CALIFORNIA BAPTIST UNIVERSITY

# POSTTRAUMATIC GROWTH AND CHILD SEXUAL ABUSE AMONG CHRISTIAN ADULTS: THE ASSOCIATION BETWEEN GOD ATTACHMENT, SURRENDER, AND TRAUMA SYMPTOMS

by

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A dissertation submitted to the
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# DEDICATION

This dissertation is dedicated to Lora and Jackie. My original confidants and greatest listeners of my thoughts. I dedicate this dissertation to Gunnar: my oldest friend, original cheerleader, and impetus to continue working in mental health. Lastly, to Mike. For being, without question or complaint, here for the ups and downs, regardless of the result.

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ABSTRACT

Childhood sexual abuse (CSA) impacts an individual's future psychological development and is a predecessor for stress-related disorders, such as posttraumatic stress disorder (PTSD) (Hailes et al., 2019; McKay et al., 2020; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013). Drawing from several different bodies of literature (e.g., attachment theory, religious coping, posttraumatic growth), the study investigated whether attachment to God is related to posttraumatic growth (PTG) and trauma symptoms among a sample of Christian adults with a history of CSA. Further, the study examined if surrender to God as a form of religious coping mediates the relationship between attachment to God and PTG. Using an online sample of Christian adults from Amazon's MTurk who reported CSA, the study utilized Hayes' PROCESS macro to determine if a relationship exists between these variables (Hayes, 2022). The study concluded that surrender mediated the relationship between anxious attachment to God and PTG, and trauma symptoms positively correlated with anxious and avoidant attachment to God. However, no mediation relationship existed between avoidant attachment to God, PTG, and surrender to God. The results are discussed in the context of broader clinical implications for Christians and mental health professionals. Limitations and areas for further research will also be examined.

*Keywords*: child abuse, posttraumatic growth, attachment to God, attachment theory

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# CHAPTER 1

# INTRODUCTION

## Problem Statement

Childhood trauma and maltreatment are experienced throughout the United States. The United States Department of Human Services reported that, in 2020, 618,399 cases of childhood maltreatment were reported to child services (Child Maltreatment Report, 2022). Within the scope of child maltreatment, childhood sexual abuse includes rape, pornography, exposure of genitals, incest, molestation, or sexually exploitative activity (Child Maltreatment Report, 2022). While the impact of childhood sexual trauma has been frequently researched (Hailes et al., 2019; McKay et al., 2020; Mueser et al., 1998; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013), few studies have been conducted on psychological growth following trauma in the context of religion and spirituality. The posttraumatic growth (PTG) literature has attempted to capture how trauma survivors psychologically grow from trauma. Yet, to date, little research has been conducted to determine the potential role spirituality plays in helping trauma survivors experience positive psychological change. This dissertation investigates the possible influence of spirituality on posttraumatic growth among Christian adult survivors of childhood sexual abuse. In this first chapter, the author will focus on the background of the problem, the study's purpose, theoretical framework, hypotheses, an explanation of key terms, and an overview of assumptions and limitations.

## Problem Background

### *Trauma, Posttraumatic Stress Disorder, and Sexual Abuse*

In 2020, the United States Department of Health and Human Services reported 57,963 cases of child sexual abuse throughout the U.S. (Child Maltreatment Report, 2022). Sexual

assault is an enduring societal crisis that disproportionately affects women (CDC, 2022). The CDC reported that more than 1 in 3 women had experienced sexual violence, including forced physical contact, in their lives (CDC, 2022). In contrast, approximately 1 in 4 men have experienced sexual abuse (CDC, 2022). The United States Department of Justice reported that, in 2020, 108,881 reports of sexual assaults occurred, including rape in individuals aged 12 years or older (United States Department of Justice, 2022).

Although statistics on sexual trauma suggest an ongoing concern, research indicates that at least 2 out of 3 sexual assaults go unreported to law enforcement (Rape, Abuse, and Incest National Network, 2022). The CDC (2022) revealed that child sexual abuse in those under 18 years of age occurs in 1 of every 4 girls and 1 of every 13 boys. From 2009 to 2013, child protective service agencies reported that 60,000 children were victims of substantiated sexual abuse cases (CDC, 2022). Notably, 60-80% of victims of childhood sexual abuse do not disclose their abuse until adulthood (Alaggia, 2005).

Those who have experienced sexual trauma in their lifetime are significantly more likely to experience psychological distress, including suicidality, trauma-related conditions, obsessive-compulsive disorders, and psychopathology (Dworkin et al., 2017). Specifically, a history of sexual victimization predicts the future development of trauma and stress-related disorders, such as posttraumatic stress disorder (PTSD) (Dworkin et al., 2017), with women more likely than men to experience PTSD symptoms following sexual trauma (Tolin & Foa, 2006).

The impact of childhood sexual abuse places trauma survivors at risk of experiencing future psychological and physical difficulties in adulthood, such as depression, suicide, and substance use (Buzi et al., 2007; McLean et al., 2014). Some research suggests suicidality is related to the frequency of sexual abuse, meaning that chronic sexual abuse may be a risk factor

for suicidality (McLean et al., 2014). While chronic sexual abuse may be associated with suicidality, the type of abuse (e.g., sexual abuse, rape, sexual assault), frequency of abuse, and perpetrator characteristics have not been linked to the severity of PTSD, depression, or substance use (McLean et al., 2014). Because of these consequences of childhood sexual abuse, there is a need to explore constructs that may influence favorable outcomes following trauma, such as posttraumatic growth, which is the purpose of this study.

**Study Purpose**

Previous research has described childhood sexual abuse as a prominent and consistent societal issue connected to future mental health disparities, such as depression, anxiety, and posttraumatic stress (Buzi et al., 2007; Dworkin et al., 2017; McLean et al., 2014). Childhood sexual trauma dramatically affects a child's ability to securely attach to their caregiver, placing them at a heightened risk for future relationship difficulties (Roche et al., 1999).

Little research has explored the possible link between religion and spirituality and PTG and trauma symptoms. The current study is needed to understand better the potential role religion and spirituality play in influencing PTG and how they are related to trauma symptoms. Although some empirical attention has been given to the role of spirituality in PTG, few studies have acknowledged the influence that God attachment and religious coping, described in more detail in a subsequent section of this chapter, may have on trauma survivors of sexual abuse.

**Research Questions**

Considering the aforementioned gap in PTG research and the previous research that has identified God attachment and religious coping, described in a subsequent section of this chapter, as important variables for understanding the psychology of religious and spiritual functioning (Ano & Vasconcelles, 2005; Cooper et al., 2009; Hackney & Sanders, 2003), the following

research questions are considered: Is there a relationship between God attachment, PTG, and trauma symptoms? Does surrender as a form of religious coping mediate the relationship between God attachment and PTG?

While some individuals can grow following a traumatic event, the role that attachment (including God attachment) and religious coping may play in the process of PTG is currently unclear. This dissertation will explore God attachment, religious coping, PTG, and trauma symptoms in Christian adults who have experienced childhood sexual trauma. Despite two-thirds of the United States identifying as Christian (Pew Research Center, 2019), little research has been conducted on spirituality and PTG after sexual trauma. To date, most of the research on PTG and spirituality has focused on terminal medical conditions (Pargament et al., 1998), grief (Park & Cohn, 1993), or trauma stemming from living in war-trodden countries (Pargament et al., 1994).

## Theoretical Framework

### *Posttraumatic Growth*

The PTG literature defines PTG as a dynamic and changing process that highlights an individual's ability to reach positive change and find meaning following a traumatic life event (Tedeschi & Calhoun, 1996). PTG suggests trauma and distress can be catalysts for future growth and positive change (Tedeschi & Calhoun, 1996), proposing that growth and distress can exist simultaneously (Tedeschi & Calhoun, 2004). PTG encompasses trauma survivors reshaping their old perceptions about the world and incorporating a new understanding of themselves, despite their adverse experiences (Tedeschi & Calhoun, 2004).

Adverse life events create opportunities for trauma survivors to challenge core beliefs and move towards growth, a core component of PTG (Tedeschi & Moore, 2021). PTG includes realizing

new possibilities, relating to others differently, finding personal strength, discovering a new appreciation for life, and experiencing spiritual change. While some constructs may require clinical intervention by mental health professionals, Tedeschi and Calhoun (2004) argued that PTG can occur naturally following trauma, with or without professional support (Tedeschi & Calhoun, 2004).

PTG does not imply an absence of trauma symptoms; instead, it is a complex and continuous relationship between distress and recovery (Tedeschi & Calhoun, 2007). Frazier and colleagues (2009) research differentiated between perceived growth or self-reported growth and actual growth measured by Posttraumatic Growth Inventory (PTGI) after a traumatic event. The study reported that perceived growth indicated increased distress, whereas real growth was related to decreased distress (Frazier et al., 2009). These results showed that actual and perceived growth are different cognitive processes (Frazier et al., 2009). Actual growth may reflect the acknowledgment that there are positive outcomes following trauma, whereas perceived growth may indicate a denial of the adverse effects of trauma (Glad et al., 2013). In fact, reports of actual growth coincide with feelings of distress and pain rather than the absence of psychological difficulties (Glad et al., 2013).

Within the PTG literature, little research has been dedicated to investigating the spiritual change component of growth following trauma. While issues such as sexual trauma prove to be a consistent societal issue, the connection between spirituality and PTG following sexual trauma has been commonly neglected. To rectify this oversight, Tedeschi and colleagues (2017) updated their PTG scale to include additional items on a spiritual-existential changes subscale. The revised measure allowed for spiritual and existential changes within perceived growth after

trauma to be adequately represented within PTG, suggesting the need for further research on the impact spirituality may have on trauma (Tedeschi & Calhoun, 2017).

The PTG measure recognizes the importance of spirituality in growth after trauma, yet little research has been completed explicitly investigating religion and spirituality's role in PTG following trauma. To further explore spirituality in the context of PTG, the psychology of religion literature will be consulted, given that it offers a theoretical and empirical understanding of the influence of a perceived safe and secure relationship with God (i.e., God attachment) and the use of religion as a form of coping in response to a traumatic event (i.e., religious coping).

### *Attachment Theory and God Attachment*

Before God attachment can be examined, an overview of the theory behind God attachment, John Bowlby's attachment theory, must be explored. Attachment theory states that infants are born with an innate need for a dependable relationship with their caregiver or parental figures (Ainsworth, 1985; Bowlby, 1980). The child-parent relationship assists the child in creating an internal working model or internalized conceptualization of the self and others. These child-caregiver/parent relationships significantly impact future relationships with adults (Ainsworth, 1985; Bowlby, 1980).

Similarly, the God attachment literature likens this parent-child relationship to one's relationship with God. A healthy or secure attachment to God creates space for safety and comfort following traumatic experiences (Beck & McDonald, 2004). Research suggests that traumatic experiences, specifically during childhood, may significantly impact an individual's attachment to their caregiver and their attachment to God. Trauma, such as sexual abuse, may create insecure attachments to God and parents (Liem & Boudewyn, 1999; Reinert & Edwards, 2009; Roche et al., 1999). An individual's God attachment may influence how they develop

meaning or PTG following trauma (Zeligman et al., 2020). Insecure attachments to God may negatively influence psychological outcomes after trauma, including the development of PTG (Kelley & Chan, 2012; Zeligman et al., 2020). The relationship between God attachment and PTG requires further exploration in psychological research.

### *Religious Coping*

Pargament (1992) has noted that religion can be a vital component of coping and contribute to the overall coping process following adverse life events (Pargament et al., 1992). Spirituality is a foundational part of life and cannot be ignored; instead, religious and spiritual coping can be used to endure adverse life events (Pargament, 1997, 2007). Religious coping is a complex process used to help individuals cope with stress and find meaning, intimacy with others, a sense of control, and spirituality (Kirkpatrick et al., 1990; Pargament, 1992, 1996).

Rather than being used to defer or avoid trauma, religious coping is embedded in every step of the coping process, guiding the individual to find meaning in their distress (Pargament, 1996). Pargament theorized that religious coping functions in five facets: discovering meaning, gaining control, finding closeness with others, attaining comfort through closeness to God, and transforming life (Pargament et al., 2000). Religious coping allows the individual to keep spiritual intimacy during a crisis and maintain their purpose or meaning (Pargament et al., 2000).

While religious coping was initially presented as a way for individuals to find meaning in their distress, more recent writings suggest religious coping can be classified as either positive or negative (Pargament et al., 2011). Positive coping strategies include interpreting the trauma as beneficial in the future, viewing God as a partner during difficult experiences, and seeking God's care (Pargament et al., 2011). In contrast, negative religious coping entails interpreting the

distress as punishment from God, passively relying on God to rid the trauma, and rejecting God's care (Pargament et al., 2011).

Using religion as a coping mechanism has been shown to have positive implications for health. Religious coping has been used to manage trauma in many experiences, such as war (Pargament et al., 1994), severe illness, and the death of loved ones (Pargament et al., 1998; Park & Cohen, 1993). Eliciting positive religious coping has been associated with lower mortality, less depression and anxiety, and fewer posttraumatic symptoms, suggesting positive religious coping may mitigate trauma symptoms (Braxton et al., 2007; Meisenhelder & Marcum, 2004).

The religious coping literature includes constructs such as active surrender to God during distress or trauma (Wong-McDonald & Gorsuch, 2000). Surrender to God describes a positive religious coping mechanism and the decision to abdicate control to God rather than passively relinquish control and accountability (Wong-McDonald & Gorsuch, 2000). Furthermore, surrender is assumed to be used by Christians, founded on the Judeo-Christian belief of acknowledging God's control over life and giving personal power over to God (Wong-McDonald & Gorsuch, 2000).

As noted above, the current study builds upon the research of PTG, attachment theory, God attachment, and religious coping. The theoretical foundation of PTG includes the existential and spiritual change that occurs following trauma (Tedeschi & Calhoun, 1996), whereas attachment theory describes how children conceptualize themselves and the dependability of their caregivers (Ainsworth, 1985; Bowlby, 1980) and attachment styles dictate and influence future relationship development and psychological functioning (Kelley & Chan, 2012; Zeligman et al., 2020). When applied to God attachment, an individual's established attachment style may correspond with their connection to God (Beck & McDonald, 2004).

Furthermore, while God attachment research touches on how a perceived relationship with God impacts psychological functioning, the religious coping literature provides multiple positive coping skills, including surrendering to God or the active choice to give God control of one's life (Wong & McDonald, 2004). The literature addressing PTG, God attachment, and surrender to God acknowledges the effect religious and spiritual beliefs and experiences have on psychological functioning, furthering the need for the current study (Beck & McDonald, 2004; Tedeschi & Calhoun, 1996; Wong & McDonald, 2000)

**Study Hypotheses**

With the above literature and theoretical framework in mind, the author hypothesized the following:

1. Anxious attachment to God will negatively correlate with surrender to God.
2. Anxious attachment to God will negatively correlate with PTG.
3. Avoidant attachment to God will negatively correlate with surrender to God.
4. Avoidant attachment to God will negatively correlate with PTG.
5. Surrender to God will positively correlate with PTG.
6. PTG will negatively correlate with trauma symptoms.
7. Surrender to God will mediate the relationship between anxious attachment to God and PTG.
8. Surrender to God will mediate the relationship between avoidant attachment to God and PTG.

In other words, theoretically, the pathway through which secure God attachment leads to PTG is through surrender to God. See Figure 1 and Figure 2 for the theoretical model.

## Research Design

The current study recruited 204 participants from the MTurk online worker database to complete self-report surveys. All participants were at least 18 years old, had a history of childhood sexual trauma, and self-identified as Christian. In Qualtrics, an online survey platform, participants completed a demographic questionnaire, the Attachment to God Inventory (AGI) (Beck & McDonald, 2004), the Posttraumatic Growth Inventory-X (Tedeschi et al., 2017), the Surrender to God Scale (Wong-McDonald & Gorsuch, 2000), and the Trauma Symptom Checklist-40 (TSC-40) (Briere & Runtz, 1989).

Bivariate correlations were employed to examine the relationship between measures. The primary analysis was conducted through a mediation analysis using Hayes' PROCESS macro (Hayes, 2022). The independent variable was attachment to God, and the dependent variable was PTG. Surrender to God was the potential mediating variable explaining the relationship between attachment to God and PTG.

## Explanation of Key Terms

Important terms are defined in this section to understand best the concepts used in this study. *Attachment theory* is based on the notion that a child's relationship with their caregiver significantly impacts future development, as theorized by John Bowlby (1980). Attachment is categorized into three subtypes, including (a) secure attachment, (b) anxious attachment, and (c) avoidant attachment (Ainsworth et al., 1971). The securely attached child views their parental figure as dependable, responsive, and accessible to their needs. They can establish a secure base with their parent and feel safe enough to explore their environment (Ainsworth, 1985; Bowlby, 1980).

In contrast to the securely attached child, the anxiously attached child views their parent or caregiver as erratic and inconsistent in response to their needs (Ainsworth, 1985). In contrast to the securely attached child, the avoidantly attached child expects their caretaker or parent to be unresponsive in providing life essentials. The child may ignore their needs to keep their caregiver close (Ainsworth, 1985). As one more contrast to the securely attached child, the ambivalently attached, or disorganized, child presents complex and contradictory behaviors toward the child's caregivers (Ainsworth, 1985). Ambivalently attached children exhibit crying and distress when separated from their caregivers; when their caregivers return, however, they are avoidant and appear unbothered (Ainsworth, 1985).

The *attachment behavioral system* activates when a child or infant perceives a threat and seeks their primary caregiver (Bowlby, 1980). In contrast, when the danger is minimal, the child explores their environment, creating an attachment pattern (Bowlby, 1980). Within attachment theory, Bowlby (1980) described a child's *secure base* as the dependable attachment figure or caretaker that acts as a form of security to allow the child to explore their environment safely. Similarly, the *safe haven* captures the child's ability to return to their attachment figure for comfort and safety following a danger or threat (Bowlby, 1980).

