as clean of a break as possible from the harmful elements of religion (Winell, 2007).

The feeling phase consists of exactly what the name suggests—intense and mixed feelings (Winell, 2007). Individuals may feel angry over what has been done to them, whether they were abused by parents who justified their behavior with scripture or at the hands of a clergy member. They can feel lost on what they can do with their anger, as they were taught to forgive or forget instead of acknowledging their feelings as valid. There may be additional anger at the consequences of this trauma, such as believing that their life has been lost, their self-image and relationships have been damaged, pleasures were denied, and they may have an ignorance about the world. Along with anger,

individuals in this phase may feel grief. Allowing this grief to be explored is a key component of recovery. This grief may be similar to losing a loved one (Winell, 2007). Due to some individuals attaching to God as a potential parental figure (Freud, 1910; McGriffith, 2010), this loss of a relationship could be traumatic, as if losing a parent, the Heavenly Father (Winell, 2007). Further, the individual will likely feel guilty for exiting their religion and fear that they will never experience a strong enough love that they were taught God had for them. Again, they may feel the urge to return to their religion; however, they will also feel as if it is impossible, which can make the recovery process more challenging (Winell, 2007).

The last phase of Winell's (2007) recovery trajectory is rebuilding. Individuals who have reached this phase have worked through their pain and their strengths have emerged. They have rediscovered their self-worth and have reconstructed their perceptions and beliefs. Sometimes, this process can lead to them having some of their values change, but not always. What is critical is that these individuals have examined their lives and tossed what was not valuable and meaningful to them and kept what was. Individuals may begin to do things by choice and recognize that their thoughts and feelings are worthy of respect and are valid. They become empowered to create meaning out of their lives, on their terms. They may form new friendships, deepen existing ones, and seek new sources of support. For some individuals, they may choose to explore spiritual practice (Winell, 2007). While this can certainly be a healthy avenue for some and demonstrates growth, the emergence of spiritual bypass must be considered.

### *Issues in the Recovery Process*

In addition to providing phases of recovery, Winell (2007) details several areas that may create issues in this process. These are normal consequences for individuals who exit a conservative, fundamentalist church, and should be kept in mind while completing recovery work. The first consequence focuses on the individual's sense of self. As with other emotions, pride and selfishness are considered sinful in conservative Christianity. Because of this, individuals may not have felt it appropriate to think too deeply about who they are. Additionally, they are taught that they are born with sin and can only be redeemed if they are a child of God. With leaving a religion, those thoughts about themselves may linger. Individuals may struggle with viewing themselves as worthy, as they are inherently corrupted. Without atonement, that original sin will remain. Similarly, individuals may also struggle with feeling helpless and hopeless, as they now are left without the promise of salvation. In healing, it is critical to achieve a sense of self that does not depend on external sources and to tap into the inner resources that an individual has (Winell, 2007).

Another roadblock in recovery is emotional struggles (Winell, 2007). As detailed, moving through these recovery phases can lead to a mixture of emotions surfacing, such as grief. Not only may individuals grieve the loss of their relationship to God, but they can mourn the loss of a once supportive community. Individuals may feel alienated from their family by no longer having the common thread of religion. There may be fear and anxiety surrounding their place in the scheme of things. Their prior defenses brought to them by their teachings and scripture are no longer applicable. Additionally, they may feel immense guilt, as they can no longer seek forgiveness to address this. Individuals

may devolve into believing they must be perfect because fundamentalism functions in black-and-white thinking. A significant task in this part of recovery is the individual learning to trust themselves and to foster the skills they require to navigate the world. They must give themselves permission to be human and deconstruct the rigidity that has consumed their lives up to this point (Winell, 2007).

Winell (2007) explains that it is challenging for those who leave their religion to be present in their world. For so long, they had basked in the idealism of a grand plan and a Heavenly future (Winell, 2007). They may have engaged in a practice similar to spiritual narcissism (Picciotto et al., 2018), where they believe they are superior to others because of their religiosity. Learning to be present in their current environment and acknowledging that they are at home, now, will benefit the recovery process (Winell, 2007).

Some individuals may struggle with self-responsibility (Winell, 2007). A core part of recovery is taking control of life. In Winell's (2007) phases, it is important for individuals to learn to let go, while also regaining control. In letting go of passivity, in waiting for God's will to happen, they are able to reclaim their right to express how they want and to feel how they feel (Winell, 2007). This will be a challenge, as it is common practice in conservative Christianity to discourage the expression of emotions (Stone, 2013); additionally, individuals may not be particularly skilled in making decisions for themselves or setting goals. However, in shedding this, it will open multiple trajectories for life.

The last consequence affects meaning and spirituality (Winell, 2007). Some individuals may choose to engage in spiritual practice following their recovery from

religious indoctrination. There will be others who are hesitant in exploring this area, because of the harm they have experienced from fundamentalism. However, a significant struggle that individuals who leave religion experience is having to create meaning out of their life on their own volition. Spirituality, when approached in a healthy manner, is one such avenue to explore potential meanings for their lives. For those who shy away from spirituality, the majority of this meaning-making work will be left up to them. They must examine what their values are and how they can work on honoring them in their lives. This reconstruction can be gradual, just as the leaving process may have been for some. As individuals who have exited their religion work on broadening their world, they will gain experiences to help them establish a structure and meaning to their lives (Winell, 2007).

When treating religious trauma, it is first critical to assess for the client's religiosity and spirituality (Cashwell & Swindle, 2018). Not doing so may lead the clinician to miss important information to fully conceptualize the client. If clinicians are uncomfortable with discussing religion, they may inadvertently demonstrate to the client that this is not the appropriate place to discuss religion or spirituality and clients may be discouraged to fully discuss what may have brought them into the clinician's office in the first place (Cashwell & Swindle, 2018). Religious abuse may present as other mental health conditions (Winell, 2011), and clients may only report certain mental health symptoms, such as depression or anxiety (Cashwell & Swindle, 2018). This may be because they feel unwelcome in discussing their religious trauma or they may not be aware that some of their religious experiences were abusive (Cashwell & Swindle, 2018). Additionally, when working with this population, clinicians need to attend to their own

reactions that may negatively impact the therapeutic relationship. It is also advised to use a less directive approach with these clients, as the directiveness may stimulate the powerlessness they have experienced throughout their life (Cashwell & Swindle, 2018).

The clinician should gather more information on the client's current religious affiliation and whether they desire to leave their religious community (Cashwell & Swindle, 2018). The clinician must avoid assuming that because the client has experienced religious trauma that they are choosing to leave or have already left their religion. This may or may not be one of the client's goals for treatment, and prematurely making this assumption may damage the therapeutic process. It is critical to have the client lead the formation of goals for treatment. Relatedly, the clinician demonstrating respect by collaboratively establishing goals and the course of treatment with the client directly empowers them. This is inherently a corrective experience for the client, in that they were likely in an environment where they did not have much validation or respect in having a deciding hand in their lives. By displaying this without reservations to the client, the clinician may assist in providing them with a realization that this is what they deserve (Cashwell & Swindle, 2018).