Per attachment theory, an *internal working model* (IWM) is an individual's template developed through their early attachment with caregivers and on which they model future relationships (Bowlby, 1973, 1980). IWMs include the cognitive framework of mental representations of oneself, others, and one's understanding of the world (Bowlby, 1969, 1980). The IWM dictates how a child learns to interpret and respond to their caregiver's behavior, using it as a template for interacting with others (Bowlby, 1969, 1980).

According to the American Psychological Association (2012), *childhood sexual trauma* is defined as "any forced or coerced sexual activity with a minor, including noncontact abuse, sexual molestation, and rape." The *Diagnostic Statistical Manual, Fifth Edition-TR* (APA, 2022) describes posttraumatic stress disorder as a response to witnessing or experiencing a traumatic event. Posttraumatic symptoms must occur for at least one month and include but are not limited to intrusive, recurrent, and involuntary memories of the traumatic event; nightmares related to the event; dissociative responses (e.g., flashbacks); avoidance of negative memories or thoughts; irritable behaviors or outbursts; hypervigilance; and depressive symptoms (e.g., negative emotional states, diminished interest in normal activities, inability to experience happiness) (APA, 2022).

Calhoun and Tedeschi (1996) coined the term *posttraumatic growth* to include an individual's ability to attain positive change and significance from struggling with a traumatic event. Five constructs measure posttraumatic growth: (a) new possibilities, (b) relating to others, (c) personal strength, (d) spiritual change, and (e) appreciation of life (Calhoun & Tedeschi, 1996).

Pargament et al. (1992) defined *religious coping* as a complex process to help individuals with distress find meaning through spiritual mechanisms. Religious coping relies on spiritual or religious attitudes or beliefs to reduce the impact of distressing life events (Pargament et al., 1992).

*Attachment to God* relates to the individual perceiving God as a secure base to provide security, safety, and support during distress (Beck & McDonald, 2004). God acts as a theoretical caregiver, like a parent, who is available to receive fears, problems, and desires (Beck & McDonald, 2004*). Surrender to God* details the active decision to give complete control to God

(Wong-McDonald & Gorsuch, 2000). It describes an individual's subjection of their will, thoughts, and desires to God's authority and will (Wong-McDonald & Gorsuch, 2000).

**Assumptions, Delimitations, and Limitations**

The proposed study must consider multiple assumptions, delimitations, and limitations. One of the most important limitations of the study is the usage of MTurk. MTurk samples are representative of the U.S. population in areas such as gender and race (Burnham et al., 2018). Yet, MTurk samples differ in education level and religious beliefs (Burnham et al., 2018). Due to MTurk participant limitations, the study is vulnerable to sample bias.

The current study assumes that the collected participants will have experienced childhood sexual trauma as defined by the American Psychological Association (2012). Additionally, all participants endorsed identifying as Christian (Protestant, Eastern Orthodox, or Catholic). To ensure honesty, attention check questions will be intermittently dispersed throughout the survey questions to discourage random answering. Although the participants recruited must identify as Christians with a history of childhood sexual abuse, the level of religious commitment of the sample will vary. While honesty is assumed, it is also a limitation due to the inability to ensure truthful responses within the surveys and scales. The current study's choice to use Christian adults also limits the generalizability of the results to other religious groups and populations. Lastly, the study's cross-sectional design indicates that causality among variables cannot be established.

# CHAPTER 2

# LITERATURE REVIEW

This chapter reviews the existing research on sexual abuse and posttraumatic stress disorder (PTSD), posttraumatic growth (PTG), and trauma, followed by a review of attachment theory and God attachment. Next, religious coping will be reviewed, including its use in response to sexual trauma. The literature review also highlights the need for additional studies on the relationship between God attachment, religious coping, PTG, and sexual trauma.

## Childhood Sexual Trauma and Posttraumatic Stress Disorder

Childhood sexual trauma (CST) is a widespread problem, crossing international and cultural barriers (Collin-Vezina et al., 2013). Numerous studies within the CST literature reveal that survivors of CST are at risk for adverse psychological outcomes, including PTSD and mood disorders such as depression (McKay et al., 2020; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013). In addition, CST has explicitly been linked to higher reports of PTSD compared to trauma occurring in adulthood (McKay et al., 2020; Mueser et al., 1998) or other types of childhood abuse, such as physical abuse (Rodriguez et al., 1997). Notably, PTSD symptoms affect more women than men (Breslau, 2009; Tolin & Foa, 2008), regardless of trauma type (Brewin & Valentine, 2000).

In a study by Subica (2013), the author concluded that, in their sample of individuals with severe mental illness, those who had experienced CST demonstrated significantly more PTSD symptoms and worse mental health outcomes than those without similar histories. Compared with childhood physical abuse (CPA), CST experiences predicted several health-related issues, such as depression and lowered physical health (Subica, 2013). Notably, the author concluded

that the female participants experienced a more significant amount of childhood sexual abuse (CSA) when compared to the males (Subica, 2013).

In a meta-analysis examining the long-term effects of CSA into adulthood, Hailes and colleagues (2019) concluded that CSA was positively correlated with PTSD and substance misuse outcomes. Additionally, the study revealed that CSA positively correlated to other mental disorders, such as borderline personality disorder, depression, anxiety, and conversion disorders (Hailes et al., 2019). Similarly, Spataro et al. (2018) completed a study on the impact of CSA on mental health outcomes. In a sample of predominantly female children, the results revealed that those with CSA were three times more likely to experience anxiety or stress disorder-related symptoms when compared to those without CSA in their background (Spataro et al., 2018).

In a review of the effects of CSA by Paolucci et al. (2001), the authors revealed more significant PTSD, depression, sexual promiscuity, academic difficulties, occurrences of the victim-perpetrator cycle, and suicide among those with a history of CSA when compared to those without such a history. The analysis utilized a CSA participant group and a control group without a history of CSA. Their analyses revealed that the demographics of victims and the number of abuse incidents did not mediate the effects of CSA on these outcomes, while other meta-analyses have noted otherwise. The authors attributed their findings to the assumption that CSA is so impactful and damaging that it commonly affects a child's development, regardless of demographics (Paolucci et al., 2001).

Research consistently supports the understanding that CSA negatively affects mental health and psychological adjustment into adulthood (McKay et al., 2020; Mueser et al., 1998; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013). Specifically, CSA survivors are at significantly higher risk of developing mental health issues, such as mood disorders, anxiety

disorders, suicide risk, and PTSD (McKay et al., 2020; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013). While the impact of CSA on many psychological outcomes is known, additional research is needed to more fully capture the range of processes that occur following trauma, which includes PTG.

**Posttraumatic Growth**

PTG, as defined by Tedeschi and Calhoun (1996), is a dynamic and constant process that highlights an individual's ability to reach positive change and find significance or meaning following a traumatic event. PTG involves five processes that occur after a traumatic life event. These processes include new possibilities, relating to others, personal strength, appreciation for life, and spiritual change (Tedeschi & Calhoun, 1996).

The first process, new possibilities, describes an individual's belief that they can do better or find new opportunities after a traumatic event (Tedeschi & Calhoun, 1996). These new possibilities establish a framework for an individual's ability to accept change and be willing to explore new opportunities in their life (Tedeschi & Calhoun, 1996). Second, traumatic events can change a survivor's perspective on relationships (Tedeschi & Calhoun, 1996). PTG creates space for survivors to appreciate their relationships more than before or seek new relationships that offer support, safety, and sensitivity to their needs (Tedeschi & Calhoun, 1996). Third, according to PTG, personal strength is the feeling of self-reliance or the individual believing they can handle future difficulties (Tedeschi & Calhoun, 1996). The survivor may conclude they are stronger than they previously thought. Fourth, an appreciation for life following trauma characterizes a new recognition of essential priorities and acknowledging the value of the individual's life (Tedeschi & Calhoun, 1996). Lastly, spiritual change includes strengthening religious faith and understanding spirituality after trauma (Tedeschi & Calhoun, 1996). The

core components of PTG describe the complex process that trauma victims may experience.

Furthermore, PTG is described as a constantly changing process rather than a static moment or occurrence (Tedeschi & Calhoun, 2004). Fostering the development of PTG includes different cognitive strategies that assist in rebuilding and adapting to the world after trauma (Greenberg, 1995). For PTG to grow, a continuation and development of cognitive processes, such as rumination and challenging core beliefs, is needed (Calhoun et al., 2000; Tedeschi & Calhoun, 1995). Research suggests that rumination may assist an individual in making sense of or analyzing their experience after trauma, leading to the eventual growth of PTG (Calhoun et al., 2000; Tedeschi & Calhoun, 1995). Although rumination may be helpful, negative rumination may inhibit growth and cause the individual to feel "stuck" (Calhoun et al., 2000; Tedeschi & Calhoun, 1995).

Practicing deliberate or positive rumination and challenging core beliefs may lead to PTG (Cann et al., 2010; Lindstrom et al., 2013). Studies indicate that PTG begins when trauma survivors question their perceived world through deliberate rumination (Cann et al., 2010; Lindstrom et al., 2013). Deliberate rumination is practiced by protesting core beliefs or previous views, creating space for PTG to build (Tedeschi & Moore, 2021). In contrast, unwanted thoughts or intrusive rumination can cause ongoing distress (Cann et al., 2010; Lindstrom et al., 2013). Deliberate rumination allows trauma survivors to reflect on the aftermath of their trauma with others or their support system, eventually leading to the understanding that their trauma was the price for positive change or growth (Tedeschi & Moore, 2021).

Similarly, Triplett et al. (2007) suggested that challenges to an individual's perceived world that led to deliberate rumination or cognitive restructuring are more likely to result in growth following a traumatic event. The PTG literature continuously indicates the influence

cognitive processes may have on PTG development (Cann et al., 2010; Lindstrom et al., 2013; Triplett et al., 2007), but little research explicitly examines the cognitive processes behind the spiritual construct of PTG. To better understand the relationship between PTG and spiritual functioning, Calhoun and colleagues (2000) researched the possible link between posttraumatic growth and religious and cognitive processing. The researchers examined religious variables included on the Quest Scale (e.g., the readiness to face existential questions, self-criticism and perception of doubt as positive, and openness to religious change). Results indicated an association between event-related rumination or being preoccupied with a negative experience and the amount of PTG reported by participants (Calhoun et al., 2000). Participants who reported higher levels of intrusive and negative ruminating thoughts also showed lower levels of PTG and higher levels of distress (Calhoun et al., 2000). The level of religious participation after a traumatic event did not predict growth; instead, general openness to religious change was predictive of the growth reported, consistent with PTG's new possibilities dimension (Calhoun et al., 2000). Trauma survivors may use various cognitive strategies following trauma beyond religious participation and rumination.

Research from Kaye-Tzadok and Davidson-Arad (2016) hypothesized that various cognitive strategies, such as self-forgiveness, resiliency, and hope, in female survivors of sexual abuse would be linked to higher levels of posttraumatic growth. Results of the analysis indicated that realistic control, unrealistic control, and hope were positively correlated with PTG (Kaye-Tzadok & Davidson-Arad, 2016). A significant contribution to the variance of PTG was related to participants' demographics (birth order and the number of siblings), suggesting that demographic variables and social support may significantly influence the development of PTG following a traumatic event (Kaye-Tzadok & Davidson-Arad, 2016). While cognitive processes

may impact the developing PTG (Calhoun et al., 2000; Tedeschi & Calhoun, 1995; Triplett et al., 2007), how a trauma survivor processes new information on an emotional and intellectual level also influences PTG growth (Tedeschi & Calhoun, 2007).

Tedeschi and Calhoun (2007) understood that PTG is influenced by personality, sociocultural backgrounds, and growth-related disclosures or discussing trauma with others. Likewise, Sehgal and Sethi (2016) found that psychosocial factors, such as resilience, optimism, social support, and spiritual well-being, contribute to PTG in survivors of motor vehicle accidents. Each facet of PTG reveals a complex process, including multiple aspects of a survivor's cognitive strategies and psychosocial systems (Sehgal & Sethi, 2016). While psychosocial systems may shape the outcomes of PTG, demographic variables such as gender appeared to be influential in PTG reporting (Vishnevsky et al., 2020).

Women are more likely to report and experience PTSD symptoms following sexual trauma than men (Tolin & Foa, 2006). In addition, a review of the PTG literature found that women report more instances of PTG than men. The study indicated a small to moderate gender difference between women and men, suggesting a distinction between genders when reporting PTG (Vishnevsky et al., 2010). One of the study's most important findings revealed that age moderated the relationship between gender and PTG, meaning women reported more growth than men as the average age of the sample increased (Vishnevsky et al., 2010).

The development of PTG is impacted by many psychosocial variables, such as demographics, social support, spiritual well-being, and gender (specifically women) (Sehgal & Sethi, 2016; Tedeschi & Calhoun, 2007; Vishnevsky et al., 2020). PTG requires complex cognitive processes like deliberate rumination to assertively challenge a trauma survivor's perceived world and create an openness for change (Cann et al., 2010; Lindstrom et al., 2013).

When addressing the processes of PTG, the trauma type and experience must be considered throughout the psychology literature.

### *Posttraumatic Growth and Trauma*

The development of PTG may occur following a traumatic experience and requires the survivor to grow and adapt to their world post-trauma. PTG occurs after various distressful and negative experiences (Greenberg, 2015; Tedeschi & Calhoun, 1996). In a systematic review of PTG in trauma survivors, Wu and colleagues (2019) found that specific demographics impact the development of moderate to high posttraumatic growth development. The meta-analysis included men, women, adults, and children with many traumatic experiences, including cancer, natural disasters, special profession trauma (e.g., law enforcement), chronic disease, sexual abuse, and only-child-lost parents (Wu et al., 2019). The study revealed that women under 60 who experienced trauma within the last six months or less and worked in certain professions reported moderate to high levels of PTG (Wu et al., 2019). Notably, the study suggested that demographic variables may account for differences and development in PTG among trauma survivors (Wu et al., 2019).

Similarly, Shakespeare-Find and Lurie-Beck (2014) completed a meta-analysis to determine the relationship between PTSD symptoms and perceived PTG. Their results suggested that the nature of the trauma and the victim's age impact the relationship between PTSD and PTG. Importantly, their analyses revealed a stronger correlation between PTSD and PTG among survivors of natural disasters or conflict zones rather than survivors of sexual assault (Shakespeare-Find & Lurie-Beck, 2014). The relationships between variables were weak, suggesting other factors may play a more significant part in trauma survivors attaining PTG

following sexual trauma, such as demographic variables (Shakespeare-Find & Lurie-Beck, 2014).

Prati and Pietrantoni's (2009) meta-analysis researched the roles of optimism, social support, and coping strategies and their contributions to PTG. Results of the study indicated that the three variables had a significant contribution to PTG (Prati & Pietrantoni, 2009). Specifically, religious and positive reappraisal coping yielded the strongest correlation with PTG, whereas social support had a medium effect (Prati & Pietrantoni, 2009). In a sample of adult female survivors of childhood sexual abuse with demographic variables like HIV and risk factors such as sexual revictimization, high-risk sexual behavior, and drug/alcohol abuse or dependence, Lahav and Spiegel (2020) suggested that if PTG is not developed appropriately, it may encourage detaching from trauma rather than moving through it for positive change. The results also revealed no significant relationship between PTG and sexual revictimization (Lahav & Spiegel, 2020).

However, the results indicated that associations between PTG and revictimization were moderated by dissociation; specifically, PTG acted as a risk factor for those with sexual revictimization and high dissociation (Lahav & Spiegel, 2020). For survivors with high dissociation, PTG may act as an unconscious barrier to their ability to confront their trauma (Lahav & Spiegel, 2020). While findings from Lahav and Spiegel suggested that PTG may be a barrier to treatment, it is possible that the participants did not reach "true" PTG. In other words, they may not have achieved positive change after their trauma because they did not process it appropriately (Lahav & Spiegel, 2020).

Reviewing the literature on PTG and sexual abuse reveals a gap in studies utilizing diverse gender participants. Most research on sexual abuse tends to be on women, indicating a

gap in research on PTG among men with a history of sexual assault. For example, in a one-year post-sexual assault study using a sample of female sexual assault survivors over 16, women reported positive life changes associated with social support and religious coping. They perceived they had control over their recovery process (Frazier et al., 2004)—the research aligned with other PTG and trauma studies, sampling primarily female participants.

In a large sample of female child sexual abuse assault survivors, Ullman (2014) found that demographic variables influenced the development of PTG more than childhood sexual trauma. Of the demographic variables, race, older age, and less education were associated with higher levels of PTG (Ullman, 2014). Interestingly, the survivor's perception of the threat of losing their lives during the sexual assault was related to higher levels of PTG (Ullman, 2014). Ullman hypothesized that variables such as age might encourage survivors of childhood sexual assault to process their trauma and growth over time. Like other research, harmful coping mechanisms, such as avoidance or self-blame, were related to less PTG, while social support encouraged PTG (Frazier et al., 2004).

On the other hand, Schaefer et al. (2018) controlled child demographics to examine protective factors associated with resilience and PTG following childhood abuse, such as sexual and physical violence. Their study revealed that higher resiliency was positively correlated with family support, optimism, and positive religious coping (Schaefer et al., 2018). Similarly, PTG was related to greater optimism and positive religious coping, such as seeking religious help, benevolent appraisals, and forgiveness. The study highlighted that positive religious coping was the most robust associated variable with PTG (Schaefer et al., 2018). The authors noted the importance of examining the role of positive religious coping and PTG rather than broadly focusing on religiosity (Schaefer et al., 2018). The authors' finding of the significant impact of

positive religious coping on the PTG furthers the current study's reasoning to investigate the relationship between specific religious coping mechanisms and PTG.

In sum, PTG details the positive cognitive restructuring and development that may occur following a traumatic event (Tedeschi & Calhoun, 1996, 2004). Demographic factors and social support systems significantly impact PTG and whether trauma survivors can cognitively reach growth following their adverse life experiences (Kaye-Tzadok & Davidson-Arad, 2016; Schaefer et al., 2018). PTG is the outcome of change and growth following a traumatic event. However, various factors influence an individual's ability to achieve PTG. One of these factors may be an individual's attachment to their caregivers and others.

**Attachment Theory**

This section will review the tenets of attachment theory, including attachment types, the attachment behavioral system, internal working models, secure base/safe haven dynamics, and attachment styles, with their corresponding behaviors. Attachment theory and its relationship to trauma will also be examined.

John Bowlby developed attachment theory to explain personality and psychopathology development through the parent-child relationship (Bowlby, 1982,1973). Bowlby hypothesized that all children are born with an attachment behavioral system, an internal psychobiological structure that encourages children to seek proximal support from others or attachment figures (Bowlby, 1982). Attachment figures are used as protectors from threats, promoting self-efficacy and emotional regulation tools (Bowlby, 1982).

Attachment theory states that caregivers must acknowledge the needs of their children through safety and consistency while promoting their autonomy (Bowlby, 1980). Relationships with caregivers influence a child's future relationships and development and continue into

adulthood (Ainsworth, 1989; Bowlby, 1980). Children develop their internal working models, or their mental representation of their caregivers and themselves, based on their early experiences with their caregivers or parents (Ainsworth, 1985). A faulty internal working model may make children vulnerable to developing maladaptive attachment styles in their current and future relationships (Ainsworth, 1985).

Internal working models (IWMs) are mental constructions that form the child's personality and develop a child's understanding of their caregivers and themselves (Bowlby, 1980). Positive IWMs may consist of mental representations of caregivers as responsive, caring, and supportive, fostering self-worth (Bowlby, 1980). Conversely, negative IWMs may promote powerlessness and a lack of self-esteem (Bowlby, 1980). The development of negative IWMs and insecure attachments places the child at a disadvantage in curating healthy psychological functioning (Ensink et al., 2020; Liem & Boudewyn, 1999; Roche et al., 1999). Children develop their IWMs, or their mental representation of their caregivers, based on their early experiences with their caregivers or parents (Ainsworth, 1985). A faulty IWM may make children vulnerable to developing maladaptive attachment styles in their current and future relationships (Ainsworth, 1985).

Mary Ainsworth (1985) theorized at least three subtypes of attachment styles in infants: secure, insecure-avoidant, and insecure-ambivalent/resistant. An insecure-avoidant attached child shows little concern when their caregiver is separated from them. The child may avoid interacting with their caregiver and show no response when reunited with their caretaker following a separation (Ainsworth, 1985). These children may not show any preference between a stranger or their caretakers. Avoidantly attached children may have caretakers who ignore the

child's attempts for affection, reinforcing the child's internal working model that they cannot depend on others (Ainsworth, 1985).

On the other hand, an insecure-ambivalent/resistant attached child presents complex and contradictory behaviors toward the child's caregivers (Ainsworth, 1985). A child displaying an insecure-ambivalent/resistant attachment has created an internal working model labeling their parent or caregiver as erratic and not consistently responsive to their needs (Ainsworth, 1985). An ambivalent/resistant attached child may display apprehension and fear when their caregiver is out of sight due to the parent's inconsistency in returning or responding to their needs (Ainsworth, 1985).

Ambivalently/resistant attached children exhibit crying and distress when separated from their caregivers, but when their caregiver returns, they are avoidant and appear unbothered (Ainsworth, 1985). This behavior indicates they have an internal working model that views caregivers as rejecting and detached (Ainsworth, 1985). In general, insecurely attached children experience negative views of themselves. Specifically, negative IWMs cause children to view themselves as unworthy of care and protection from their caregivers (Ainsworth, 1985). The IWM guides a child in formulating their opinion of themselves and the world around them, ultimately becoming a guide for how they approach interpersonal relationships (Bowlby, 1973).

The securely attached child views their parental figure as dependable, responsive, and accessible to their needs (Ainsworth, 1985). The securely attached child can establish a secure base with their parent and feel safe enough to explore their environment (Ainsworth, 1985; Bowlby, 1980). A securely attached child can apply their positive and healthy internal working model to future and new relationships that they develop (Ainsworth, 1985). Furthering work by Ainsworth (1985), Mary and Solomon added the disorganized subtype to the established

attachment styles (Duschinsky, 2015). Disorganized attachment styles are characterized by inconsistent, possibly dangerous, and distressing caregivers (Hayes et al., 2013). Children with disorganized attachment styles are characterized by conflict and the inability to regulate emotions when separated or reunited with their caregivers (Hayes et al., 2013). They cannot regulate because the caregiver is the source and solution to the child's distress (Alexander, 1992).

Attachment styles may have a moderating effect for survivors of childhood sexual abuse. Alexander (1992) suggested that anxiously attached children may be at a higher risk of experiencing anxiety and depression due to their tendency to ruminate on negative emotions. They may also be targeted for further victimization by other children. In contrast, avoidantly attached children may simultaneously depend on others and experience distrust of others (Alexander, 1992). They may employ minimizing and avoid expressing emotions, leading to higher levels of substance abuse later in life (Alexander, 1992; Aspelmeier et al., 2007).

Bowlby (1973) understood that a child uses their parent as a safe haven and a secure base to develop cognitive models that inform them that their caregivers are responsive and available to meet their needs (Bowlby, 1973). The secure base is found in an attentive and sensitive caregiver, allowing the child to launch into the world and explore confidently (Bowlby, 1973). The secure base becomes a place of safety, allowing the child to explore their new environment with the trust that their caregiver will not abandon them. The absence of a dependable and sensitive secure base may foster insecure attachments rooted in anxiety or avoidance (Bowlby, 1988). Similarly, a safe haven describes the process of a child returning to their attachment figure for comfort in times of threats or unsafety (Bowlby, 1988). The child must trust and rely on their caregiver, knowing that their caregiver will be available for soothing (Collins & Feeney, 2000).

Furthering research by Bowlby and Ainsworth, authors Bartholomew and Horowitz (1991) developed a four-part model describing the attachment styles of adults. The four-category model included secure, preoccupied, dismissive, and fearful attachment styles (Bartholomew & Horowitz, 1991). A secure adult attachment describes an adult who is comfortable with intimacy and is independent (Bartholomew & Horowitz, 1991). A preoccupied attachment style involves an adult who struggles to separate from their partner and have autonomy (Bartholomew & Horowitz, 1991). A fearfully attached adult is afraid of intimacy and avoids developing close and meaningful relationships (Bartholomew & Horowitz, 1991). Lastly, the dismissive adult attachment style is highly independent and tends to reject closeness with others (Bartholomew & Horowitz, 1991).

***Insecure Attachment and Trauma***

Multiple traumatic experiences in childhood may lead to insecure attachments, causing self-blame, low self-efficacy, and negative expectations of others (Liem & Boudewyn, 1999). Insecure attachments, such as disorganized attachment styles, which inconsistent and possibly dangerous caregivers characterize, place the child at a higher risk of developing anxiety (Ainsworth, 1985).

While it is clear childhood abuse negatively impacts attachments to caregivers, Alexander (1992) examined the applicability of attachment theory to childhood sexual abuse (CSA) specifically. CSA may cause different interpersonal issues for avoidant and anxious attachment styles. Avoidant attachment styles may appear as an inability to trust others or as social isolation (Briere, 1989; Kobak & Sceery, 1988; Wooley & Vigilanti, 1984). In contrast, anxious attachment styles manifest negative self-image and desperation for love (Feeney & Noller, 1990; Troy & Sroufe, 1987). Additionally, CSA victims may experience relational distortions with

their children, possibly continuing their insecure attachment styles within their families and into adulthood (Alexander, 1992; Roche et al., 1999).

In fact, Liem and Boudewyn (1999) reviewed the effects of childhood sexual abuse on adult social functioning. They concluded that traumatic events in childhood are related to future maltreatment from others as adults. Adults with a history of childhood sexual abuse may tolerate more significant abuse in adult relationships than adults without a history of childhood sexual abuse (Liem & Boudewyn, 1999). The researchers also indicated that self-blame, hostility, and paranoia predicted the need to control others, suggesting that childhood trauma follows survivors into adult relationships (Liem & Boudewyn, 1999).

Likewise, Roche and colleagues (1999) suggested that adult attachment style and overall adult psychological adjustment are related to childhood sexual abuse (CSA). Their analysis concluded that CSA did not predict psychological adjustment independent of the individual's attachment style, implying that attachment style and psychological functioning are intertwined (Roche et al., 1999). Furthermore, women who experienced CSA were generally more fearful and displayed insecure attachments as adults (Roche et al., 1999). Specifically, women who experienced sexual abuse within their families experienced more psychological problems than those suffering from abuse outside of the family (Roche et al., 1999). The researchers characterized abuse within the family as a violation of the child's basic instincts of trust and safety, ultimately disrupting their IWMs (Roche et al., 1999).

Additional to the influence that demographic variables have on CSA survivors, parent-child attachment styles may also influence the development of mental health issues in children with a history of abuse (Reinert & Edwards, 2009). Reinert and Edwards (2009) hypothesized that in a sample of college students who had experienced childhood mistreatment as physical or

verbal abuse, the strength of attachment to one parent would moderate the negative psychological symptoms following abuse. The study results only supported one parental relationship, mother and daughter (Reinert & Edwards, 2009). When fathers verbally mistreat their daughters, the attachment to the mother moderates negative psychological symptoms, such as depression or sexual problems (Reinert & Edwards, 2009). When fathers physically mistreat their daughters, attachment to mothers moderates depression and sexual difficulties (Reinert & Edwards, 2009).

While Roche and colleagues (1999) suggested that interfamilial sexual abuse greatly disrupts IWMs, Ensink et al. (2020) examined the effect of childhood sexual abuse histories on attachment styles and psychological difficulties. In a sample of children with CSA histories and no prior abuse, insecure attachments appear to be the primary predictor of depressive symptoms, regardless of abuse history (Ensink et al., 2020). Furthermore, coupled with depressive symptoms, insecurely attached children are also at risk of developing stress-related disorders such as PTSD. Notably, the authors stated that securely attached children with backgrounds of CSA were less likely to disclose their abuse to their caretakers. Roche et al. (2020) suggested that after securely attached children were sexually abused, they may feel the tension between their IWMs, concluding that others can be generally trusted. In contrast, anxiously or avoidantly attached children may have IWMS that already support the idea that others cannot be trusted, leading to more disclosure (Roche et al., 2020).

Murphy and colleagues (2016) examined the relationship between anxious and avoidant attachment styles and posttraumatic stress symptoms in a sample of Dutch women with a history of CSA. The participants' posttraumatic stress symptoms were measured when they entered treatment, six months after treatment, and again at 12 months post-treatment for follow-up

(Murphy et al., 2016). The study's findings indicated that posttraumatic stress symptoms decreased across all three time increments as attachment insecurities improved (Murphy et al., 2016). Also, those with avoidant attachment appeared more vulnerable to posttraumatic stress symptoms than those with anxious attachment (Murphy et al., 2016).

Not only does CSA impact attachment styles into adulthood, but CSA may have implications for the cognitive development of meaning-making or constructs such as PTG. Bodner and colleagues (2012) analyzed the impact attachment styles have on an individual's search for meaning in life and perceiving meaning in life. The results concluded that securely attached participants report a more significant presence of meaning in life and a lower search for meaning than insecurely attached participants (Bodner et al., 2012). Securely attached individuals' favorable view of the self may assist them in perceiving meaning in their life rather than feeling as if they must find it. Notably, fearfully attached individuals scored the highest in searching for purpose in life compared to all other attachment styles (Bodner et al., 2012).

Similarly, Nelson et al. (2019) found that an adult's attachment style mediated the relationship between CSA and PTG. Their results indicated that levels of trauma are significantly related to insecure attachments, whereas a secure attachment style is positively correlated with PTG development (Nelson et al., 2019). Attachment style was considered a mediator between CSA and psychological adjustment; notably, the participant's attachment style was still related to PTG outcome when the trauma was controlled (Nelson et al., 2019).

The impact of trauma and attachment development is primarily influenced by the failure of the child to attach to their caregiver and ultimately develop healthy IWMs (Ensink et al., 2020; Liem & Boudewyn, 1999). Specifically, with sexual abuse, an attachment may be disrupted, leading to many mental health issues such as depression and PTSD symptoms

(Murphy et al., 2016; Paolucci et al., 2001). While childhood sexual abuse often preceded mental health issues, the current literature lacks research on how trauma symptoms are related to religious coping strategies or attachment to God.

**Attachment to God**

The attachment to God construct, developed by Beck and McDonald (2004), is derived from Bowlby's attachment theory, which compares God to the attachment relationships an individual experiences with their primary caregiver (Beck & McDonald, 2004). The relationship between an individual and God can be described as an attachment relationship. God is considered a secure base and safe haven needed for healthy growth (Beck & McDonald, 2004). Attachment to God mirrors the avoidance and anxiety attachment styles described by Brennan et al. (1998). Brennan and colleagues (1998) presented two primary adult attachment styles, avoidant and anxious. In adult relationships, avoidant attachment is characterized by discomfort with closeness and dependence on others, whereas anxious attachment appears as a fear of abandonment and rejection from others (Brennan et al., 1998).

Similarly, an anxious attachment to God involves fear of abandonment by God, resentment towards God's perceived lack of affection, jealousy over God's love towards others, and a preoccupation with one's relationship with God (Beck & McDonald, 2004). In contrast, an avoidant attachment involves the need for self-reliance, difficulty depending on God, and an unwillingness to be emotionally vulnerable with God (Beck & McDonald, 2004). While God can serve as a surrogate caretaker to those with insecure parental attachments, the attachment to God literature details two different explanations for this process.

The attachment to God literature describes two hypotheses detailing how an attachment to God is formed (Kirkpatrick & Shaver, 1990). The compensation hypothesis states that

individuals may use their attachment to God to "make up for" or replace their attachment to their caregiver (Kirkpatrick & Shaver, 1990). In contrast, the correspondence hypothesis assumes that an attachment style to God is derived from an individual's attachment style (Kirkpatrick & Shaver, 1990). An insecurely attached individual will then have an insecure attachment to God due to their internal working model corresponding to negative representations of God (Kirkpatrick & Shaver, 1990). The current study will rely upon the correspondence hypothesis (Kirkpatrick & Shaver, 1990) to theorize that an individual's attachment to their caregivers will correspond with how they relate to God, possibly impacting their PTG.

Leman et al. (2018) examined whether God's attachment or image accounted for psychological distress and well-being differences in a sample of individuals with "high certainty about their belief in God." The study analyzed secure, avoidant, and anxious attachments to God concerning depression, anxiety, and stress symptoms (Leman et al., 2018). Similarly, as was psychological distress, God-image conceptualizations, such as a forgiving or wrathful God, were analyzed. The study results suggested that a forgiving or wrathful God-image was unrelated to participants' self-reported psychological well-being when attachment to God was controlled (Leman et al., 2018). The authors concluded that a secure attachment to God might be a predecessor to positive mental health outcomes (Leman et al., 2018).

In a study analyzing the connection between nonsuicidal self-injury, such as cutting, and anxious/avoidant attachment to God or a higher power, Buser and colleagues (2020) found that those who worried about their higher power abandoning them or questioned their higher power's attention or compassion reported more instances of nonsuicidal self-injury (Buser et al., 2020). Out of the participants with avoidant and anxious attachments to God, those with fear of abandonment and anxious attachment showed higher nonsuicidal self-injury and distress when

compared to those with avoidant attachments (Buser et al., 2020). While the study noted the impact attachment to God might have on self-injury, the study's sample did not require its participants to identify from one religious group, limiting the applicability of the results to one specific religious tradition.

In a sample of Italian adults, Cassibba et al. (2014) examined the role of attachment to God within spiritual or religious coping. Results indicated that attachment type, insecure or secure, impacted an individual's ability to endure serious diseases such as cancer or a chronic illness (Cassibba et al., 2014). A secure God attachment was related to functional ways to cope with the disease, such as regarding cancer as a challenge and adopting a positive attitude (Cassibba et al., 2014). The research indicated that insecure attachment to God was linked to hopelessness and anxiousness (Cassibba et al., 2014). In contrast, a secure attachment to God resulted in the ability to view cancer as a challenge; also, the authors noted a connection between a secure attachment with God and fatalism (Cassibba et al., 2014). While the Cassibba and colleagues' (2014) study with Italian participants revealed a relationship between God attachment and medical trauma, the current study utilizes American participants, which may limit cross-cultural applicability.

Reinert and Edwards (2009) examined the impacts of childhood maltreatment (physical, sexual, and verbal abuse) on religiosity and overall attachment to God. Participants who experienced sexual abuse as a child reported higher insecure attachment to God while also conceptualizing God as controlling and distant (Reinert & Edwards, 2009). The researchers noted that attachment to parents mediated the relationship between attachment to God and verbal and physical maltreatment (Reinert & Edwards, 2009). Surprisingly, attachment to parents did not mediate God attachment and sexual abuse, suggesting parental attachment could not

compensate for the insecure God attachment (Reinert & Edwards, 2009). The study indicated that the intrusive and traumatic impact of sexual abuse might result in substantial negative experiences of God attachment and parental support (Reinert & Edwards, 2009).

### *Attachment to God and Posttraumatic Growth*

Few studies exist in the literature that has examined whether an insecure or secure attachment to God may affect PTG or meaning-making. In a sample of Christian adults, Bock and colleagues (2018) found that avoidant attachment to God was negatively correlated to redemptive appraisals of suffering, such as reframing suffering as an opportunity for God to facilitate positive change. In contrast, the study revealed a positive correlation between anxious attachment to God and appraising suffering as having meaning (Bock et al., 2018). Also, the researchers noted that spiritual awareness (understanding of one's limits, need for spiritual rebirth, and awareness of one's place concerning God) did not mediate the relationship between an anxious attachment to God and meaning-making (Bock et al., 2018). Furthermore, avoidant attachments to God were negatively correlated with spiritual awareness and PTG (Bock et al., 2018).