People who have experienced religious abuse and have decided to disengage with their religious community will often lose significant social support (Nica, 2019). In addressing religious trauma in treatment, it may be necessary for clinicians to mimic this social support while also working with the individual to safely obtain this support elsewhere. Nica (2019) defines the social support that comes from religious communities as including emotional support, informational support, and instrumental support. Emotional support encompasses the individual perceiving that they are being cared for

and others are concerned for their well-being. Informational support refers to the individual receiving advice or, as the name suggests, information about of-interest topics. Lastly, instrumental support is given when the individual receives resources and practical help. Clinicians who are able to provide a safe place, be genuine and validating, and willing to answer the individual's questions and direct them to needed resources, can replicate the social support they likely received in their religious community (Nica, 2019). Importantly, however, it was given in an unconditional manner.

### ***Psychotherapy Groups***

Clinicians may choose to address religious trauma in individual psychotherapy or in a group setting. Stone (2013) proposes a hybrid treatment setting, in which group psychotherapy is added after several individual sessions and then runs concurrently. The first priority of group psychotherapy is establishing safety among the members. This is especially important for trauma work. In the group setting, there will likely be religious-based transference, as clients' earliest religious experiences may have begun in their families and then spanned into groups, such as a congregation, as they became older. Individuals with religious trauma were taught that the expression of emotions, particularly negative ones, were not to be encouraged. Positive emotions and traits were, to a degree, more accepted. Because of this, early in the group experience, members may be reluctant to share the full expression of how they may think and feel. This is an important piece to keep in mind, as it may trigger countertransference in the clinician. Just because a client may have limited expression in sessions does not inherently mean they are withholding on purpose. There is often a function behind this behavior. In this case, it is an impact of their religious trauma (Stone, 2013).



The group transforms into a place for holding and mirroring emotions together (Stone, 2013). Traumatic experiences can be contained and then broken down together in the group. Clients' self-concepts will eventually be restructured by experiencing repeated validation from the other group members and the clinician. They will recognize their value in the group and as an individual, as parts of themselves will not be immediately shamed or shunned. The group provides an open space for self-reflection and less emotional reactivity. Clients' emotional resilience and insulation will develop and deepen, wherein healthy experiences will be readily taken in while the harmful ones be ignored. As the relationships grow during the group, they serve as secure bases for clients to work and process their relationships with God. In all, the group setting provides a corrective experience for the client, in which they do not feel invalidated or guilty for expressing their emotions or concerns. They are given a safe space to process their trauma (Stone, 2013).

### ***Deconstructing Religion***

Another way to approach treating religious trauma is deconstruction work (Russell-Kraft, 2021). This can be a process that a client does on their own, before entering a formal psychotherapy setting, or together with a clinician. It requires the client to analyze their thoughts and beliefs deeply and intentionally. They evaluate where the thoughts and beliefs came from and how they were taught, and whether they believed them to be true. This may involve the client examining and interpreting scripture and acknowledging how their current values may align with it (Russell-Kraft, 2021).

Russell-Kraft (2021) proposes that one complicating factor in treating religious trauma is that those who have experienced it are often told to not listen to their bodies,

where trauma often lives. She proposes that it is critical to guide clients to become more attuned to their bodies and learn to listen to the cues their bodies are giving them (Russell-Kraft, 2021). Maxwell (2017) explains that bottom-up approaches, such as physical therapy and other somatic-focused treatments, are needed. In order for trauma-encoded memories pertaining to God, their church, or anything related to their religious abuse, to be fully removed from the paired emotional response, the healing process must begin in the body. While cognitive techniques are beneficial in deconstructing the rigid thinking and negative self-concepts some clients may have as a result of their trauma, this is an area of treatment that cannot be ignored (Maxwell, 2017).

Brooks (2019) provides some considerations for clinicians in working with this population. Particularly with Mormons and ex-Mormons, it is important for clinicians to avoid re-traumatizing their clients. This may be done if they suggest talking about their trauma experiences and faith crisis with members of their church, friends who still practice their faith, or estranged family members. In the Mormon faith, to even question the church can lead the individual to be labeled as an “apostate” and condemned for committing an unforgiveable sin. Therefore, an ignorance to the Mormon culture, and broader conservative Christian religions, may lead the clinician to inadvertently re-traumatize the client. Additionally, Brooks (2019) suggests that mental health professionals be culturally sensitive to these concerns and become versed in culture-specific idioms. In understanding the client’s world, the therapeutic relationship can strengthen, and the client may trust the clinician in helping them process their religious trauma. Clinicians must also reflect on their own personal spiritual beliefs and attitudes

and how they view those who exit their religion and the unique challenges that come with that (Brooks, 2019).

### *Adapting Trauma-Focused Cognitive Behavior Therapy*

There have also been adaptations to trauma-focused cognitive behavior therapy (TF-CBT) in addressing religious trauma for children and adolescents (Walker et al., 2010). In beginning treatment, the clinician is encouraged to directly ask the client about their religion and spirituality. Not only does this demonstrate respect on the clinician's part, but it will also allow them to assess for any religious trauma in the client's presenting concerns. Further, the clinician may specifically ask how the client views their religion or spirituality is affecting their presenting concerns, such as any trauma-related symptoms. The client may discuss that their religious practices have been helpful in addressing their trauma; conversely, the client may reveal that their trauma may be exacerbated by this or be the cause of it. When assessing, it is important for the clinician to maintain a neutral and supportive stance. Additionally, as trauma is processed, a client's religious and spiritual beliefs may change. Because of this, the clinician should continually reassess as treatment progresses (Walker et al., 2010).

TF-CBT consists of several components: psychoeducation, parenting skills, relaxation, affective expression and modulation, cognitive coping and processing I, trauma narrative, cognitive coping and processing II, in vivo exposure, conjoint sessions with parents and children, and safety planning and future development (Walker et al., 2010). During psychoeducation, the clinician may educate the client and their caregiver on how religious and spiritual struggles may present in different ways. They may present as intrapsychic, wherein the client may be doubting the nature of God; interpersonal, such

as having conflicts with other members of the congregation; or with the Divine, as in questioning God about why He allowed their trauma to occur. The client and caregiver may also be educated on how an individual's religious beliefs may change due to the abuse they experienced. Additionally, if applicable and permission given, clinicians may consider consulting with a non-offending clergy member to gather more information about the client's religious and ethnic culture (Walker et al., 2010).