In a study examining the relationship between God representation, attachment to God, and PTG in trauma survivors, Zeligman and colleagues (2020) concluded that trauma symptoms and PTG grow simultaneously. The researchers investigated whether authoritarian or benevolent God representation or avoidant attachment to God moderated the relationship between trauma and PTG. Notably, avoidant attachment to God negatively affected the ability of participants to develop PTG, whereas viewing God as an authoritarian encouraged PTG (Zeligman et al., 2020). Specifically, an avoidant attachment to God was negatively correlated with an authoritarian representation of God (Zeligman et al., 2020). While the study indicated that either God's

representation or avoidant attachment to God did not moderate trauma symptoms, the study utilized an attachment to God inventory not normed in a specific religious group. This lack of specificity may not appropriately capture the impact of religious coping and PTG's impact on specific religious groups.

Kelley and Chan (2012) examined the role of attachment to God and its effect on positive religious coping, meaning-making, and depression. The study's results suggested that a secure attachment to God was negatively correlated to grief and depression. Similarly, positive religious coping was positively related to meaning-making. Overall, the study revealed that a secure attachment to God significantly influences the development of depression and stress-related growth post-trauma.

Overall, studies employing the Attachment to God Inventory (AGI) tended to administer the measure to non-Christian samples. The AGI was normed on Christian adults, limiting the literature on God attachment (Beck & McDonald, 2004). The existing literature affirming the importance of God attachment and its influence on positive mental health outcomes highlights the need for further examination into God attachment and other important variables, such as PTG and religious coping (Cassibba et al., 2014; Kelley & Chan, 2012; Leman et al., 2020). Similarly, the gap in the literature surrounding the relationship between PTG and attachment to God further supports the current study's need.

**Religious Coping**

Many religious groups use religious coping to handle stressful life events, including mental health difficulties, illness, war, and bereavement (Pargament et al., 1998). Religion is a widely used method for coping with trauma, crossing cultural and religious lines (Abu-Raiya & Pargament, 2014). The belief in a religious tradition can contribute to coping processes by

shaping one's worldview and how one perceives traumatic events. Religion offers a resource for integrating one's belief system, relationship with God, and spiritual practices to cope with distress (Pargament et al., 1992).

Pargament and colleagues (2000) broke down religious coping into five primary functions: meaning-making, finding control, attaining comfort through closeness with God, maintaining closeness with others, and transforming one's life. These five functions can be further examined in two broad categories of either positive or negative religious coping (Pargament et al., 1998). Positive religious coping approaches view God as a partner, encourage a secure relationship with a higher power, and view distress as valuable (Pargament et al., 2011). On the other hand, negative religious coping entails interpreting distress as a punishment from God, passively depending on God, and attempting to manage stress alone (Pargament et al., 2011). Positive religious coping has been associated with lower mortality, less depression, lessanxiety, and fewer posttraumatic symptoms (Braxton et al., 2007; Meisenhelder & Marcum, 2004). Some studies suggest that negative religious coping may offer pathways for more growth than distress, reflecting some religious notions that struggles must come before spiritual growth (Pargament et al., 1999, 2000).

Religion may contribute to coping and shape the outcome of events following trauma (Pargament et al., 1992). Religion brings a set of beliefs, values, and relationships that can be used in trauma to effectively cope with the discomfort and eventually be translated and integrated into an individual's appraisal systems and daily life (Pargament et al., 1992). Coupled with religious beliefs, religious community support is more likely to be seen as a source of acceptance and support, rather than pain or rejection, in times of distress (Bearon & Koening, 1990).

In a meta-analysis completed by Hackney and Sanders (2003), findings revealed a significant positive relationship between religiosity and mental health. The results suggest religiosity may have an impact on psychological outcomes. While the current study focuses on Christian adults, Hackney and Sanders (2003) did not limit their meta-analysis to one religious denomination or tradition but considered religiosity a broad construct. While their comprehensive understanding of religiosity may reveal a general connection between religion and positive mental health outcomes, such as life satisfaction, and psychological distress, the study cannot account for specific religions' impact on mental health (Hackney & Sanders, 2003).

Similarly, Ano and Vasconcelles (2005) conducted a meta-analysis to study the relationship between religious coping and stress and trauma. The researchers concluded that positive religious coping, such as seeking spiritual support and benevolent appraisals, was linked to stress-related growth, spiritual growth, and positive affect (Ano & Vasconcelles, 2005). Interestingly, the meta-analysis found no relationship between negative religious coping strategies and unhealthy psychological adjustment (Ano & Vasconcelles, 2005). Individuals who employed positive religious coping also reported fewer depressive and anxiety symptoms (Ano & Vasconcelles, 2005). In contrast, those who used negative religious coping, such as believing God punishes them or that they deserve stress, reported more depression and anxiety symptoms (Ano & Vasconcelles, 2005).

In a study examining how religious coping, gender, PTSD, and PTG interact, Gerber et al. (2011) found that positive religious coping positively correlated to PTG, while negative religious coping was associated with PTSD symptoms. Even after the researchers controlled for demographics such as race and gender, these associations remained significant. The authors suggested that religious coping is essential to developing PTG (Gerber et al., 2011). A negative

coping style, such as blaming God, defeats the individual's ability to use their religious beliefs to provide a sense of meaning following trauma (Gerber et al., 2011). In contrast, positive religious coping, such as surrendering to God, may encourage trauma survivors to find purpose (Gerber et al., 2011).

Bryant-Davis and colleagues (2011) found that social support and religious coping following sexual assault in African-American women were protective factors for depression and PSTD symptoms. The study highlighted that women who endorsed negative religious coping reported higher levels of PTSD symptoms (Bryant-Davis et al., 2011). The results suggested that negative religious coping, such as believing God is punishing, passively waiting for God to change their situation or symptoms, using prayer as a tool for avoidance, and assuming they failed in their faith may hinder their recovery following trauma (Bryant-Davis et al., 2011)

It is essential to recognize the impact religious coping may have in processing trauma and protecting against the development of mental health difficulties such as PTSD (Ano & Vasconcelles, 2005; Gerber et al., 2011; Hackney & Sanders, 2003). The religious coping literature highlights the influence of positive religious coping mechanisms on meaning-making and constructs such as PTG (Ano & Vasconcelles, 2005; Gerber et al., 2011). While little research exists examining associations between religious coping and PTG, even less study has been dedicated to Judeo-Christian coping mechanisms such as surrendering to God.

***Surrender to God***

Part of the religious coping literature mentions the active surrender to God during distress (Wong-McDonald & Gorsuch, 2000). Surrendering to God is a positive religious coping mechanism detailing the active decision to abdicate control to God during distress (Wong-McDonald & Gorsuch, 2000). Wong-McDonald and Gorsuch (2000) attributed surrender to the

intrinsic motivation to follow God, regardless of what happens in the future. Negative coping styles endorse passiveness or deference of responsibility and the expectation of God to fix negative experiences without having an active say (Wong-McDonald & Gorsuch, 2000). Surrender is assumed to be used by Christians, founded on the Judeo-Christian belief of acknowledging God's control over life and relinquishing personal power to God (Wong-McDonald & Gorsuch, 2000).

The utilization of surrender as a coping skill is strongly related to spiritual well-being (Wong-McDonald & Gorsuch, 2000). Surrender to God is associated with lower stress levels, suggesting that elements of religiosity impact health (Clements & Ermakova, 2012). God's perceived help predicts adaptation to religious/spiritual struggles above and beyond God-focused coping efforts (Clements & Ermakova, 2012). While the theoretical construct of surrendering to God is linked to mental health, research utilizing surrender as a coping skill is minimal.

In a sample of adults, God's perceived help was related to adaptation to religious/spiritual struggles above and beyond God-focused coping efforts (Wilt et al., 2019). Those who understand God in a relational sense may prefer to cope by working with God as a collaborator and considering ways God may intervene in their struggles (Wilt et al., 2019). In a study on the link between religiosity and health among female college students, Clements and Ermakova (2012) found that surrendering to God as a coping mechanism was associated with lower stress levels. The mechanism of surrender, an individual's ability to relinquish control to God and willingness to submit to God, may ameliorate the development of physical ailments and anxiety symptoms (Clements & Ermakova, 2012).

The religious coping literature often fails to specify which specific coping strategies may impact overall psychological well-being; instead, the research focuses on broad positive or

negative religious coping. Despite the research outlining positive religious coping as a source for growth following trauma, little research details how surrounding to God may influence meaning-making efforts such as PTG.

In sum, the above literature review highlights how attachment to caregivers (e.g., attachment theory and internal working models), attachment to God, and the experience of childhood sexual abuse related to PTG. Research supports the notion that CSA may negatively impact psychological functioning (Hailes et al., 2019; McKay et al., 2020; Mueser et al., 1998; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013). Still, little has been mentioned about how God attachment or religious coping mechanisms, such as surrender to God, influence the development of trauma symptoms or PTG.

The current study aimed to determine whether God attachment was linked to PTG and trauma symptoms in Christian adults. Furthermore, the study examined if a positive religious coping strategy, surrender to God, is a potential mediator for explaining the relationship between God attachment and PTG. The study hypothesized that an (a) anxious attachment to God would negatively correlate with surrender to God, (b) anxious attachment to God will negatively correlate with PTG, (c) avoidant attachment to God will negatively correlate with surrender to God, (d) avoidant attachment to God will negatively correlate with PTG, (e) surrender to God will positively correlate with PTG, (f) PTG will negatively correlate with trauma symptoms, (g) surrender to God will mediate the relationship between anxious attachment to God and PTG, and (h) surrender to God will mediate the relationship between avoidant attachment to God and PTG.

# CHAPTER 3

# METHODOLOGY

## Participants and Procedure

Participants were recruited following California Baptist University's Institutional Review Board (IRB) approval. All participants completed informed consent before participation in the current study. Participants were recruited via an online platform, Amazon's Mechanical Turk (MTurk). Participants were asked to complete a demographics questionnaire about their sex, gender, religious affiliation, socioeconomic status (SES), education, and ethnicity. The participants were asked to complete surveys about their attachment to God, surrender to God (as a form of religious coping), posttraumatic growth, and trauma symptoms. Participants were included in the study if they had experienced sexual abuse before 18 and identified with one of the three major branches of Christianity (Catholic, Eastern Orthodox, or Protestant).

Before participants began the study, a screener determining if each participant identified as Christian (Eastern Orthodox, Catholic, or Protestant) and had experienced sexual abuse before the age of 18 years was employed. If the participant did not meet the inclusion criteria, the study ended. Attention check questions were mixed throughout the questionnaires and instruments, requiring a correct response before the participant could continue. Participants that answered attention check questions incorrectly were disqualified from the study and unable to complete the survey. Lastly, participants who filled out the screener and completed the entirety of the study were paid $1.50. Those who completed the study but whose data were not used were still paid $1.50.

## Measures

### *Attachment to God Inventory*

The Attachment to God Inventory (AGI) is a 28-item scale utilizing a 7-point Likert (1 = *strongly disagree* to 7 = *strongly agree*) scale measuring two subscales of insecure God attachment, anxiety about abandonment, and avoidance of intimacy (Beck & McDonald, 2004). The scale includes items to measure avoidance, such as "I am uncomfortable allowing God to control every aspect of my life," and anxiety, such as "I fear God does not accept me when I do wrong." The AGI demonstrated good internal consistency and construct validity (Beck & McDonald, 2004). In the current study, the results were separated by avoidant attachment to God and anxious attachment to God. The internal consistency in the current study for anxious attachment to God was .92, and the avoidant attachment to God was .77.

### *Surrender to God Scale*

The Surrender to God Scale is a 12-item scale measuring the willingness of an individual to let go of their control and give control to God (Wong-McDonald & Gorsuch, 2000). The Surrender to God Scale was developed with the Judeo-Christian tradition and is considered a form of Christian coping. The Surrender to God Scale includes items such as, "When I first try to make sense of a problem, I put God's understanding above my own" and "I seek meaning in my difficulties by surrendering to God's guidance" (Wong-McDonald & Gorsuch, 2000). The Surrender to God Scale has demonstrated strong internal consistency reliability and positively relates to spiritual well-being and internal locus of control. The scale is structured as a 5-point Likert scale (1 = *strongly disagree* and 5 = *strongly agree*), with high scores indicating a willingness to surrender to God (Wong-McDonald & Gorsuch, 2000). The internal consistency in the current study was .91.

### *Posttraumatic Growth Inventory-X*

The Posttraumatic Growth Inventory-X (PTGI-X) is a 25-item instrument to measure positive changes and growth following a traumatic event (Tedeschi et al., 2017). The measure uses a 5-point Likert scale (0 = *I did not experience this change as a result of my crisis*, and 5 = *I experienced this change to a great degree as a result of my crisis*). The PTGI-X includes subscales measuring personal strength, new possibilities, relating to others, appreciation of life, and spiritual change. The PTGI-X was normed on samples from Turkey, Japan, and the United States. The PTGI-X is an updated version of the original Posttraumatic Growth Inventory (PTGI), adding four new items to the spiritual change subscale to better represent spiritual change following trauma. The PTGI-X showed good internal reliability within the United States sample (Tedeschi et al., 2017). The internal consistency in the current study was .97.

### *Trauma Symptom Checklist-40*

The Trauma Symptom Checklist-40 (TSC-40) is a 40-item self-report instrument assessing different types of childhood or adult trauma symptoms (Briere & Runtz, 1989). The 40-item measure uses a 4-point Likert scale (0 = *never* and 4 = *often*) to investigate six subscales: anxiety, depression, sexual abuse, sleep disturbance, sexual problems, and dissociation. Higher scores suggest more experiences of trauma symptoms. In prior research, the TSC-40 demonstrated good internal consistency reliability and construct validity (Elliott & Briere, 1992). The internal consistency in the current study was .96.

## Data Analytic Strategy

In the current study, multiple steps were completed to analyze the data. The study utilized Statistical Package for Social Sciences (SPSS) and checked the data for normality, such as kurtosis, skewness, and outliers. The data revealed three outliers within the avoidant attachment

to God scores. The outlier avoidant attachment to God scores were coded as "missing" in SPSS so as not to impact the data's kurtosis and skewness. After normality was established, SPSS was used to gather demographic statistics for the study's demographic variables, and Pearson correlations were generated. Bivariate correlations were conducted to examine the relationships between the variables. The author interpreted correlation strengths according to Cohen's (1988) standard, indicating .10 as small/weak, .30 as medium/moderate, and .50 as large/strong. The study used Hayes' (2022) PROCESS macro via SPSS to conduct the mediation analyses, exploring surrender to God as a mediating variable, linking God attachment and PTG. Per Kenny and Baron (1986), mediation is established if the independent variable and the mediator, and dependent variable and mediator, were significant. Consistent with Hayes (2022), mediation is established when the confidence interval for the unstandardized regression coefficient does not reach zero.

# CHAPTER 4

# RESULTS

SPSS was used to organize, code, and collect data from psychological instruments and provide summaries of the scores, means, and standard deviations. Demographic data were sorted, including gender, ethnicity, Christian denomination, level of education completion, marital status, and type of childhood sexual abuse experienced. Pearson correlations were conducted utilizing the hypothesis variables: anxious and avoidant attachment to God, surrender to God, PTG, and trauma symptoms. The following hypotheses were analyzed: (a) anxious attachment to God will negatively correlate with surrender to God, (b) anxious attachment to God will negatively correlate with PTG, (c) avoidant attachment to God will negatively correlate with surrender to God, (d) avoidant attachment to God will negatively correlate with PTG, (e) surrender to God will positively correlate with PTG, (f) PTG will negatively correlate with trauma symptoms, (g) surrender to God will mediate the relationship between anxious attachment to God and PTG, and (h) surrender to God will mediate the relationship between avoidant attachment to God and PTG.

## Demographics

Among the 345 participants surveyed via MTurk and Cloud Research, 204 met the eligibility criteria for the current study. Of the initial gathered participants, 12 did not agree to the consent, 4 were not 18 years or older, 1 identified as an atheist, 1 identified as a Jehovah's Witness, 40 did not report experiencing sexual abuse before the age of 18 years old, 7 failed attention check question #1 ("Please answer yes to this question"), 21 failed attention check question #2 ("Please select 'never true of me' for this question"), 20 failed to answer attention check question #3 ("Please select '1' to this question"), 11 failed to answer attention check

question #4 ("Please answer no to this question"), and 24 failed to answer attention check question #5 ("Please answer '5 = I experienced this change to a very great degree as a result of my crisis'").

All participants used in the study completed the measures in their entirety. The participants included 204 ($N = 204$) individuals above 18 years old (115 female, 89 male). The ethnicity breakdown of the participants revealed it to be 78.9% White, 8.3% Black, 5.4% Hispanic, 3.9% Native American, .5% Asian American, .5% Arab American, 2% Multiracial, and .5% other. All participants identified as Christian, with over half classifying themselves as Catholic (59.3%), with the remaining distributions representing Baptists (6.9%), Lutheran (.5%), Methodist (.5%), Presbyterian (.5%), Church of Christ (16.7%), Pentecostal (2.0%), Nondenominational (9.8.%), Evangelical (2.0%), and other (1.5%). Over half of the sample reported being married (67.6%), with the additional participants identifying as single (25.5%), divorced (3.9%), separated (1%), widowed (1%), and other (1%). Furthermore, most of the sample reported being a college graduate (61.3%), with the remaining participants identifying as having some postgraduate work (5.4%), postgraduate work (6.4%), some college (16.2%), trade or vocational training (2.0%), and a high school graduate (8.8%). Lastly, the sample was asked to categorize the type of sexual abuse they experienced before the age of 18 years old. Participants' responses indicated 68.6% experienced fondling or rubbing in private areas of the body, 29.9% penetration (i.e., vaginal, anal, objects or fingers), 29.9% oral sex, 14.2% sex trafficking, 23.5% exposure to sexually explicit images, and 1% other. Some participants reported experiencing multiple types of sexual abuse throughout childhood.

## Statistical Analyses

### *Pearson Correlations*

Pearson correlation analyses and descriptive statistics were gathered and included in Table 2. The results of the analyses revealed multiple significant small to large effect sizes (.10 = small, .30 = medium, and .50 = large; Cohen, 1992). Specifically, avoidant attachment to God was moderately and positively associated with trauma symptoms and PTG. Avoidant attachment to God was weakly and negatively correlated with surrender to God. Anxious attachment to God was weakly and positively associated with surrender to God and moderately and positively correlated with PTG and trauma symptoms. Trauma symptoms were also weakly and positively associated with surrender to God and moderately and positively correlated with PTG.

### *Mediation Analyses*

The study assessed the mediating role of surrender to God in explaining the relationship between anxious and avoidant attachment to God and PTG. Mediation analyses were conducted using PROCESS v4.0 macro model 4 via SPSS (Hayes, 2022). Before the analyses were run, the confidence interval (CI) was set at 95% to assess the indirect effects of the variables. Two separate mediation analyses were conducted and used anxious and avoidant attachment to God as separate variables. Results are presented in Figures 3 and 4. Anxious attachment to God was used as the independent variable, PTG was the dependent variable, and surrender to God was the mediator. Similarly, a second mediation analysis was run using an avoidant attachment to God as the independent variable, PTG as the dependent variable, and surrender as the mediator.

The first analysis concluded that anxious attachment to God was significantly associated with surrender to God ($b$ = .161, $SE$ = .039, $t(202) = 4.08$, $p$ = .001, $R^2$ =.01) and surrender to God was associated with PTG ($b$ = .304, $p$ = .000). Furthermore, the results suggested a possible

mediation relationship between anxious attachment to God and PTG ($b$ = .0049, $SE$ = .0023, CI [.0010, .0097]). The second analysis concluded that avoidant attachment to God was not significantly associated with surrender to God ($b$ = -.0110, $SE$ = .064, $t$(198) = -.172, $p$ = .863, $R^2$ =.00), but surrender to God was associated with PTG ($b$ = .037, $p$ = .000). In contrast, surrender to God ($b$ = .037, $SE$ = .006, $t$(198) = 5.36 $p$ = .000) and avoidant attachment to God ($b$ = .049, $SE$ = .005, $t$(198) = 8.66, $p$ = .000) were related to PTG. Lastly, no mediation relationship existed between avoidant attachment to God, surrender to God, and PTG ($b$ = -..0004, $SE$ = .0029, CI [-.0055, .0057]).

# CHAPTER 5

# DISCUSSION

The current study contributed to the growing psychological literature on the impact childhood sexual abuse may have on attachment to God, development of PTG, and trauma symptoms. Among 204 self-identified Christians with a history of childhood sexual abuse, the study examined the relationships between insecure attachment to God (anxious and avoidant), PTG, surrender to God, and trauma symptoms. A mediation analysis was conducted to test whether surrender to God mediates the relationships between avoidant and anxious attachment to God and PTG. The results of the study found partial support for the hypotheses.

## Anxious Attachment to God

Although the results were inconsistent with the hypotheses, they were consistent with some literature highlighting anxious attachment to God was positively correlated with surrender to God and PTG (Bock et al., 2018). Surrender to God mediated the relationship between anxious attachment to God and PTG. Interestingly, anxious attachment to God was also positively correlated with trauma symptoms. However, the current study's results contrasted with the initial hypotheses, suggesting Christians with higher attachment anxiety may turn to God for religious coping (surrender to God) and, as a response, engage in PTG. Anxiously attached individuals may exacerbate negative emotions via worry, rumination, and criticism (Cassidy, 1994). The current study may highlight an anxiously attached individual's tendency to intensify their symptoms or distress. Those with an anxious attachment to God demonstrate a fear of abandonment and a preoccupation with one's relationship with God (Beck & McDonald, 2004). This fear of abandonment by God may lead anxiously attached individuals to surrender to God to internally soothe the preoccupation and worry about their relationship with God. Anxiously

attached individuals may demonstrate an extrinsic motivation to engage in surrendering to God to achieve personal gain (Schaefer & Gorsuch, 1991). In other words, anxiously attached individuals may passively surrender to God in an attempt to alleviate their uneasiness around their relationship with God, rather than assertively giving control of their lives to God as defined by surrender to God.

It is also possible that those with anxious attachment styles can access and utilize positive religious coping skills in times of need. Prior research suggests that those with anxious or "preoccupied" attachment styles may be more likely to engage in religious coping mechanisms and take an active role in their faith when compared to avoidant attachment styles. An anxiously attached individual may be likely to practice surrender to God due to their assumption and perception that God is accessible rather than distant (Cooper et al., 2009). The anxiously attached Christian may simultaneously convey surrender to God as an adaptive coping skill while experiencing anxiety about their relationship with God. For example, according to the biblical text and the Christian tradition, anxious feelings and surrender to God occurring simultaneously is not new. Psalms 139:23-24 described King David crying out to God saying,
“Search me, O God, and know my heart! Try me and know my thoughts! And see if there be any grievous way in me and lead me in the way everlasting!” (*English Standard Version Bible*, Psalm 139:23-24). The verses represent the anxious individual seeking reassurance through their relationship with God and an attempt to soothe their anxieties via God and surrender.

The results of the current study indicate that anxious attachment to God, surrender to God, and trauma symptoms were positively associated with PTG. PTG has been described by Calhoun and Tedeschi (1996) as an individual's ability to reach positive change and significance following a traumatic event. The results of the current study contrasted with prior research that

included variables such as preoccupation with and rumination of a traumatic event negatively impacting PTG (Calhoun et al., 2000). While rumination on negative experiences may hinder PTG, reassessing negative thoughts can eventually lead to PTG through an individual's attempt to reexamine the traumatic event (Brooks et al., 2019). Based on the characteristics of anxious attachment to God, anxiously attached participants may experience the positive outcome of PTG and acknowledge the intensity of their trauma symptoms rather than avoid them. Similar to previous research, those with an anxious attachment to God may view their suffering as having meaning rather than viewing their trauma symptoms as negative (Bock et al., 2018).

The current study identified possible mediation, suggesting that surrender to God may help to explain the relationship between anxious attachment to God and PTG. Little research examines the relationship and impact of surrender to God on PTG and attachment to God. The results suggest that mediation may account for the possibility of anxiously attached participants reassessing their traumatic experiences through intrusive thoughts (Brooks et al., 2019). The results may reflect an anxiously attached individual's process of continuing to experience PTG via rumination and intrusive thinking while actively surrendering their will to God in an adaptive manner. Specifically, the anxious subscale of the AGI reflects a preoccupation, worry, fear of unacceptance of God, and jealousy of others' perceived closeness with God (Beck & McDonald, 2004). In comparison, the PTGI-X factor IV, spiritual and existential change, describes a general "clarity about life's meaning" and comfortability of facing "questions about life and death" (Tedeschi et al., 2017). PTG's spiritual and existential change factor depicts an individual's ability to be comfortable with the unknown of life and lean into one's religious faith. Similarly, individuals with anxious attachments to God may connect to PTG's focus on life and death, including concentrating on their faith. The PTGI-X does not measure whether the disclosure of

adhering to a stronger religious faith and pondering questions about life and death indicates a more anxious attachment to God or elicits anxiety in its participants.

For example, the AGI includes items such as "I worry a lot about damaging my relationship with God," depicting an anxiously attached Christian's fear of injuring their relationship with God. In the current study, it is possible Christians who were anxiously attached to God strongly identify with the tenets of PTG, including feeling connected to their faith and meaning-making, but continue to worry about how God perceives them or are preoccupied with doing "good" to please God, including responding to the PTGI-X in a way that reflects their need for acceptance and closeness with God. Additionally, surrender to God may reflect a similar process of seeking meaning by entirely depending on God but may fail to capture if surrender is an anxious response to gain favor in a Christian's relationship with God.

The Surrender Scale includes items such as "Although I may not see results from my labor, I will continue to implement God's plans as long as God directs me to do so." Anxiously attached Christians may use surrender to cope with CSA and still maintain a preoccupation with receiving reassurance from God. As mentioned before, anxious attachment to God may leave space for Christians to contemplate the factors of PTG that lead to eventual growth by reassessing trauma, specifically using religious coping mechanisms such as surrender to God.

**Avoidant Attachment to God**

In contrast with the hypothesis, the current study found that avoidant attachment to God positively correlated with PTG and trauma symptoms, differing from past research (Bock et al., 2018; Murphy et al., 2016). In other words, avoidantly attached participants reported higher levels of PTG and more trauma symptoms following the experience of childhood sexual abuse. Prior psychological research suggested that PTG does not indicate a lack or erasure of trauma

symptoms; instead, it is a complex relationship between trauma and recovery (Tedeschi & Calhoun, 2007). The complexity of trauma symptoms, PTG, and avoidant attachment to God may explain the results concluding that PTG is positively associated with avoidant attachment to God.

In the current study, surrender to God did not mediate the relationship between an avoidant attachment to God and PTG. Instead, the study concluded there was a negative association between surrender to God and avoidant attachment to God. Prior psychological literature indicates that those with avoidant attachment styles appear more vulnerable to developing posttraumatic stress symptoms than those with anxious or secure attachment styles, contrasting with the current study's results (Murphy et al., 2016). Avoidantly attached individuals may adopt maladaptive coping styles and mechanisms, ultimately sustaining trauma symptoms and inhibiting healing (Brooks et al., 2019).

In general, an individual with an avoidant attachment to God may struggle to depend on God, require self-reliance, and have the unwillingness to be emotionally vulnerable with God (Beck & McDonald, 2004). The characteristics of an avoidant attachment to God may explain the negative relationship between avoidant attachment to God and surrender to God. Surrendering to God requires an assertive and intentional abdicating of control to God (Wong-McDonald & Gorsuch, 2000), contrasting with avoidance coping styles. Individuals with CSA in their background and an avoidant attachment may demonstrate difficulties trusting others or engaging in social isolation (Briere, 1989; Kobak & Sceery, 1988; Wooley & Vigilanti, 1984). The current study's results may reflect the avoidantly attached individual's tendency to minimize and avoid expressing emotions, leading to the appearance of growth following trauma, despite

the participants demonstrating a maladaptive attachment style (Alexander, 1992; Aspelmeier et al., 2007).

The utilization of surrender to God as a coping skill is connected to spiritual well-being and adaptive coping efforts (Clements & Ermakova, 2012). Similarly, avoidant attachment to God depicts a general unwillingness to depend on God, suggesting difficulty for avoidantly attached participants to assertively give control to God in times of distress (Beck & McDonald, 2004). In general, surrendering to God as a coping skill requires individuals to collaborate with God and to allow God to intervene in their distress. This action may prove inherently difficult to an individual with an avoidant attachment to God.

The current study indicated that avoidant attachment to God was positively associated with trauma symptoms and PTG. Surrender to God did not mediate the relationship between avoidant attachment to God and PTG. Prior psychological research indicated that when PTG is not developed correctly following a traumatic event, it may encourage detachment rather than viewing the negative experience as an opportunity for positive change. Lahav and Spiegel (2020) suggested that if individuals are detached from their trauma and cannot achieve positive change following trauma, they may not have experienced PTG; instead, they may not have processed their trauma appropriately. Previous psychological research also indicates that childhood trauma survivors make greater use of avoidance coping (Simons et al., 2003), which may be used as a survival strategy to maintain a relationship with an abusive caregiver (Freyd, 1996).

In contrast with prior studies using an avoidant attachment, the current study indicated that avoidant attachment to God was positively correlated with PTG (Yu et al., 2016). In preceding psychological literature, avoidant attachment hinders the development and experience of PTG (Yu et al., 2016). While avoidantly attached individuals may isolate themselves from

support and use maladaptive coping skills, the current study may reflect a theological underpinning. The results do not illuminate the participants' perceptions of God, religious socialization, and conceptions of God (Smith & Cooperman, 2016).

In other words, avoidantly attached participants may not have been socialized to need to believe in a "close" or proximal relationship with God. Instead, for some Christians, avoidant attachment to God may not necessarily reflect an emotionally invulnerable relationship with God; instead, they may not find it helpful or essential to cultivate a close relationship with God to maintain spiritual well-being (Henderson & Kent, 2022).This understanding of closeness with God may explain the positive association between avoidant attachment to God and PTG (Henderson & Kent, 2022). Similarly, the result of surrendering to God, failing to mediate the relationship between avoidant attachment and PTG, may also be explained by a distal conception of God or mixed results of legitimate emotional avoidance of God and an understanding that God does not need to be close.

The current study indicated that, in avoidantly attached participants, surrender to God was positively correlated with PTG. The Surrender Scale's items contain statements reflecting finding meaning in hard times through God, choosing God's plan or solution when in distress, and finding hope by following God's way. The premise of surrender to God contrasts with the characteristics of an avoidant attachment to God in that it requires Christians to adhere to God's plan assertively and willingly. PTG's tenets, such as the "personal strength" and "relating to others" factors, may relate to surrender to God in that it highlights an individual's ability to rely on others in times of need and accept the result of events rather than avoid it. Surrendering to God may encourage and foster Christian survivors of CSA to adhere to the tenets of PTG and, ultimately, find meaning from their trauma.

## Clinical Implications

The results of the current study have implications for clinical settings and psychologists working with Christian clients with backgrounds of CSA. Specifically, clinicians working with Christian clients who may demonstrate an avoidant attachment to God may require further exploration of the client's religious socialization and perception/need for closeness to God. As the results of the study show, those with an avoidant attachment to God may require further intervention and assistance in processing their trauma related to CSA. Similarly, a low surrender to God score may serve as a risk factor or screener to identify possible avoidant tendencies or maladaptive coping strategies in Christian clients.

Avoidantly attached clients may struggle to emotionally engage in therapy, which may lead to poorer outcomes following therapy. Avoidant clients may also reject therapeutic interventions that are perceived to be emotionally overwhelming or require emotional disclosure. Due to this, clinicians may fail to properly challenge the avoidant client's defenses (Mikulincer et al., 2012). Specifically, avoidantly attached Christians may require intervention to turn outward and allow God into their lives, rather than turning inward and focusing on the self. Avoidantly attached Christians may require interventions that challenge their tendency to withdraw to the self and disallow a relationship or attachment with God. They may need guidance to begin to slowly invite God into a relationship with them. Avoidant patterns of attachment towards others and God can be challenged via the therapeutic relationship by employing corrective attachment experiences meant to move an avoidantly attached individual towards a more secure way of relating to others and God (Mikulincer et al., 2012).

The current study's results also affect those with anxious attachments to God. If those with anxious attachments to God continue to experience trauma symptoms while simultaneously

maintaining PTG, other variables that the current study did not include, such as intrusive thinking or rumination, may significantly impact growth following trauma. The results also indicate that while anxious attachment to God may suggest individuals fear abandonment and fixate on their relationship with God (Beck & McDonald, 2004), it may not necessarily inhibit the ability to reach PTG following CSA. Furthermore, religious coping skills such as surrender to God may be beneficial when working with Christian clients, particularly those who identify as anxiously attached to God.

Surrender to God may be helpful when working with anxiously attached Christians due to their willingness to engage in positive religious coping skills in times of distress (Cooper et al., 2009). Although anxiously attached Christians may be inclined to utilize positive religious coping skills, it is important for clinicians to understand and identify when skills such as surrender are being used incorrectly. A secure and assertive surrender to God describes a collaborative, trusting, and confident submission to God's will. In contrast, an insecure surrender to God includes a passive preoccupation with letting go of one's control in an attempt to alleviate internal distress or anxiety about one's perceived closeness or relationship with God. Clinicians attempting to decipher between secure and insecure expressions of surrender to God should seek clarification of their client's motivation to surrender to God.

Similar to avoidant attachment, anxious attachment can be challenged and reorientated through corrective attachment experiences within the therapeutic relationship (Mikulincer et al., 2012). Clinicians working with clients with anxious attachments must be mindful of demonstrating consistency and reliability as the therapist. In contrast with the avoidantly attached client's refusal to engage in emotional exploration, the anxiously attached client may need assistance in adopting and learning cognitive skills to avoid intensifying their tendency to

perseverate on past traumatic experiences (Berry & Danquah, 2015). Working with a Christian's anxious attachment to God entails tailoring interventions to encourage looking outward rather than focusing on the self. This encouragement to look outside of the self may challenge the anxiously attached Christian's tendency to worry and focus on their relationship with God. Rather than preoccupy the self with one's standing with God, an anxious Christian can begin to turn outward, focusing on living in a collaborative relationship with God.

**Limitations**

The current study has limitations, which should be considered when interpreting results. The present study relied on self-report measures and data, leaving room for response bias and under- and over-reporting symptoms. The study's limited sample size to Christian adults with a CSA background restricts the findings' generalizability to other populations and religious groups. Similarly, the current study utilized the Attachment to God Inventory, whose measure was primarily normed on Christians. The present study's demographics revealed that the majority were Catholics rather than Protestants, relative to the normative sample in how the current study's participants may have answered the measure.

Furthermore, the current study did not control for demographic variables in both mediation models, which may have impacted results. Specifically, the study did not control for gender differences despite prior research suggesting gender may impact development of trauma symptoms following abuse (Breslau, 2009; Tolin & Foa, 2008). Lastly, while the current study concluded that surrender to God mediated the relationship between anxious attachment to God and PTG, no mediation relationship was found between avoidant attachment to God and PTG. Instead, several of the results concluded opposite relationships than what was initially proposed in the hypotheses. These results suggested other variables may be involved with or account for

the relationship between avoidant attachment to God and PTG, such as coping styles, demographic variables, religious socialization, etc. Likewise, the current study collected a sample of primarily Caucasian participants, limiting the generalizability to other demographic groups.

**Future Research Directions**

Future research should determine the number of CSA experiences and if the type of CSA impacts attachment to God. The current study outlined multiple types of CSA. Still, it did not utilize the results to determine if the type of CSA or relationship to the perpetrator would impact attachment style to God. Furthermore, further exploration of CSA within church settings or by church leaders should be studied as to its impact on attachment to God. The violation of trust and relationship between a church leader and child may have an additional negative psychological impact.