While working through the parenting skills component, it is important for clinicians to be aware that parents who are highly religious may view their role with sacred significance (Walker et al., 2010). Detailed in Chapter II, parents may believe they are operating in good faith by disciplining their children, sometimes harshly, to save them from eternal damnation. In this component, clinicians may use stories from scripture to demonstrate the parenting strategies of praise, selective attention, time-out, and contingency reinforcement (Walker et al., 2010).

During the relaxation component, clinicians explain that mindfulness practices are compatible with many religious traditions (Walker et al., 2010). If the client chooses to engage in the relaxation training in this way, the clinician may modify these practices to align with the client's religious and spiritual beliefs. However, caregivers belonging to conservative monotheistic religions may disapprove of their child engaging in practices without a focus on a Divine. Clinicians may modify these exercises in order to address this (Walker et al., 2010).

For the affective expression and modulation component, clients are to identify emotions, interrupt their thoughts, and conjure positive imagery (Walker et al., 2010). Parents are also taught to effectively express their emotions. The cognitive-behavioral

techniques involved in this component are compatible with elements of a variety of religious affiliations. Clinicians can incorporate thought-stopping techniques, positive imagery, and positive self-talk through stories of scripture to make it more meaningful (Walker et al., 2010).

Cognitive coping and processing I involves the clinician guiding the client to see the relationship between their thoughts, feelings, and behaviors (Walker et al., 2010). Clients then are taught to replace their thoughts with more adaptive ones to stave off negative feelings and unwanted behavior outcomes. Due to the religious trauma they may have, children and adolescents often have cognitive distortions related to religion that can be addressed in this component. It is critical that these are addressed now before processing their trauma and creating a trauma narrative. Discrepancies between what a client may have learned about God in church and by their family can be examined. Additionally, any religious threats that the client may have received can also be deconstructed in treatment (Walker et al., 2010).

In creating a trauma narrative, the clinician may again think it would be helpful to find parallels of the client's traumatic experience with stories from their religion (Walker et al., 2010). Many religious groups have stories that aim to make meaning out of suffering and overcome adversity through their faith. Having this demonstrated to the client may benefit them in reconciling the religious abuse they experienced. The clinician's role is not to answer the client's question about why God may have allowed the trauma and their suffering to occur in the first place, but to hold this space with the client as they process their abuse and find their own meaning to their experiences. The client may be encouraged to pose the questions they have to God and create His

responses to these questions. For example, they may ask why God allowed the abuse to occur. The client is then asked to think of responses God could give. Another exercise that can be used in this component is an adaptation of the empty chair technique. The client is asked to consider where God was during the abuse and how He may feel about it. They are then instructed to alternate between asking God questions and then responding how they think He would (Walker et al., 2010).

In cognitive coping and processing II, the clinician explores and restructures any trauma-related cognitive errors the client may have (Walker et al., 2010). A common cognitive error is the client believing that they could have prevented the trauma and that the world is not a safe place. The clinician should explore the cognitive errors that have religious content, such as the client wondering what sin they committed to deserve the abuse. Further, clients may be more willing to discuss their religious issues if their trauma experience had religious-related abuse as a part of it. These cognitions can be directly challenged (Walker et al., 2010).

In vivo exposure is used to prevent the generalization of anxious reactions to unrelated stimuli in the environment (Walker et al., 2010). If clients are using their religion to cope with their trauma, then incorporating a mindfulness meditation or prayer can be beneficial in alleviating anxieties. Additionally, some clients may collaboratively work with the clinician to identify passages from scripture that may give them courage (Walker et al., 2010).

During the conjoint sessions with the parents and the client, the clinician may facilitate an open discussion with the group about the meaning the client had found for their trauma and subsequent suffering (Walker et al., 2010). This collaborative discussion

can lead toward support and healing. The family may also have this space to process their own questions about the religious or spiritual meaning to the client's trauma and their own concerns about God and how He may have felt about the trauma (Walker et al., 2010).

The last component of TF-CBT, safety planning and future development, focuses on helping the client express their emotions in a variety of settings (Walker et al., 2010). This is in the event they may be victimized in the future. Additionally, they are taught to identify warning signs that abuse may happen and to also attend to their internal, bodily warning signs. Religion may be used as a mechanism to enhance a client's sense of safety. Depending on how the client views religion at the end of treatment, they may continue to lean into their religious beliefs to provide this support (Walker et al., 2010).

### ***Acknowledging Religious Abuse***

In addressing religious abuse that occurred either by a clergy member or a family member, several approaches can be taken. Farrell (2009) suggests taking a deconstructionist approach in addressing religious trauma from clergy-perpetrated sexual abuse. Clients are encouraged to consider that the abuse had nothing to do with God, religion, or the church. Instead, the abuse took place because of an individual in a position of power manipulating another human being for their own sexual gratification—nothing else. A reason why this abuse has had such a profound impact is because that powerful individual used God to silence the client. This deconstruction task relies on the client considering both the clergy-perpetrator and God separately. Further, the client will have to deconstruct God, where He is the God portrayed in their religion and the God that the clergy-perpetrator manipulated to abuse them. When viewing God in this way, it

allows the client to view Him as a victim of the abuse, as well. Farrell (2009) explains that the concept of God being a bystander to the abuse needs further research. Similar exercises to deconstruct this concept may be helpful (Farrell, 2009).

Before the client can begin to process their religious-related abuse, they need to be able to recognize that what they experienced was abusive (Novšak et al., 2012). Clients must also recognize that they were not to blame for the abuse. It is important for the client to redirect the responsibility for the abuse back onto the perpetrator. The client must also process what the abuse entailed and how it may have occurred. This leads the client to observe and honor the beliefs, emotions, and relationships from their past and present. Should the abuse still be taking place, the priority is maintaining the client's safety and efforts need to be made to decrease contact with the perpetrator or completely cease it. Following the religious-related emotional abuse, clients have the task of readjusting their perspective on life and the world and restructuring their understanding of God, religion, and their relationship with Him. This may involve the client separating themselves from what they have learned, though it may be familiar and comforting, in order to learn how to engage with their damaged sense of self. Clients can be guided in seeking out new sources of support to help them experience consistent safety, something they may not have had experienced in their lives (Novšak et al., 2012).

Clinicians may notice a pattern of religious-related abuse in a client's life, even though they may not have presented to therapy with those concerns (Novšak et al., 2012). The client not viewing their experience as abusive does not mean that it is not abuse. In this circumstance, the clinician may guide the client in further describing potentially abusive situations. Clinicians may provide clients with clear definitions of what religious-



related abuse and abuse, in general, are and clear criteria of what may constitute religious-related abuse (Novšak et al., 2012).

Novšak and colleagues (2012) explain that one of the main goals of treatment is to help the client alter the abusive patterns they experienced in their relationships. Additionally, there are other fundamental emotional conflicts that should be targeted in therapy. These include feelings of worthlessness versus having self-respect; the need to have control versus having trust in God; shame versus accepting who they are; constant feelings of guilt versus forgiveness; hopelessness versus optimism; fearing punishment versus having faith in God's love; fearing intimacy versus having a sense of belonging; expecting betrayal versus having trust for others; and spiritual confusion versus believing in God's love. The client can acknowledge the responsibility and control they may have in their lives and the impact they can have on others' lives, as well (Novšak et al., 2012).

In order to emphasize helping a client learn to regulate their emotions, the clinician should provide an emotionally safe therapeutic relationship (Novšak et al., 2012). This must include elements of vulnerability, empathy, responsiveness, trust, and respect. This is necessary because the religious-related emotional abuse was maintained due to a high degree of mutuality between the client and the perpetrator. By providing these elements in the therapeutic work, the clinician is presenting a corrective experience for the client. They are modeling how relationships should be in their lives, and what they need to seek in future relationships (Novšak et al., 2012).

### ***Relational Family Therapy***

Simonič and colleagues (2013) propose using relational family therapy (RFT) to address religious-related abuse in the family. The purpose of this therapeutic approach is

to uncover the underlying psychobiological states and affects and allows for new potentials for better quality relationships. This approach integrates components of general systems theories with relational models, combining object relational theories, self-psychology, and interpersonal analysis. In the beginning phase of RFT, the focus is on building the therapeutic relationship by the clinician extending empathy for each member of the family. The clinician also describes how each family member is involved in the abusive dynamics. In this stage, there may be moments of family members feeling rejected or betrayed. These in-the-moment experiences are connected to past relationships and situations in order to demonstrate how current stressors may be reproductions of past abuse, religious-related and otherwise. The clinician must maintain respect for the clients' religion; however, they must also clearly present how this may have contributed to the abusive experiences of the family. As the clinician is continuously attuned to each client's emotional and bodily experiences, it allows the clients to not feel so isolated and dysregulated. The clinician may address how specific parts of the parenting relationship could be characterized as religious-related emotional abuse. While doing so, the clinician also attempts to search for each partner's place in this family dynamic. As the clients are provided the space to express their emotions, with the clinician preventing any old patterns of dysfunction from occurring, it creates trust in the overall therapeutic process (Simonič et al., 2013).

In the middle stage of RFT, the focus is on deepening the therapeutic relationship (Simonič et al., 2013). The clinician provides opportunities for the clients to have novel emotional experiences. Clients make sense of these experiences by the clinician's continued promotion of reflecting, articulating how they perceive it to be, and being

attuned to their situation. Old patterns of communication and reacting are soon no longer go-to responses and are replaced with new ways of examining what they are experiencing. Additionally, in this stage, family members begin to shift away from seeing one as the abuser and recognize the part each of them may have played in the dynamic cycle of the family. The family member who engaged in the abusive behavior may accept responsibility for their actions. The clinician's skill in handling the immense emotional content of these sessions allows the clients to fully recognize how they may have responded to each other in the past and how they could potentially respond in the future (Simonič et al., 2013).

In the final stage of RFT, the focus is on integration and consolidation (Simonič et al., 2013). The goal of this stage is to reinforce the clients' faith and use their relationship to God to encourage a sense of connectedness. The clinician may reframe their previous usage of religion as a way to harm and encourage the clients to create a narrative of their own experiences. In learning more about their families of origin, the clinician may help articulate the unjustness and abusive aspects they may have experienced as children and how that has played a role in their current family dynamics. The clinician is mindful of not invalidating the clients' religious beliefs; instead, the clinician is intentional in how they reframe the components of their religion that may have encouraged and maintained the abusive behavior (Simonič et al., 2013).

### ***For LGBTQ Populations***

In recognizing the impact religious trauma has had on the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community, special attention should be had on therapeutic interventions that specifically address this. First, Lefevor et al. (2020) advises

that clinicians recognize that there is a significant difference in traumatic experiences an LGBTQ client may have because of their LGBTQ identity and traumatic experiences they may have because of their LGBTQ identity in a religious setting. This difference is important in the treatment planning process. While there may be overlap between these two categories, it is simplistic and a disservice to assume that they are one in the same. A clinician does not want to rely on the assumption that all LGBTQ clients may face religious trauma, given the history of the community. In fact, the LGBTQ client may not even be religious (Lefevor et al., 2020). Careful assessment about a client's religion and spirituality is critical.

It is also important to gather further information if the LGBTQ client has experienced religious trauma (Lefevor et al., 2020). This can vary in the source of the religious abuse, the intent, and the impact depending on the client. Obtaining enough data will make treatment planning more efficient. In this circumstance, the clinician may have to prioritizing the client's LGBTQ or religious identity over the other, depending on which is more salient to their current concerns. However, the clinician may also try to balance any potential identity conflict with their trauma. Throughout this assessment process, the clinician should collaboratively set goals and the course of treatment with the client in such a way that encourages their authenticity (Lefevor et al., 2020).

Morrow (2003) focuses on addressing religious trauma in lesbian clients. She suggests that as Judeo-Christian religions have its roots in heterosexist ideals, then the impact of this religious oppression should not be ignored in therapy. In targeting the needs of lesbian clients, Morrow (2003) provides four recommendations. The first is to evaluate the extent of the client's religious trauma. This may entail asking specific

questions about the client's experience with religion and how they may have been harmed. Exploring the client's experience with guilt, shame, and internalized homophobia is also important. The second recommendation is to honor the losses caused by religious oppression. The clinician examines what specific losses they have encountered and what the impact of those were. It is important to name the losses clients have had, as it can be a steppingstone toward recovery. The third recommendation is to address the impact of religion as a tool for social injustice toward lesbians. The clinician can explore the intersection of the client's lesbian identity with their religious identity. Analyzing scripture and processing how that may have led toward historical oppression can be helpful. Additionally, it is important for the client to have the space to process and evaluate their own religious beliefs in the context of social justice for their community. Finally, the clinician should develop a list of religious and spiritual resources to share with the client. Lesbian clients may still want to pursue religious and spiritual practice but might not know where to go. The clinician can provide them with a list of lesbian-affirming churches and reading material related to lesbian-affirming theology (Morrow, 2003).