Due to religious socialization's impact on avoidant attachment to God, future research should explore the importance and need for perceived "closeness" of God for Christians. The avoidant attachment to God subscale may not capture the lack of inherent need or want for a close relationship with God. Further research would better illuminate the nuanced features of avoidant attachment to God. Furthermore, most participants were Catholic, highlighting a possible need for further investigation into any unique aspects of Catholicism versus Protestantism when measuring attachment to God. While both Catholicism and Protestantism adhere to many of the same core tenets of Christianity, the historical backgrounds and traditions of each branch or denomination of Christianity are inherently different. Protestants and Catholics may differ on how they perceive their salvation, including whether or not good deeds and church teachings or traditions are needed to attain salvation from God (Pew Research, 2017). In 2017,

Pew Research suggested Catholics believed in the need for additional church teachings, traditions, and church guidance alongside the usage of the Bible to attain salvation, whereas Protestants were split on this issue. The differences, traditions, and perceptions of how salvation is attained may impact how a participant responds when reflecting on their attachment to God.

Additionally, further research should examine how surrender to God and other religious coping skills relate to and impact the different tenets of PTG. Surrender to God was positively associated with anxious attachment to God and PTG, suggesting a possible unique variable connecting them. PTG's multidimensional tenets may highlight different aspects of religious coping that may benefit individuals with an anxious attachment to God. Lastly, although beyond the scope of this study, future research should continue to research attachment to God within different religious belief systems.

**Conclusion**

In conclusion, this study contributes to the current literature by providing insight into the unique relationships between anxious and avoidant attachment to God, PTG, surrender to God, and trauma symptoms in Christian adult survivors of CSA. Surrender to God mediated the relationship between anxious attachment to God and PTG. In contrast, surrender to God did not mediate the relationship between avoidant attachment to God and PTG. However, other factors such as religious socialization and perception of the relationship with God may impact how individuals who are avoidantly attached to God view their relationship and distress. The unique characteristics of avoidant and anxious attachment to God and the negative psychological impact of CSA encourage the need for future research into this population.

**Figure 1**

*The Theoretical Model for the Relationship Between Anxious Attachment to God and Posttraumatic Growth, Mediated by Surrender to God*

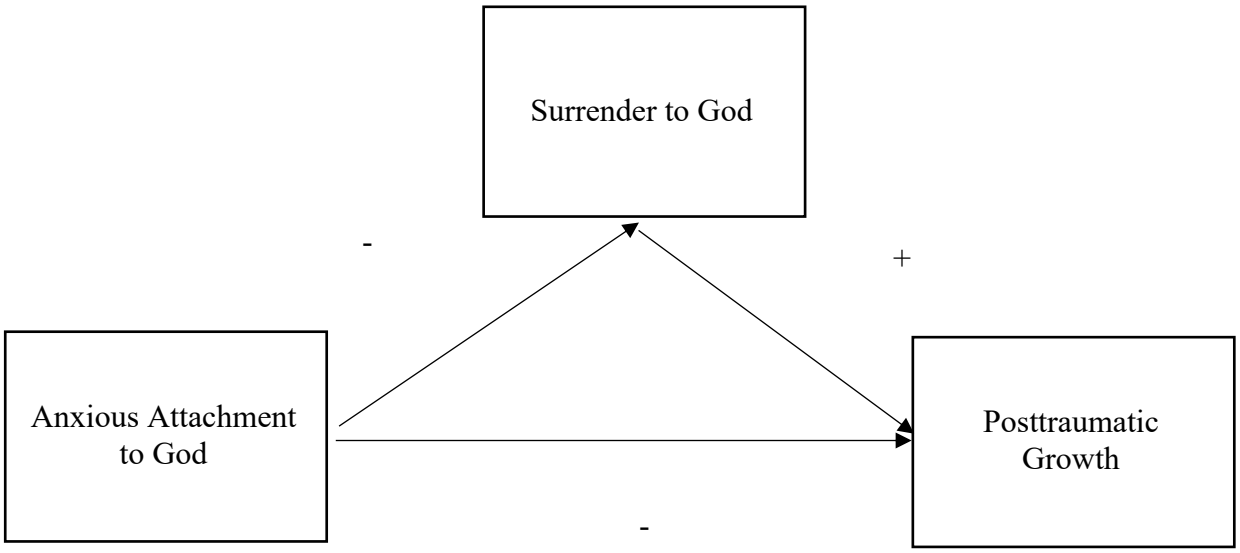


**Figure 2**

*The Theoretical Model for the Relationship Between Avoidant Attachment to God and Posttraumatic Growth, Mediated by Surrender to God*

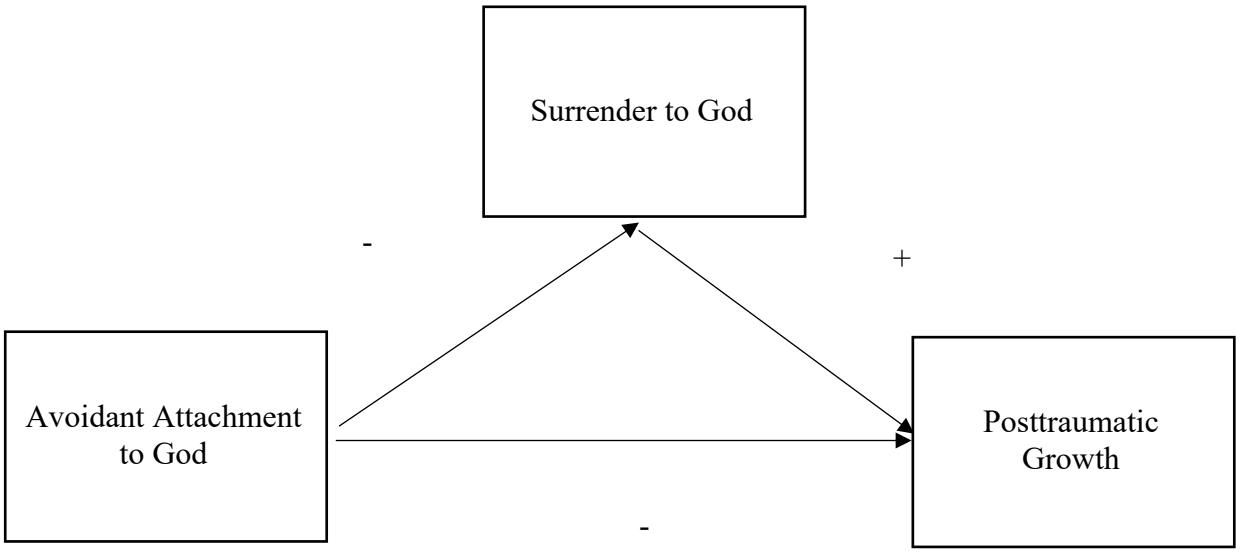
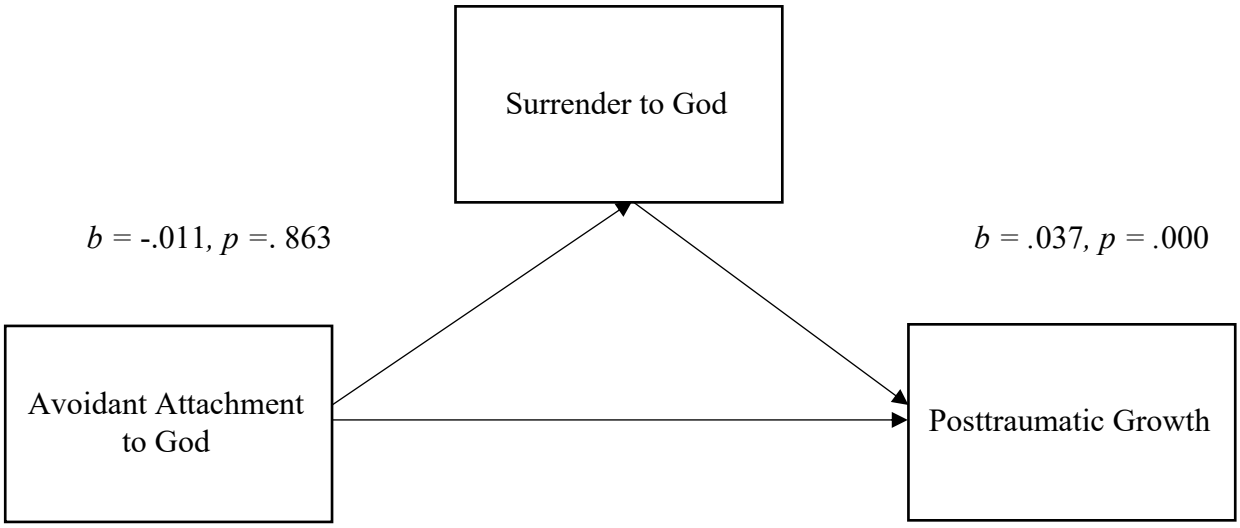


**Figure 3**

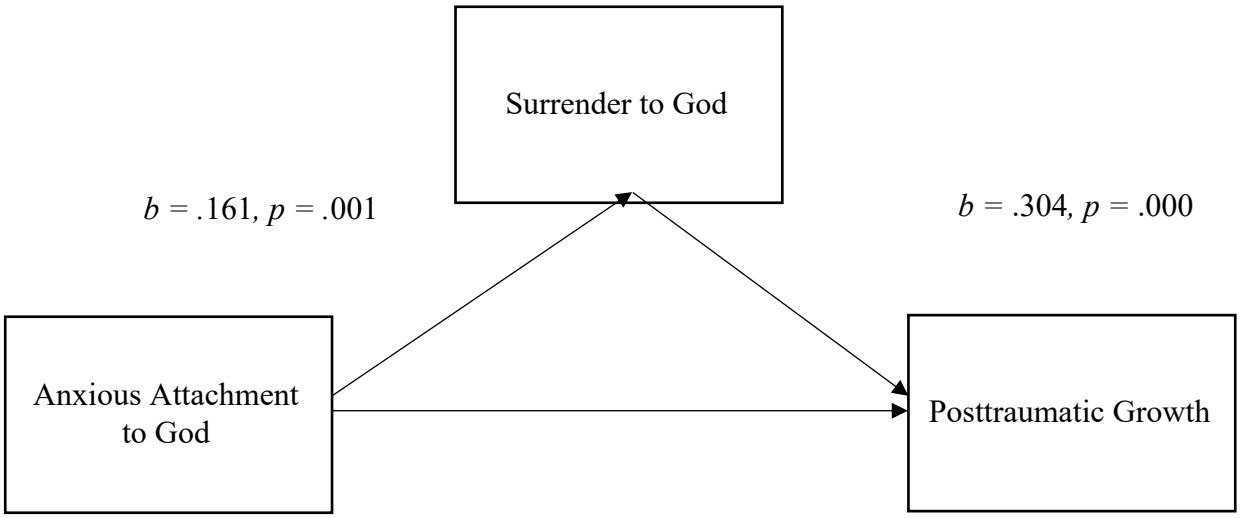
*Relationship Between Avoidant Attachment to God and Posttraumatic Growth, Mediated by Surrender to God*




*Note.* $N$ = 201. The CI is based on 5,000 bootstrap samples. $b$= unstandardized regression coefficient. CI = confidence interval.

**Figure 4**

*Relationship Between Anxious Attachment to God and Posttraumatic Growth, Mediated by Surrender to God*




Direct effect, $b = 0.03$, $p = .02$
Indirect effect, $b = .0049$, 95% CI [0.0010, .0097]

*Note.* $N = 204$. The CI is based on 5,000 bootstrap samples. *b*= unstandardized regression coefficient. *CI* = confidence interval.

**Table 1**

*Demographic Characteristics*

| Variable ($N$ = 204) | |
|---|---|
| Education (%) | |
| High school graduate | 8.8% |
| Some college | 16.2% |
| Trade/technical/vocational training | 2.0% |
| College graduate | 61.3% |
| Some postgraduate work | 5.4% |
| Postgraduate work | 6.4% |
| Gender (%) | |
| Male | 43.6% |
| Female | 56.4% |
| Other | .5% |
| Marital status (%) | |
| Married | 67.6% |
| Single | 25.5% |
| Divorced | 3.9% |
| Widowed | 1.0% |
| Separated | 1.0% |
| Other | 1.0% |
| Ethnicity (%) | |
| Black | 8.3% |
| White | 78.9% |
| Hispanic | 5.4% |
| Native American | 3.9% |
| Asian American | .5% |
| Arab American | .5% |
| Multiracial | 2.0% |
| Other | .5% |
| Denominational affiliation (%) | |
| Catholic | 59.3% |
| Baptist | 6.9% |
| Lutheran | 0.5% |
| Methodist | 1.0% |
| Presbyterian | 0.5% |
| Church of Christ | 16.7% |
| Pentecostal | 2.0% |
| Nondenominational | 9.8% |
| Evangelical | 2.0% |
| Seventh-Day Adventist | 2.0% |
| Other | 1.5% |
| Sexual abuse type before the age of 18 years [a] | |
| Fondling/kissing of private areas | 68.6% |

| | |
|---|---|
| Penetration | 29.9 % |
| Oral Sex | 29.9% |
| Sex Trafficking | 14.2 % |
| Exposure to sexually explicit images | 23.5% |

[a] Some respondents experienced multiple types of sexual abuse.

**Table 2**

*Correlations, Means, and Standard Deviations of Variables*

| Variable | 1 | 2 | 3 | 4 | 5 | *M* | *SD* | α |
|---|---|---|---|---|---|---|---|---|
| 1. TSCL | – | .43** | .52** | .20** | .43** | 62.1 | 25.1 | .96 |
| 2. AGI AV | – | – | .60** | -.012 | .46** | 51.4 | 10.0 | .77 |
| 3. AGI AX | – | – | – | .28** | .51** | 63.3 | 16.2 | .92 |
| 4. SS | – | – | – | – | .38** | 39.9 | 9.5 | .91 |
| 5. PTGI-X | – | – | – | – | – | 3.9 | 1.1 | .97 |

*Note*. $N = 204$. * $p < .05$. ** $p < .01$. α = Cronbach's alpha coefficients. TSCL = Trauma Symptom Checklist-40; AGI AV = Attachment to God Avoidant; AGI AX = Attachment to God Anxious; Surrender to God= SS; PTGI-X = Posttraumatic Growth Inventory-X.

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# APPENDIX A

# MANUSCRIPT VERSION

**Posttraumatic Growth and Child Sexual Abuse Among Christian Adults: The Association Between God Attachment, Surrender, and Trauma Symptoms**

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ABSTRACT

Childhood sexual abuse (CSA) impacts an individual's future psychological development and is a predecessor for stress-related disorders, such as posttraumatic stress disorder (PTSD) (Hailes et al., 2019; McKay et al., 2020; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013). Drawing from several different bodies of literature (e.g., attachment theory, religious coping, posttraumatic growth), the study investigated whether attachment to God is related to posttraumatic growth (PTG) and trauma symptoms among a sample of Christian adults with a history of CSA. Further, the study examined if surrender to God as a form of religious coping mediates the relationship between attachment to God and PTG. Using an online sample of Christian adults from Amazon's MTurk who reported CSA, the study utilized Hayes' PROCESS macro to determine if a relationship exists between these variables (Hayes, 2022). The study concluded that surrender mediated the relationship between anxious attachment to God and PTG, and trauma symptoms positively correlated with anxious and avoidant attachment to God. However, no mediation relationship existed between avoidant attachment to God, PTG, and surrender to God. The results are discussed in the context of broader clinical implications for Christians and mental health professionals. Limitations and areas for further research will also be examined.

*Keywords*: child abuse, posttraumatic growth, attachment to God, attachment theory

## Posttraumatic Growth and Child Sexual Abuse Among Christian Adults: The Association Between God Attachment, Surrender, and Trauma Symptoms

### Introduction

Childhood trauma and maltreatment are experienced throughout the United States. The United States Department of Human Services reported that, in 2020, 618,399 cases of childhood maltreatment were reported to child services (Child Maltreatment Report, 2022). Within the scope of child maltreatment, childhood sexual abuse includes rape, pornography, exposure of genitals, incest, molestation, or sexually exploitative activity (Child Maltreatment Report, 2022). While the impact of childhood sexual trauma has been frequently researched (Hailes et al., 2019; McKay et al., 2020; Mueser et al., 1998; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013), few studies have been conducted on psychological growth following trauma in the context of religion and spirituality. The posttraumatic growth (PTG) literature has attempted to capture how trauma survivors psychologically grow from trauma. Yet, to date, little research has been conducted to determine the potential role spirituality plays in helping trauma survivors experience positive psychological change.

Childhood sexual trauma (CST) is a widespread problem, crossing international and cultural barriers (Collin-Vezina et al., 2013). Numerous studies within the CST literature reveal that survivors of CST are at risk for adverse psychological outcomes, including PTSD and mood disorders such as depression (McKay et al., 2020; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013). In addition, CST has explicitly been linked to higher reports of PTSD compared to trauma occurring in adulthood (McKay et al., 2020; Mueser et al., 1998) or other types of childhood abuse, such as physical abuse (Rodriguez et al., 1997).

In 2020, the United States Department of Health and Human Services reported 57,963 cases of child sexual abuse (CSA) throughout the United States (Child Maltreatment Report, 2022). Sexual assault is an enduring societal crisis that disproportionately affects women (CDC, 2022). The CDC reported that more than 1 in 3 women had experienced sexual violence, including forced physical contact, in their lives (CDC, 2022). In contrast, approximately 1 in 4 men have experienced sexual abuse (CDC, 2022). The United States Department of Justice reported that, in 2020, 108,881 reports of sexual assaults occurred, including rape, in individuals aged 12 years and older (United States Department of Justice, 2022).

The impact of childhood sexual abuse places trauma survivors at risk of experiencing future psychological and physical difficulties, such as depression, suicide, and substance use, in adulthood (Buzi et al., 2007; McLean et al., 2014). Some research suggests suicidality is related to the frequency of sexual abuse, meaning that chronic sexual abuse may be a risk factor for suicidality (McLean et al., 2014). While chronic sexual abuse may be associated with suicidality, the type of abuse (e.g., sexual abuse, rape, sexual assault), frequency of abuse, and perpetrator characteristics have not been linked to the severity of PTSD, depression, or substance use (McLean et al., 2014). Because of these consequences of childhood sexual abuse, there is a need to explore constructs that may influence favorable outcomes following trauma, such as posttraumatic growth, which is the purpose of this study.