Super and Jacobson (2011) discuss that clinicians can question LGBTQ clients about their religious experiences to identify if they may have experienced any religious-related abuse. Exploring the impact of any potentially negative religious experiences is also important for assessing any religious trauma. The client's ability to integrate their LGBTQ identity and religious identity may be impacted by the clinician's forthrightness in processing the level of support the client currently has in comparison to the acceptance or rejection they receive from that same religious system. Not only does this willingness

to discuss this help the LGBTQ client integrate these identities, but they also can restructure their moral values and address any distress. Additionally, the clinician can be critical in guiding a LGBTQ client in developing a spiritual identity either within or outside a formal religious entity, depending on what the LGBTQ client may be interested in. The clinician can use cognitive-behavioral techniques to target specific cognitive distortions and challenge their irrational beliefs. It should be noted that to clients that do not identify as a part of the LGBTQ community, these beliefs may be irrational; however, there are “irrational” beliefs, such as the world being an unsafe place, that will likely make the LGBTQ client feel invalidated if it is outright challenged with no consideration of the historical basis behind that belief. Clinicians should ultimately provide a space that centers the LGBTQ client, respects their unique identity, and validates their rational fear due to the religious abuse (Super & Jacobson, 2011).

There are three goals of treatment that Super and Jacobson (2011) recommend. The first is to identify and name the abuse the LGBTQ client has experienced. The clinician will help the LGBTQ client process being victimized and stigmatized by their religion. Clinicians may inquire about specific emotions, such as guilt and shame, that LGBTQ clients may have because of their sexuality intersecting with their religious beliefs. The second goal is to assist the client to define their sexuality within a spiritual framework. This allows the client to consider if these two identities could co-exist in their life. This also addresses potentially dichotomous thinking, in that they believe they cannot be a member of the LGBTQ community and also be religious. The last goal of treatment is to alleviate the symptoms and identity conflict. This may include incorporating a spiritual timeline, wherein the LGBTQ client draws significant spiritual

events on a timeline. This provides the LGBTQ client the space to share their experience and when they may have first felt that identity conflict or religious abuse. To further target this goal, the clinician may also utilize cognitive restructuring techniques and reframe the pain from the religious abuse as a mechanism toward healing. Specific techniques can be used to intentionally uncover the LGBTQ client's thoughts, feelings, and beliefs (Super & Jacobson, 2011).

### **Spiritual Bypass**

Similar to treating religious trauma, it is important to first assess if clients are currently in spiritual bypass. As a reminder, spiritual bypass is a term coined by Welwood (1984) to capture the tendency to avoid or prematurely bypass basic human needs, feelings, and developmental tasks. In the case of religious abuse and trauma, an individual may engage in spiritual bypassing to avoid any unresolved psychological pain (Stone, 2013). For a clinician who is not well informed about spiritual bypass, they may not further examine a client who reports they are strongly spiritual (Cashwell et al., 2010). This can potentially impede treatment, because if this client is in spiritual bypass, then they are likely not going to fully engage in therapy. Additionally, if a clinician does not adequately assess for spiritual bypass, they may create a treatment plan that includes a heavy spiritual element. This will inadvertently reinforce a client's current avoidance strategy. By conducting a comprehensive assessment and inquiring directly about a client's spiritual practices and if they view their spirituality as helpful or harmful for their presenting concerns, this may be avoided (Cashwell et al., 2010). Knowing how spiritual bypass may manifest in an individual's life can be helpful in guiding this assessment.

Cashwell and colleagues (2007) discuss how healing can occur at five levels: spiritual, cognitive, emotional, interpersonal, and physical. To move toward complete healing, it is imperative to address healing in all levels. Therefore, healing must not only focus on one level. In the case of spiritual bypass, clients are often dedicating much of their energy into the spiritual level (Cashwell et al., 2007). The function of spiritual bypass, in essence, is avoiding the unresolved psychological pain that they have experienced, likely due to religious trauma (Stone, 2013; Welwood, 1984). When a client takes charge in healing on all the levels, they may reach spiritual maturity (Cashwell et al., 2007). Once a client has reached that height, they may experience a unitedness that others can observe (Cashwell et al., 2007).

### ***Using the Developmental Counseling and Therapy Model***

The developmental counseling and therapy (DCT) model has served as an approach to addressing spiritual bypass (Cashwell et al., 2004). This process begins with the client creating an image that reflects their presenting issue. The clinician will help the client explore this image in the present and build upon it. Clients are encouraged to attend to their bodily sensations when creating this image. Having the client intentionally attune to these sensations will have them begin to understand how their feelings may arise, how they currently manifest in their life, and how they could be changed in the direction of a more positive experience. This process helps set the stage in order to target the client's spiritual bypassing in a noncombative manner. Additionally, their current concerns and issues can be integrated with their spiritual experiences, because for a client who is in spiritual bypass, nearly all things are of a spiritual nature and can be addressed in such a way (Cashwell et al., 2004).



The second stage of DCT allows the client to attribute meaning to their feelings by inquiring for a second example or image of a time when the same physical sensations occurred (Cashwell et al., 2004). During this process, the client is instructed to discuss this in a linear manner, only focusing on the sequence of events and not on what they might have been emotionally or bodily experiencing at the time. This provides the client with the opportunity to examine the cause-and-effect nature of their thoughts, feelings, and behaviors. This leads clients to recognize that when they behave in a certain manner, a predictable chain of events may occur (Cashwell et al., 2004).

During the third stage, the client reflects on similarities between the two experiences they had described earlier and begins to identify any patterns (Cashwell et al., 2004). This helps foster the client's insight and lets them become aware of any repeating thoughts, feelings, or behaviors in their lives. Recognizing these patterns can help clients achieve authentic spirituality, rather than the avoidance behavior they have been previously enmeshed in (Cashwell et al., 2004).

For the first three stages of the DCT model, the client has been processing their internal experiences and their thoughts, feelings, experiences, and any patterns (Cashwell et al., 2004). For the fourth and last stage, the client is then asked to take a step outside of themselves and consider how those patterns may have developed. Clients may have difficulty with this stage; however, those who are able to progress through the first three stages will have still benefited from the integration of bodily sensations with the connection to thoughts, feelings, and behaviors. This is still critical for addressing spiritual bypass. Although, clients who are able to reach this dialectic view will obtain a

deeper understanding of their spiritual development. Again, however, this may not be necessary to fully recover (Cashwell et al., 2004).

### ***In 12-Step Work and Using Motivational Interviewing***

Spiritual bypass has also been identified in individuals in 12-step substance use recovery programs (Cashwell et al., 2009). In this, it is important that the clinician assess the client's spiritual views and if they view their higher power as loving or vengeful, as it may give insight into how spirituality may ultimately be addressed in therapy. Avoidance of psychological pain and spiritual narcissism are common symptoms for individuals in recovery and are also symptoms of spiritual bypass. Overall, because of this, it again emphasizes the importance of assessing for spiritual bypass. However, the client's purpose for delving into spiritual bypass should be considered. It is an avoidance strategy, but it also has protective utility. It may have significantly helped the client in their past, and they will likely have resistance to addressing it. The clinician and client can collaboratively brainstorm potential replacement behaviors that may serve the same function as spiritual bypass; although, it is also important for the clinician to lead this discussion in a nonjudgmental manner due to possible defensiveness (Cashwell et al., 2009).

Clarke and colleagues (2013) propose motivational interviewing as an effective tool in treating spiritual bypass. To begin, they recognize that the general therapeutic approach must be gentle and client-centered. The client may have ambivalence in addressing spiritual bypass, as, again, it is an avoidance strategy that is allowing them to ignore unresolved psychological pain. Motivational interviewing is a specific technique that is adept at targeting ambivalence (Clarke et al., 2013).

Motivational interviewing has four principles (Clarke et al., 2013). The first principle is expressing empathy. The clinician reflects the client's statements and asks open-ended questions to provide the client with a validating space to process their experience. The second principle is rolling with resistance. The clinician should be mindful of not falling into a power struggle about the client's usage of spiritual bypass. They should also be intentional in reinforcing that the client will have the final decision on if spiritual bypass will be targeted. When there is reluctance or combativeness, the clinician can redirect to another potential presenting concern that the client is willing to process. The third principle is developing discrepancy. The client is engaging in spiritual bypass because it is serving a purpose. This purpose should be highlighted and further explored in detail. The client may then voice their ambivalence on whether they wish to change, perhaps because they recognize that there are unresolved concerns they may like to process. The clinician can explore the cost and benefits of this potential change, emphasizing the discrepancies they and the client may be noticing (Clarke et al., 2013).

Finally, the fourth principle is supporting self-efficacy (Clarke et al., 2013). This is accomplished by the clinician acknowledging the client's previous experiences with change and when they have been successful. These acknowledgements are especially important in regard to the client's spiritual life. Clinicians may also review the reasons as to why the client wants to move away from spiritual bypass. Importantly, the clinician should allow the client to pick the best approach in addressing their spiritual bypass. Further, the clinician and client must collaboratively pinpoint alternative, healthy spiritual and emotional resources the client may instead use to cope (Clarke et al., 2013).

Once the client agrees to target their spiritual bypass, the clinician should then help explore what specifically needs changing in their life (Clarke et al., 2013). As spiritual bypass is often used to avoid unresolved psychological pain, potentially due to religious trauma, a change the client may want to pursue is to begin processing their traumatic experiences (Clarke et al., 2013). In addressing this underlying problem, the need for spiritual bypass will likely decrease (Fox et al., 2020). When shifting to work on the primary concern, the clinician can provide the client with coping and self-soothing strategies, as well as skills to track their anxiety and distress (Fox et al., 2020).

### ***Importance of Prevention***

Having treatment options to address spiritual bypass is helpful; however, there is utility in knowing how to prevent spiritual bypass from occurring (Picciotto et al., 2018). One such prevention method is to offer psychological support. If individuals had broader access to psychological services or psychoeducation about the negative long-term benefits of avoidance strategies, in addition to suggestions about healthy coping skills, then spiritual bypass may be less utilized. Another prevention method was psychospiritual education. In other words, having information about spiritual bypass in the first place to decrease the chance of individuals engaging in this process. A third prevention strategy is spiritual leadership. Having a visible spiritual leader who could inform them about the importance of integrating the psychological and spiritual aspects of themselves, instead of putting more energy into their spiritual practices, may be helpful. Lastly, having a spiritual community can be a prevention method. Similar to having informed spiritual leaders, being a part of a community that understood the significance of and encouraged processing underlying psychological pain, no matter the

cause, would likely be effective in preventing spiritual bypass. Clinicians can provide psychoeducation about these concepts to their clients, when appropriate, and also seek alliances in religious and spiritual communities to advocate for these concerns (Picciotto et al., 2018).

## **V. Recommendations for Clinicians**

### **Considerations Before Treatment**

There are several recommendations for clinicians when beginning to work with clients with potential religious trauma. First, the clinician must directly ask and learn about clients' religious affiliations. Without this, a clinician will be unable to have a complete conceptualization of their client and may fail to acknowledge the presence of religious trauma (Cashwell et al., 2010). This can be done in a number of ways, such as a part of the paperwork in the intake process or during the initial session. Doing so demonstrates respect for the client's history (Walker et al., 2010), while also letting them know that this is not a topic to be shied away from. However, this requires clinicians to be comfortable with asking for this information (Cashwell & Swindle, 2018). If they are not, clients may perceive religion and their experiences tied to it are not appropriate topics to discuss in therapy. Intentional self-reflection on the clinician's own religious backgrounds and experiences is critical in this process. Additionally, clinicians should examine how they view the concept of religious trauma and spiritual bypass and process any unhelpful thoughts or feelings about the topic. A client presenting with religious trauma would unlikely be aided by a clinician who is skeptical about the concept. In the least, a clinician should arrive with an open mind, willing to learn from their client, and seek supervision and consultation when appropriate. This reflective process will be continuous throughout their clinical work (Cashwell & Swindle, 2018).

Identifying a client's level of religiosity and spirituality is only one piece and requires further assessment to discover if these factors are not beneficial in a client's life (Cashwell & Swindle, 2018). This can be done through a line of questioning during the

initial session, such as asking about the client's perception of the helpfulness and support of their religious services and community and if they find themselves leaning further into spirituality during difficult times. It should be noted that these concepts and actions are not inherently harmful. Exploration of these areas of a client's life is critical in evaluating if they are generating more problems than solutions or comfort. Additionally, a client may be unaware of what religious trauma or spiritual bypass are and may not identify this trauma outright. Approaching this topic will require delicate balance by the clinician, in educating the client on what religious trauma and spiritual bypass are while not immediately suggesting that this is what the client is experiencing. Having this discussion too soon in treatment will likely cause the client to be defensive and ward away deeper processing in the moment. Though the clinician may think it necessary to address the fact the client may have experienced religious trauma, it is ideal to have these conversations indirectly and provide them with as much education as possible, so they can approach this conclusion themselves. Further, Cashwell and Swindle (2018) advise against clinicians having a wholly directive approach to treatment, as it may replicate the powerlessness the client may have experienced during their trauma.

It is also important to note that religious trauma can present as other mental health conditions (Winell, 2011). To the uneducated clinician, they may be working with a client who has religious trauma in their background but is not presenting with this condition as their main concern (Winell, 2011). In fact, they may instead present with concerns related to anxiety or depression (Cashwell & Swindle, 2018). Winell (2011) describes religious trauma syndrome as "mimicking" disorders, such as depression, anxiety, bipolar disorder, obsessive-compulsive disorder, borderline personality disorder,

eating disorders, and substance use disorders, among others. Clinicians may find it helpful to be educated on these conditions and how religious trauma may present in clients' lives (Cashwell & Swindle, 2018; Winell, 2011).