### *Childhood Sexual Trauma and Posttraumatic Stress Disorder*

Numerous studies within the CST literature reveal that survivors of CST are at risk for adverse psychological outcomes, including PTSD and mood disorders such as depression (McKay et al., 2020; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013). In addition, CST has explicitly been linked to higher reports of PTSD compared to trauma occurring in

adulthood (McKay et al., 2020; Mueser et al., 1998) or other types of childhood abuse, such as physical abuse (Rodriguez et al., 1997). Notably, PTSD symptoms affect more women than men (Breslau, 2009; Tolin & Foa, 2008), regardless of trauma type (Brewin & Valentine, 2000).

Research consistently supports the understanding that CSA negatively affects mental health and psychological adjustment into adulthood (McKay et al., 2020; Mueser et al., 1998; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013). Specifically, CSA survivors are at significantly higher risk of developing mental health issues, such as mood disorders, anxiety disorders, suicide risk, and PTSD (McKay et al., 2020; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013). While the impact of CSA on many psychological outcomes is known, additional research is needed to more fully capture the range of processes that occur following trauma, which includes PTG.

**Posttraumatic Growth**

PTG, as defined by Tedeschi and Calhoun (1996), is a dynamic and constant process that highlights an individual's ability to reach positive change and find significance or meaning following a traumatic event. PTG involves five processes that occur after a traumatic life event. These processes include new possibilities, relating to others, personal strength, appreciation for life, and spiritual change (Tedeschi & Calhoun, 1996).

The first process, new possibilities, describes an individual's belief that they can do better or find new opportunities after a traumatic event (Tedeschi & Calhoun, 1996). These new possibilities establish a framework for an individual's ability to accept change and be willing to explore new opportunities in their life (Tedeschi & Calhoun, 1996). Second, traumatic events can change a survivor's perspective on relationships (Tedeschi & Calhoun, 1996). PTG creates space for survivors to appreciate their relationships more than before or seek new relationships that

offer support, safety, and sensitivity to their needs (Tedeschi & Calhoun, 1996). Third, according to PTG, personal strength is the feeling of self-reliance or the individual believing they can handle future difficulties (Tedeschi & Calhoun, 1996). The survivor may conclude they are stronger than they previously thought. Fourth, an appreciation for life following trauma characterizes a new recognition of essential priorities and acknowledging the value of the individual's life (Tedeschi & Calhoun, 1996). Lastly, spiritual change includes strengthening religious faith and understanding spirituality after trauma (Tedeschi & Calhoun, 1996). These core components of PTG describe the complex process that trauma victims may experience.

Furthermore, PTG is described as a constantly changing process rather than a static moment or occurrence (Tedeschi & Calhoun, 2004). Fostering the development of PTG includes different cognitive strategies that assist in rebuilding and adapting to the world after trauma (Greenberg, 1995). For PTG to grow, a continuation and development of cognitive processes, such as rumination and challenging core beliefs, is needed (Calhoun et al., 2000; Tedeschi & Calhoun, 1995). Research suggests that rumination may assist an individual in making sense of or analyzing their experience after trauma, leading to the eventual growth of PTG (Calhoun et al., 2000; Tedeschi & Calhoun, 1995). Although rumination may be helpful, negative rumination may inhibit growth and cause the individual to feel "stuck" (Calhoun et al., 2000; Tedeschi & Calhoun, 1995).

Similarly, Triplett et al. (2007) suggested that challenges to an individual's perceived world that led to deliberate rumination or cognitive restructuring are more likely to result in growth following a traumatic event. The PTG literature continuously indicates the influence cognitive processes may have on PTG development (Cann et al., 2010; Lindstrom et al., 2013;

Triplett et al., 2007), but little research explicitly examines the cognitive processes behind the spiritual construct of PTG. To better understand the relationship between PTG and spiritual functioning, Calhoun and colleagues (2000) researched the possible link between posttraumatic growth and religious and cognitive processing. The researchers examined religious variables included on the Quest Scale (e.g., the readiness to face existential questions, self-criticism and perception of doubt as positive, and openness to religious change). Results indicated an association between event-related rumination or being preoccupied with a negative experience and the amount of PTG reported by participants (Calhoun et al., 2000). Participants who reported higher levels of intrusive and negative ruminating thoughts also showed lower levels of PTG and higher levels of distress (Calhoun et al., 2000). The level of religious participation after a traumatic event did not predict growth; instead, general openness to religious change was predictive of the growth reported, consistent with PTG's new possibilities dimension (Calhoun et al., 2000). Trauma survivors may use various cognitive strategies following trauma beyond religious participation and rumination.

### *Posttraumatic Growth and Trauma*

The development of PTG may occur following a traumatic experience and requires the survivor to grow and adapt to their world post-trauma. PTG occurs after various distressful and negative experiences (Greenberg, 2015; Tedeschi & Calhoun, 1996). In a systematic review of PTG in trauma survivors, Wu and colleagues (2019) found that specific demographics impact the development of moderate to high posttraumatic growth development. The meta-analysis included men, women, adults, and children with many traumatic experiences, including cancer, natural disasters, special profession trauma (e.g., law enforcement), chronic disease, sexual abuse, and only-child-lost parents (Wu et al., 2019). The study revealed that women under 60 who

experienced trauma within the last six months or less and worked in certain professions reported moderate to high levels of PTG (Wu et al., 2019). Notably, the study suggested that demographic variables may account for differences and development in PTG among trauma survivors (Wu et al., 2019).

Similarly, Shakespeare-Find and Lurie-Beck (2014) completed a meta-analysis to determine the relationship between PTSD symptoms and perceived PTG. Their results suggested that the nature of the trauma and the victim's age impact the relationship between PTSD and PTG. Importantly, their analyses revealed a stronger correlation between PTSD and PTG among survivors of natural disasters or conflict zones rather than survivors of sexual assault (Shakespeare-Find & Lurie-Beck, 2014). The relationships between variables were weak, suggesting other factors may play a more significant part in trauma survivors attaining PTG following sexual trauma, such as demographic variables (Shakespeare-Find & Lurie-Beck, 2014).

In sum, PTG details the positive cognitive restructuring and development that may occur following a traumatic event (Tedeschi & Calhoun, 1996, 2004). Demographic factors and social support systems significantly impact PTG and whether trauma survivors can cognitively reach growth following their adverse life experiences (Kaye-Tzadok & Davidson-Arad, 2016; Schaefer et al., 2018). PTG is a powerful outcome for change and growth following a traumatic event. However, various factors influence an individual's ability to achieve PTG. One of these factors may be an individual's attachment to their caregivers and others.

**Attachment Theory**

John Bowlby developed attachment theory to explain personality and psychopathology development through the parent-child relationship (Bowlby, 1982, 1973). Bowlby hypothesized

that all children are born with an attachment behavioral system, an internal psychobiological structure that encourages children to seek proximal support from others or attachment figures (Bowlby, 1982). Attachment figures are used as protectors from threats, promoting self-efficacy and emotional regulation tools (Bowlby, 1982).

Attachment theory states that caregivers must acknowledge the needs of their children through safety and consistency while promoting their autonomy (Bowlby, 1982). Relationships with caregivers influence a child's future relationships and development and continue into adulthood (Ainsworth, 1985; Bowlby, 1980). Children develop their internal working models, or their mental representation of their caregivers and themselves, based on their early experiences with their caregivers or parents (Ainsworth, 1985). A faulty internal working model may make children vulnerable to developing maladaptive attachment styles in their current and future relationships (Ainsworth, 1985).

Mary Ainsworth (1985) theorized at least three subtypes of attachment styles in infants: secure, insecure-avoidant, and insecure-ambivalent/resistant. (Ainsworth, 1985). The securely attached child views their parental figure as dependable, responsive, and accessible to their needs (Ainsworth, 1985). The securely attached child can establish a secure base with their parent and feel safe enough to explore their environment (Ainsworth, 1985; Bowlby, 1980). A securely attached child can apply their positive and healthy internal working model to future and new relationships that they develop (Ainsworth, 1985). An insecure-avoidant attached child shows little concern when their caregiver is separated from them. The child may avoid interacting with their caregiver and show no response when reunited with their caretaker following a separation (Ainsworth, 1985).

On the other hand, an insecure-ambivalent/resistant attached child presents complex and contradictory behaviors toward the child's caregivers (Ainsworth, 1985). A child displaying an insecure-ambivalent/resistant attachment has created an internal working model labeling their parent or caregiver as erratic and not consistently responsive to their needs (Ainsworth, 1985). An ambivalent/resistant attached child may display apprehension and fear when their caregiver is out of sight due to the parent's inconsistency in returning or responding to their needs (Ainsworth, 1985).

Attachment styles may have a moderating effect on survivors of childhood sexual abuse. Alexander (1992) suggested that anxiously attached children may be at a higher risk of experiencing anxiety and depression due to their tendency to ruminate on negative emotions. They may also be targeted for further victimization by other children. In contrast, avoidantly attached children may simultaneously depend on others and experience distrust of others (Alexander, 1992). They may employ minimizing and avoid expressing emotions, leading to higher levels of substance abuse later in life (Alexander, 1992; Aspelmeier et al., 2007).

**Insecure Attachment and Trauma**

Multiple traumatic experiences in childhood may lead to insecure attachments, causing self-blame, low self-efficacy, and negative expectations of others (Liem & Boudewyn, 1999). Insecure attachments, such as disorganized attachment styles, which inconsistent and possibly dangerous caregivers characterize, place the child at a higher risk of developing anxiety (Ainsworth, 1985).

While it is clear childhood abuse negatively impacts attachments to caregivers, Alexander (1992) examined the applicability of attachment theory to specifically CSA. CSA may cause different interpersonal issues for avoidant and anxious attachment styles. Avoidant attachment

styles may appear as an inability to trust others or as social isolation (Briere, 1989; Kobak & Sceery, 1988; Wooley & Vigilanti, 1984). In contrast, anxious attachment styles manifest negative self-image and desperation for love (Feeney & Noller, 1990; Troy & Sroufe, 1987). Additionally, CSA victims may experience relational distortions with their children, possibly continuing their insecure attachment styles within their families and into adulthood (Alexander, 1992; Roche et al., 1999).

In fact, Liem and Boudewyn (1999) reviewed the effects of childhood sexual abuse on adult social functioning. They concluded that traumatic events in childhood are related to future maltreatment from others as adults. Adults with a history of childhood sexual abuse may tolerate more significant abuse in adult relationships than adults without a history of childhood sexual abuse (Liem & Boudewyn, 1999). The researchers also indicated that self-blame, hostility, and paranoia predicted the need to control others, suggesting that childhood trauma follows survivors into adult relationships (Liem & Boudewyn, 1999).

Likewise, Roche and colleagues (1999) suggested that adult attachment style and overall adult psychological adjustment are related to CSA. Their analysis concluded that CSA did not predict psychological adjustment independent of the individual's attachment style, implying that attachment style and psychological functioning are intertwined (Roche et al., 1999). Furthermore, women who experienced CSA were generally more fearful and less secure than adults (Roche et al., 1999). Specifically, women who experienced sexual abuse within their families experienced more psychological problems than those suffering from abuse outside of the family (Roche et al., 1999). The researchers characterized abuse within the family as a violation of the child's basic instincts of trust and safety, ultimately disrupting their IWMs (Roche et al., 1999).

In a sample of children with CSA histories and no prior abuse, insecure attachments appear to be the primary predictor of depressive symptoms, regardless of abuse history (Ensink et al., 2020). Furthermore, coupled with depressive symptoms, insecurely attached children are also at risk of developing stress-related disorders such as PTSD. Notably, the authors stated that securely attached children with backgrounds of CSA were less likely to disclose their abuse to their caretakers. Roche et al. (2020) suggested that after securely attached children are sexually abused, they may feel the tension between their IWMs, concluding that others can generally be trusted. Instead, anxiously or avoidantly attached children may have IWMs that already support the idea that others cannot be trusted, leading to more disclosure (Roche et al., 2020).

Murphy and colleagues (2016) examined the relationship between anxious and avoidant attachment styles and posttraumatic stress symptoms in a sample of Dutch women with a history of CSA. The participants' posttraumatic stress symptoms were measured when they entered treatment, six months after treatment, and again at 12 months post-treatment for follow-up (Murphy et al., 2016). The study's findings indicated that posttraumatic stress symptoms decreased across all three time increments as attachment insecurities improved (Murphy et al., 2016). Also, those with avoidant attachment appeared more vulnerable to posttraumatic stress symptoms than those with anxiety attachment (Murphy et al., 2016).

Not only does CSA impact attachment styles into adulthood, but CSA may have implications for the cognitive development of meaning-making or constructs such as PTG. Bodner and colleagues (2012) analyzed the impact attachment styles have on an individual's search for meaning in life and perceiving meaning in life. The results concluded that securely attached participants report a more significant presence of meaning in life and a lower search for meaning than insecurely attached participants (Bodner et al., 2012). Securely attached

individuals' favorable view of the self may assist them in perceiving meaning in their life rather than feeling as if they must find it. Notably, fearfully attached individuals scored the highest in searching for purpose in life compared to all other attachment styles (Bodner et al., 2012). Similarly, Nelson et al. (2019) found that an adult's attachment style mediated the relationship between CSA and PTG.

Their results indicated that levels of trauma are significantly related to insecure attachments, whereas a secure attachment style is positively correlated with PTG development (Nelson et al., 2019). Attachment style was considered a mediator between CSA and psychological adjustment; notably, the participant's attachment style was still related to the PTG outcome when the trauma was controlled (Nelson et al., 2019).

The impact of trauma and attachment development is primarily influenced by the failure of the child to attach to their caregiver and, ultimately, develop healthy IWMs (Ensink et al., 2020; Liem & Boudewyn, 1999). Specifically with sexual abuse, an attachment may be disrupted, leading to many mental health issues such as depression and PTSD symptoms (Murphy et al., 2016; Paolucci et al., 2001). While childhood sexual abuse often preceded mental health issues, the current literature lacks research on how trauma symptoms may be mitigated through religious coping strategies or attachment to God.

**Attachment to God**

The attachment to God constructs, developed by Beck and McDonald (2004), are derived from Bowlby's attachment theory, which compares God to the attachment relationships an individual experiences with their primary caregiver (Beck & McDonald, 2004). The relationship between an individual and God can be described as an attachment relationship. God is considered a secure base and safe haven needed for healthy growth (Beck & McDonald, 2004).

Attachment to God mirrors the avoidance and anxiety attachment styles described by Brennan et al. (1998). Brennan and colleagues (1998) presented two primary adult attachment styles, avoidant and anxious. In adult relationships, avoidant attachment is characterized by discomfort with closeness and dependence on others, whereas anxious attachment appears as a fear of abandonment and rejection from others (Brennan et al., 1998). Similarly, an anxious attachment to God involves fear of abandonment by God, resentment towards God's perceived lack of affection, jealousy over God's love towards others, and a preoccupation with one's relationship with God (Beck & McDonald, 2004). In contrast, an avoidant attachment involves the need for self-reliance, difficulty depending on God, and an unwillingness to be emotionally vulnerable with God (Beck & McDonald, 2004). While God can serve as a surrogate caretaker to those with insecure parental attachments, the attachment to God literature details two different explanations for this process.

The attachment to God literature describes two hypotheses detailing how an attachment to God is formed (Kirkpatrick & Shaver, 1990). The compensation hypothesis states that individuals may use their attachment to God to "make up for" or replace their attachment to their caregiver (Kirkpatrick & Shaver, 1990). In contrast, the correspondence hypothesis assumes that an attachment style to God is derived from an individual's attachment style (Kirkpatrick & Shaver, 1990). An insecurely attached individual will then have an insecure attachment to God due to their internal working model corresponding to negative representations of God (Kirkpatrick & Shaver, 1990). The current study will rely upon the correspondence hypothesis (Kirkpatrick & Shaver, 1990) to theorize that an individual's attachment to their caregivers will correspond with how they relate to God, possibly impacting their PTG.

Reinert and Edwards (2009) examined the impacts of childhood maltreatment (physical, sexual, and verbal abuse) on religiosity and overall attachment to God. Participants who experienced sexual abuse as a child reported higher insecure attachment to God while also conceptualizing God as controlling and distant (Reinert & Edwards, 2009). The researchers noted that attachment to parents mediated the relationship between attachment to God and verbal and physical maltreatment (Reinert & Edwards, 2009). Surprisingly, attachment to parents did not mediate God attachment and sexual abuse, suggesting parental attachment could not compensate for the insecure God attachment (Reinert & Edwards, 2009). The study indicated that the intrusive and traumatic impact of sexual abuse might result in substantial negative experiences of God attachment and parental support (Reinert & Edwards, 2009).

### *Attachment to God and Posttraumatic Growth*

Few studies exist in the literature that have examined whether an insecure or secure attachment to God may affect PTG or meaning-making. In a sample of Christian adults, Bock and colleagues (2018) found that avoidant attachment to God was negatively correlated to redemptive appraisals of suffering, such as reframing suffering as an opportunity for God to facilitate positive change. In contrast, the study revealed a positive correlation between anxious attachment to God and appraising suffering as having meaning (Bock et al., 2018). Furthermore, avoidant attachments to God were negatively correlated with spiritual awareness and PTG (Bock et al., 2018).

In a study examining the relationship between God representation, attachment to God, and PTG in trauma survivors, Zeligman and colleagues (2020) concluded that trauma symptoms and PTG grow simultaneously. The researchers investigated whether authoritarian or benevolent God representation or avoidant attachment to God moderated the relationship between trauma

and PTG. Notably, avoidant attachment to God negatively affected the ability of participants to develop PTG, whereas viewing God as an authoritarian encouraged PTG (Zeligman et al., 2020). Specifically, an avoidant attachment to God was negatively correlated with an authoritarian representation of God (Zeligman et al., 2020). While the study indicated that either God's representation or avoidant attachment to God did not moderate trauma symptoms, the study utilized an attachment to God inventory not normed in a specific religious group. This lack of specificity may not appropriately capture the impact of religious coping and PTG's impact on specific religious groups.