Overall, clinicians should make intentional efforts in providing their clients with a corrective experience. As reviewed extensively, this population has often suffered at the hands of repeated invalidation, restrictive teachings, and the inherent idea that they are born evil and sinful (Russell-Kraft, 2021; Stone, 2013; Winell, 2011). With the therapy setting providing the direct opposite of this, it can be shocking and provoke confusion. However, it is essential for the healing process.

### **Assessing for Spiritual Bypass**

When beginning the assessment process to identify the client's level of religiosity and spirituality, the clinician must also be mindful if a client engages in spiritual bypass. This is an attitude and coping skill that clients may flock to when processing their religious trauma becomes too painful (Stone, 2013); although helpful in the short-term to avoid these emotions, it is ultimately in the client's best interest to not avoid their experiences. A useful tool that may be referenced when completing this assessment is the Spiritual Bypass Scale-13 (SB-13) (Fox et al., 2017; Picciotto et al., 2018). This is a 13-item instrument with statements that respondents rate the extent they are true for them on a four-point Likert-scale. Some of the statements include "My spiritual life helps me feel my emotions more fully," "When something tragic happens (to me or to others) I say that God will intervene," and "It is more important to me to seek spiritual guidance than to seek aid from a psychological helper" (Fox et al., 2017; Picciotto et al., 2018). The complete scale can be found in the Appendix.



Using this tool alone cannot determine if a client may be in spiritual bypass. This can be used in conjunction with the other useful information a clinician can obtain from an initial session or throughout treatment with a client. It may be helpful to discuss these items with a client, allowing them the opportunity to provide context and their own impressions of the items. If a clinician identifies a client is in spiritual bypass, then they must first address this before proceeding to process their religious trauma. Techniques have been discussed in detail in Chapter IV and will be reviewed later.

It is important to note that a client may present with religious trauma and no indications that they are currently in spiritual bypass. The clinician should not force a client to engage in treatment approaches to address spiritual bypass if this is not a concern. However, the clinician should not dismiss the potentiality of a client engaging in spiritual bypass as trauma work proceeds. Should this occur, it is important for the clinician to collaboratively address this avoidance behavior with the client. It may be beneficial to have the client reflect on possible behavior changes the clinician has observed.

### **Considerations for Treatment**

To reiterate, it is ideal to first assess for and address spiritual bypass if a client presents with this as a current coping skill before delving into broader religious trauma work. As this is an initial consideration for clinicians, treatment recommendations for spiritual bypass will first be reviewed.

Clinicians may consider using elements of motivational interviewing to help a client broach the subject of spiritual bypass (Clarke et al., 2013). The main goal with this is to guide the client in discovering the underlying purpose of spiritual bypass in their

lives. While there is sufficient research that shows the avoidance purpose of this phenomenon, detailed in Chapter III, it is critical for the client to identify the specific purpose for them. At its core, spiritual bypass is a coping skill, and clinicians and clients can collaboratively brainstorm potential replacement behaviors that serve the same function as it. Motivational interviewing also allows clinicians to highlight discrepancies they observe in their clients. Clinicians and clients can discuss if the client's current behaviors have been working for them and if there is anything in their lives that may still need resolving (Clarke et al., 2013).

Clinicians may also consider using components of the developmental counseling and therapy (DCT) model (Cashwell et al., 2004), wherein clients gain the insight to identify patterns in their lives. Specifically, clinicians are recommended to guide clients in examining their thoughts, feelings, and bodily sensations when examining their spiritual bypass. Allowing clients to analyze these in a cause-and-effect nature will help strengthen their insight into their lives. This enables clients to reach more authentic spirituality instead of the avoidance they previously engaged in (Cashwell et al., 2004).

Recovery from restrictive religious teachings is similar to other recovery work, in that relapses may happen. In this case, falling back into spiritual bypass may occur, and clinicians should keep this in consideration. Should this occur, it is recommended for clinicians to be nonjudgmental and normalize this relapse. They can review their work to discover the meaning behind the relapse and collaborate to identify more adaptive coping skills to utilize. Similarly, as mentioned, clients may initially present with religious trauma and no indications of spiritual bypass. This should be continuously assessed throughout treatment.

When a client's spiritual bypass is adequately addressed, clinicians may then proceed with interventions targeting religious trauma. The breadth of treatment approaches for religious trauma were detailed in Chapter IV. Some highlighted suggestions for clinicians will be reviewed. It may be helpful for clinicians to view specific interventions and techniques within Winell's (2007) phases of recovery. These phases are one framework that clinicians may use to conceptualize their clients' progress. However, given that Winell (2007) had coined the term religious trauma syndrome, it is reasonable to concentrate on this work. As a reminder, Winell (2007) explains that these phases are not a linear process, there is overlap among them, and a client may be in more than one phase at a time.

While a client is in the separation phase, they are often questioning the restrictive religious teachings and messages they had grown up with for the first time (Winell, 2007). Super and Jacobson (2011) and Morrow (2003) consider identifying and naming the religious abuse and evaluating the extent of it to be the first steps in treating religious trauma in LGBTQ clients. These steps can easily be generalized to work with a broader population. Clients may be defensive of their religious upbringing and attempt to rationalize their experiences to reconcile what they have encountered (Winell, 2007). Ultimately, clients are faced with the decision to leave their religion or stay. With clients in this stage—and if clients decide to seek therapeutic treatment while grappling with these doubts—clinicians can provide an open, nonjudgmental space for clients to process these questions. Clinicians need not know the answers to these questions, and it is perhaps better if they do not attempt to answer them (Walker et al., 2010). The client must make this decision on their own. For some clients, they may decide to remain in

their religion, while others make a different choice (Winell, 2007). Nica (2019) discusses that individuals who consider leaving their religion but decide to remain frequently have poorer mental health over time compared to those who committed on leaving their religion or who never considered leaving in the first place. Clinicians may be mindful of this, though reminded that this is a significant, often life-changing decision for clients. It will require patience and compassion from the clinician as they work alongside their client.

In the confusion phase, clients have made the decision to exit their religion (Winell, 2007). They have often lost the inherent structure of their lives and may feel disconnected from others. The impact of their restrictive, religious upbringing may still linger (Ineichen, 2019; Russell-Kraft, 2021; Winell, 2007). It is the clinician's task to begin to collaboratively rebuild with the client their social support networks (Nica, 2019). Religious communities typically provide emotional, informational, and instrumental support. It is recommended that the clinician recognize ways that they themselves may serve as a tool in providing these supports to their clients. Specifically, clinicians must provide a safe and supportive place, be compassionate and validating, and able to direct clients to resources they may need. In modeling these supports, clients can learn that not only religious communities can provide them and be empowered to have the agency to seek them on their own (Nica, 2019). Clinicians are also recommended to normalize and validate the feelings of disconnectedness and existential angst clients may be experiencing (Winell, 2007). Having this loss of meaning in their lives may be the first occurrence of clients grappling with the full extent of their religious trauma. It should also be noted that clinicians recognize the potential for liberation in this phase. For the

first time, clients may have the opportunity to completely think, feel, and experience their whole selves. Raising this point could help quell the often-intense emotions they are having (Winell, 2007).

Clients in the avoidance phase do not want to engage in religious or spiritual practice in any way (Winell, 2007). This may be an essential part of the recovery process, however, and clinicians should not immediately guide clients away from this avoidance. Exploring this avoidance can be useful, as clients may be more willing to discuss and process their traumatic experiences due to them perceiving the religious or spiritual practices as playing a direct role. This practice can be helpful in the short-term, though it will better serve the client to not fall on extreme ends of the spectrum (Winell, 2007). As spiritual bypass and wholly embracing spiritual practice can be viewed as one end of the spectrum, complete avoidance is on the opposite end. It is essential for clinicians to provide an open space for clients to process their experiences in this way and to also gently challenge clients on this avoidance when appropriate.

Winell's (2007) feeling phase appears to be the phase in which the bulk of therapeutic work can be completed. Clients are experiencing intense and mixed emotions, ranging from anger to grief (Winell, 2007). There are a variety of techniques clinicians can use while working with clients in this phase. Two such exercises derive from an adaptation of trauma-focused cognitive-behavior therapy (TF-CBT) (Walker et al., 2010), both in the trauma narrative segment of treatment. The first exercise is the empty chair technique, in which clients are asked to think of where God was during the religious abuse they experienced and consider how God would respond to their questions. They are also asked how God may have felt about the abuse. The trauma narrative itself can be a

powerful tool, allowing the client to create a list of questions they may have for God and examine why He may have allowed them to suffer in the first place. Clinicians are recommended to not answer these questions for the client, as it is important to simply hold the space for them and be present as they process their religious abuse and begin to create meaning from it (Walker et al., 2010).

Similarly, clinicians are encouraged to engage the client in deconstruction work, leading discussions about where and how they received the restrictive teachings and messages and what they mean in comparison to their current values (Farrell, 2009). Pulling from relational family therapy (RFT), clinicians are recommended to have clients examine how religion may have played a role in the abuse they experienced (Simonič et al., 2013). Providing opportunities for clients to analyze scripture in session may help them identify messages and themes they wish to reconcile into their lives (Farrell, 2009). Additionally, clinicians may guide their clients to deconstruct their concept of God. In separating the God as the figurehead in their religion from the God that the perpetrators in their lives used to manipulate, exploit, and harm them, the clinician can help the client view God as a victim of abuse, too (Farrell, 2009).

An integral part of the feeling phase is processing the grief the client is experiencing (Winell, 2007). The relationship a client has with God and the religious leaders in their community can be as strong as someone can have with their caregivers (McGriffith, 2010). Because of this, the loss can be significant. Clinicians are recommended to recognize the depth of this loss and not diminish it. Educating the client on attachment styles and how God can serve as a notable attachment figure may help to normalize their grief (McGriffith, 2010; Winell, 2007). Clinicians can guide clients to

honor this loss, just as any other, and employ therapeutic techniques designed to address grief.

It should be noted that a significant obstacle in processing religious trauma is the emphasis on not listening to one's emotions or bodily cues, specifically in Christianity (Russell-Kraft, 2021; Stone, 2013). This is an obstacle, as trauma is often stored in the body (Van der Kolk, 2014). Clinicians are recommended to not only engage in deconstructing these Biblical verses with their clients but to also educate them on the importance of being attuned to their body (Farrell, 2009; Russell-Kraft, 2021). Bottom-up approaches, such as physical therapy and somatic-focused interventions, should be considered as a part of treatment (Maxwell, 2017). Similarly, incorporating elements of mindfulness interventions may also be beneficial in teaching clients to be more present and listen to what their body may be telling them.

Other therapeutic tools clinicians are recommended to use are a spiritual timeline and cognitive restructuring (Super & Jacobson, 2011). Though used with LGBTQ clients, these exercises can be generalized to a broader population. Clinicians may guide their client to map out a timeline wherein they identify the first times they felt conflict with their religious identity or experienced what they perceived to be religious abuse. Additionally, clinicians can assist clients with reframing the harm they experienced throughout the abuse and from the restrictive teachings as a mechanism toward healing (Super & Jacobson, 2011).

When a client has reached the rebuilding phase, it is understood that they have achieved adequate and satisfactory progress in their recovery journey (Winell, 2011). Clients are often empowered by engaging in this process. Clinicians have helped them

reconstruct their perceptions and beliefs about religion and the abusive experiences they had. Clients have access to a significant support system and may have stronger friendships than before they exited their religion. For LGBTQ clients, they may have integrated these once-conflicting parts of their identity and are able to fully navigate life as themselves. Clients may even decide to engage in healthy religious and spiritual practices. Ultimately, the clinician can assist the client in creating meaning from their experiences and learning what the valuable components of their life were (Winell, 2007).

None of this therapeutic work will be possible if clinicians do not provide an open, genuine, and nonjudgmental space for their clients. This client-centered approach, with unconditional positive regard, must be maintained. Clinicians must be intentional in their actions to impart a corrective experience for their clients, for they have been harmed by trusted figures and family members by chronic invalidation, manipulation, and taught they are inherently evil and sinful because of the doctrine of original sin (McKim, 2014; Stone, 2013). If this foundation is not eroded and replaced with one that fosters healing, recovery cannot take place.



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## Appendix A

### *Spiritual Bypass Scale-13 (SB-13)*

Item
1. My spiritual life helps me feel my emotions more fully. (R)
2. When I feel emotional pain, the first thing I want to do is pray or meditate about it.
3. When I am in pain, I believe God will deliver me from it.
4. When something tragic happens (to me or to others) I say that God will intervene.
5. It is more important to me to seek spiritual guidance than to seek aid from a psychological helper.
6. When experiencing difficulties, I believe it is most important to deal with the spiritual source of my problems.
7. I believe it is preferable to cure emotional problems by being spiritually advanced.
8. It is more important for me to be spiritually awakened than to feel emotionally intact.
9. I believe that healing one's spirit takes precedence over healing their emotions.
10. When someone I know is in trouble, I believe it is because they have done something wrong spiritually.
11. When someone I know is experiencing hardship, I believe that it is due to spiritual attack/oppression.
12. When someone confronts me, I tend to over-analyze his or her spiritual motivations for confronting me.
13. When I face a life challenge, I always consult with a spiritual or religious teacher.