Kelley and Chan (2012) examined the role of attachment to God and its effect on positive religious coping, meaning-making, and depression. The study's results suggested that a secure attachment to God was negatively correlated to grief and depression. Similarly, positive religious coping was positively related to meaning-making. Overall, the study revealed that a secure attachment to God significantly influences the development of depression and stress-related growth post-trauma.

Overall, studies employing the Attachment to God Inventory (AGI) tended to administer the measure to non-Christian samples. The AGI was normed on Christian adults, limiting the literature on God attachment (Beck & McDonald, 2004). The existing literature affirming the importance of God attachment and its influence on positive mental health outcomes highlights the need for further examination into God attachment and other important variables, such as PTG and religious coping (Cassibba et al., 2014; Kelley & Chan, 2012; Leman et al., 2020). Similarly, the gap in the literature surrounding the relationship between PTG and attachment to God further supports the current study's need.

**Religious Coping**

Many religious groups use religious coping to handle stressful life events, including mental health difficulties, illness, war, and bereavement (Pargament et al., 1998). Religion is a widely used method for coping with trauma, crossing cultural and religious lines (Abu-Raiya & Pargament, 2014). The belief in a religious tradition can contribute to coping processes by shaping one's worldview and how one perceives traumatic events. Religion offers a resource for integrating one's belief system, relationship with God, and practices to cope with distress (Pargament et al., 1992).

Pargament and colleagues (2000) broke down religious coping into five primary functions: meaning-making, finding control, attaining comfort through closeness with God, maintaining closeness with others, and transforming one's life. These five functions can be further examined in two broad categories of either positive or negative religious coping (Pargament et al., 1998). Positive religious coping approaches view God as a partner, encourage a secure relationship with a higher power, and view distress as valuable (Pargament et al., 2011). On the other hand, negative religious coping entails interpreting distress as a punishment from God, passively depending on God, and attempting to manage stress alone (Pargament et al., 2011).

Positive religious coping has been associated with lower mortality, less depression, less anxiety, and fewer posttraumatic symptoms (Braxton et al., 2007; Meisenhelder & Marcum, 2004). Some studies suggest that negative religious coping may offer pathways for more growth than distress, reflecting some religious notions that struggles must come before spiritual growth (Pargament et al., 1999, 2000).

Religion may contribute to coping and shape the outcome of events following trauma (Pargament et al., 1992). Religion brings a set of beliefs, values, and relationships that can be used in trauma to effectively cope with the discomfort and eventually be translated and integrated into an individual's appraisal systems and daily life (Pargament et al., 1992). Coupled with religious beliefs, religious community support is more likely to be seen as a source of acceptance and support, rather than pain or rejection, in times of distress (Bearon & Koening, 1990).

In a meta-analysis completed by Hackney and Sanders (2003), findings revealed a significant positive relationship between religiosity and mental health. The results suggest religiosity may have an impact on psychological outcomes. Similarly, Ano and Vasconcelles (2005) conducted a meta-analysis to study the relationship between religious coping and stress and trauma. The researchers concluded that positive religious coping, such as seeking spiritual support and benevolent appraisals, was linked to stress-related growth, spiritual growth, and positive affect (Ano et al., 2005).

In a study examining how religious coping, gender, PTSD, and PTG interact, Gerber et al. (2011) found that positive religious coping positively correlated to PTG, while negative religious coping was associated with PTSD symptoms. Even after the researchers controlled for demographics such as race and gender, these associations remained significant. The authors suggested that religious coping is essential to developing PTG (Gerber et al., 2011).

It is essential to recognize the impact religious coping may have in processing trauma and protecting against the development of mental health difficulties such as PTSD (Ano & Vasconcelles, 2005; Gerber et al., 2011; Hackney & Sanders, 2003). The religious coping literature highlights the influence of positive religious coping mechanisms on meaning-making

and constructs such as PTG (Ano & Vasconcelles, 2005; Gerber et al., 2011). While little research exists examining associations between religious coping and PTG, even less study has been dedicated to Judeo-Christian coping mechanisms such as surrendering to God.

### *Surrender to God*

Part of the religious coping literature mentions the active surrender to God during distress (Wong-McDonald & Gorsuch, 2000). Surrendering to God is a positive religious coping mechanism detailing the active decision to abdicate control to God during distress (Wong-McDonald & Gorsuch, 2000). Wong-McDonald and Gorsuch (2000) attributed surrender to the intrinsic motivation to follow God, regardless of what happens in the future. Negative coping styles endorse passiveness or deference of responsibility and the expectation of God to fix negative experiences without having an active say (Wong-McDonald & Gorsuch, 2000). Surrender is assumed to be used by Christians, founded on the Judeo-Christian belief of acknowledging God's control over life and relinquishing personal power to God (Wong-McDonald & Gorsuch, 2000).

The utilization of surrender as a coping skill is strongly related to spiritual well-being (Wong-McDonald & Gorsuch, 2000). Surrender to God is associated with lower stress levels, suggesting that religiosity impacts health (Clements & Ermakova, 2012). God's perceived help predicts adaptation to religious/spiritual struggles above and beyond God-focused coping efforts (Clements & Ermakova, 2012). While the theoretical construct of surrendering to God is linked to mental health, research utilizing surrender as a coping skill is minimal.

In a study on the link between religiosity and health among female college students, Clements and Ermakova (2012) found that surrendering to God as a coping mechanism was associated with lower stress levels. The mechanism of surrender, an individual's ability to

relinquish control to God, and willingness to submit to God may ameliorate the development of physical ailments and anxiety symptoms (Clements & Ermakova, 2012).

The religious coping literature often fails to specify which specific coping strategies may impact overall psychological well-being; instead, the research focuses on broad positive or negative religious coping. Despite the research outlining positive religious coping as a source for growth following trauma, little research details how surrounding to God may influence meaning-making efforts such as PTG.

In sum, the above psychological research highlights how attachment to caregivers, attachment to God, and the experience of childhood sexual abuse are related to PTG. Research supports the notion that CSA may negatively impact psychological functioning (Hailes et al., 2019; McKay et al., 2020; Mueser et al., 1998; Paolucci et al., 2001; Rodriguez et al., 1997; Subica, 2013). Still, little has been mentioned about how God attachment or religious coping mechanisms such as surrender to God influence the development of trauma symptoms or PTG. The current study aimed to determine whether God attachment is linked to PTG and trauma symptoms in Christian adults. Furthermore, the study will examine a positive religious coping strategy, surrender to God, as a potential mediator for explaining the relationship between God attachment and PTG.

**Study Goals and Hypotheses**

Little research has explored the possible link between religion and spirituality and PTG and trauma symptoms. The current study is needed to better understand the potential role religion and spirituality play in influencing PTG and trauma symptoms. Although some empirical attention has been given to the role of spirituality in PTG, few studies have acknowledged the

influence that God attachment and religious coping may have on PTG development in Christian adults who have experienced childhood sexual abuse.

The following hypotheses will be considered.

1. Anxious attachment to God will negatively correlate with surrender to God.
2. Anxious attachment to God will negatively correlate with PTG.
3. Avoidant attachment to God will negatively correlate with surrender to God.
4. Avoidant attachment to God will negatively correlate with PTG,
5. Surrender to God will positively correlate with PTG.
6. PTG will negatively correlate with trauma symptoms.
7. Surrender to God will mediate the relationship between anxious attachment to God and PTG.
8. Surrender to God will mediate the relationship between avoidant attachment to God and PTG.

## Methods

### *Participants and Procedure*

Participants were recruited following California Baptist University's Institutional Review Board (IRB) approval. All participants completed informed consent before participation in the current study. Participants were recruited via an online platform, Amazon's Mechanical Turk (MTurk). Participants were asked to complete a demographics questionnaire about their sex, gender, religious affiliation, socioeconomic status (SES), education, and ethnicity. The participants were asked to complete surveys about their attachment to God, surrender to God (as a form of religious coping), posttraumatic growth, and trauma symptoms. Participants were

included in the study if they had experienced sexual abuse before 18 and identified with one of the three major branches of Christianity (Catholic, Eastern Orthodox, or Protestant).

Before participants began the study, a screener determining if each participant identified as Christian (Eastern Orthodox, Catholic, or Protestant) and had experienced sexual abuse before the age of 18 years was employed. If the participant did not meet the inclusion criteria, the study ended. Attention check questions were mixed throughout the questionnaires and instruments, requiring a correct response before the participant could continue. Participants that answered attention check questions incorrectly were disqualified from the study and unable to complete the survey. Lastly, participants who filled out the screener were paid $1.50, as were those who completed the entirety of the study.

**Measures**

***Attachment to God Inventory***

The Attachment to God Inventory (AGI) is a 28-item scale utilizing a 7-point Likert (1 = *strongly disagree* to 7 = *strongly agree*) scale measuring two subscales of insecure God attachment, anxiety about abandonment, and avoidance of intimacy (Beck & McDonald, 2004). The scale includes items to measure avoidance, such as "I am uncomfortable allowing God to control every aspect of my life," and anxiety, such as "I fear God does not accept me when I do wrong." The AGI demonstrated good internal consistency and construct validity (Beck & McDonald, 2004). In the current study, the results were separated by avoidant attachment to God and anxious attachment to God. The internal consistency in the current study for anxious attachment to God was .92, and the avoidant attachment to God was .77.

### *Surrender to God Scale*

The Surrender to God Scale is a 12-item scale measuring the willingness of an individual to let go of their control and give control to God (Wong-McDonald & Gorsuch, 2000). The Surrender to God Scale was developed with the Judeo-Christian tradition and is considered a form of Christian coping. The Surrender to God Scale includes items such as, "When I first try to make sense of a problem, I put God's understanding above my own" and "I seek meaning in my difficulties by surrendering to God's guidance" (Wong-McDonald & Gorsuch, 2000). The Surrender to God Scale has demonstrated strong internal consistency and reliability and positively relates to spiritual well-being and internal locus of control. The scale is structured as a 5-point Likert scale (1 = *strongly disagree* and 5 = *strongly agree*), with high scores indicating a willingness to surrender to God (Wong-McDonald & Gorsuch, 2000). The internal consistency in the current study was .91.

### *Posttraumatic Growth Inventory-X*

The Posttraumatic Growth Inventory-X (PTGI-X) is a 25-item instrument to measure positive changes and growth following a traumatic event (Tedeschi et al., 2017). The measure uses a 5-point Likert scale (0 = *I did not experience this change as a result of my crisis*, and 5 = *I experienced this change to a great degree as a result of my crisis*). The PTGI-X includes subscales measuring personal strength, new possibilities, relating to others, appreciation of life, and spiritual change. The PTGI-X was normed on samples from Turkey, Japan, and the United States. The PTGI-X is an updated version of the original Posttraumatic Growth Inventory (PTG), adding four new items to the spiritual change subscale to better represent spiritual change following trauma. The PTGI-X showed good internal reliability within the United States sample (Tedeschi et al., 2017). The internal consistency in the current study was .97.

### *Trauma Symptom Checklist-40*

The Trauma Symptom Checklist-40 (TSC-40) is a 40-item self-report instrument assessing different types of childhood or adult trauma symptoms (Briere & Runtz, 1989). The 40-item measure uses a 4-point Likert scale (0 = *never* and 4 = *often*) to investigate six subscales: anxiety, depression, sexual abuse, sleep disturbance, sexual problems, and dissociation. Higher scores suggest more experiences of trauma symptoms. In prior research, the TSC-40 demonstrated good internal consistency reliability and construct validity (Elliott & Briere, 1992). The internal consistency in the current study was .96.

## Data Analytic Strategy

In the current study, multiple steps were completed to analyze the data. The study utilized SPSS (Statistical Package for Social Sciences) and checked the data for normality, such as kurtosis, skewness, and outliers. The data revealed three outliers within the avoidant attachment to God scores. The outlier avoidant attachment to God scores were coded as "missing" in SPSS so as not to impact the data's kurtosis and skewness. After normality was established, SPSS was used to gather demographic statistics for the study's demographic variables, and Pearson correlations were generated. Bivariate correlations were conducted to examine the relationships between the variables.

The author interpreted correlation strengths according to Cohen's (1988) standard, indicating .10 as small/weak, .30 as medium/moderate, and .50 as large/strong. The study used Hayes' (2022) PROCESS macro via SPSS to conduct the mediation analyses, exploring surrender to God as a mediating variable, linking God attachment and PTG. Per Kenny and Baron (1986), mediation was established if the independent variable and the mediator, and dependent variable and mediator, were significant. Consistent with Hayes (2022), mediation is

established when the confidence interval for the unstandardized regression coefficient does not reach zero.

## Results

Demographic data were sorted, including gender, ethnicity, Christian denomination, level of education completion, marital status, and type of childhood sexual abuse experienced. Pearson correlations were conducted utilizing the hypothesis variables: anxious and avoidant attachment to God, surrender to God, PTG, and trauma symptoms.

### *Demographics*

Among the 345 participants surveyed via MTurk and Cloud Research, 204 met the eligibility criteria for the current study. Of the initial gathered participants, 12 did not agree to the consent, 4 were not 18 years or older, 1 identified as an atheist, 1 identified as a Jehovah's Witness, 40 did not report experiencing sexual abuse before the age of 18 years old, and 83 failed the attention check questions.

All participants used in the study completed the measures in their entirety. The participants included 204 (N= 204) individuals above 18 years old (115 female, 89 male). The ethnicity breakdown of the participants revealed it to be majority White (78.9%), Catholic (59.3%), married (67.6%), and a college graduate (61.3%). Lastly, the sample was asked to categorize the type of sexual abuse they experienced before the age of 18 years old. Participants' responses indicated 68.6% experienced fondling or rubbing in private areas of the body, 29.9% penetration (i.e., vaginal, anal, objects or fingers), 29.9% oral sex, 14.2% sex trafficking, 23.5% exposure to sexually explicit images, and 1% other. Some participants reported experiencing multiple different types of sexual abuse throughout childhood. Demographic data is available in Table 1.

Pearson correlation analyses and descriptive statistics were gathered and included in Table 2. The results of the analyses revealed multiple significant small to large effect sizes (.10 = small, .30 = medium, and .50 = large; Cohen, 1992). Specifically, avoidant attachment to God was moderately and positively associated with trauma symptoms and PTG. Avoidant attachment to God was weakly and negatively correlated with surrender to God. Anxious attachment to God was weakly and positively associated with surrender to God and moderately and positively correlated with PTG and trauma symptoms. Trauma symptoms were also weakly and positively associated with surrender to God and moderately and positively correlated with PTG.

### *Mediation Analyses*

The study assessed the mediating role of surrender to God in explaining the relationship between anxious and avoidant attachment to God and PTG. Mediation analyses were conducted using PROCESS v4.0 macro model 4 via SPSS (Hayes, 2022). Before the analyses were run, the confidence interval (CI) was set at 95% to assess the indirect effects of the variables. Two separate mediation analyses were conducted and used anxious and avoidant attachment to God as separate variables. Results are presented in Figures 3 and 4. Anxious attachment to God was used as the independent variable, PTG was the dependent variable, and surrender to God was the mediator. Similarly, a second mediation analysis was run using an avoidant attachment to God as the independent variable, PTG as the dependent variable, and surrender as the mediator.

The first analysis concluded that anxious attachment to God was significantly associated with surrender to God ($b$ = .161, $SE$ = .039, $t(202) = 4.08$, $p$ = .001) and surrender to God was associated with PTG ($b$ = .304, $p$ = .000). Furthermore, the results suggested a possible mediation relationship between anxious attachment to God and PTG ($b$ = .0049, $SE$ = .0023, CI [.0010, .0097]). The second analysis concluded that avoidant attachment to God was not

significantly associated to surrender to God ($b$ = -.0110, $SE$ = .064, $t$(198) = -.172, $p$ = .863), but surrender to God was associated with PTG ($b$ = .037, $p$ = .000). In contrast, surrender to God ($b$ = .037, $SE$ = .006, $t$(198) = 5.36 $p$ = .000) and avoidant attachment to God ($b$ = .049, $SE$ = .005, $t$(198) = 8.66, $p$ = .000) were related to PTG. Lastly, no mediation relationship existed between avoidant attachment to God, surrender to God, and PTG ($b$ = .-.0004, $SE$ = .0029, CI [-.0055, .0057]).

**Discussion**

The current study contributed to the growing psychological literature on the impact childhood sexual abuse may have on attachment to God, development of PTG, and trauma symptoms. Among 204 self-identified Christians with a history of childhood sexual abuse, the study examined the relationships between insecure attachment to God (anxious and avoidant), PTG, surrender to God, and trauma symptoms. A mediation analysis was conducted to test whether surrender to God mediates the relationships between avoidant and anxious attachment to God and PTG. The results of the study found partial support for the hypotheses.

**Anxious Attachment to God**

Although the results were inconsistent with the hypotheses, they were consistent with some literature highlighting anxious attachment to God was positively correlated with surrender to God and PTG (Bock et al., 2018). Surrender to God mediated the relationship between anxious attachment to God and PTG. Interestingly, anxious attachment to God was also positively correlated with trauma symptoms. However, the current study's results contrasted with the initial hypotheses, suggesting Christians with higher attachment anxiety may turn to God for religious coping (surrender to God) and, as a response, engage in PTG. Anxiously attached individuals may exacerbate negative emotions via worry, rumination, and criticism (Cassidy,

1994). The current study may highlight an anxiously attached individual's tendency to intensify their symptoms or distress. Those with an anxious attachment to God demonstrate a fear of abandonment and a preoccupation with one's relationship with God (Beck & McDonald, 2004). This fear of abandonment by God may lead anxiously attached individuals to surrender to God to internally soothe the preoccupation and worry about their relationship with God. Anxiously attached individuals may demonstrate an extrinsic motivation to engage in surrendering to God to achieve personal gain (Schaefer & Gorsuch, 1991). In other words, anxiously attached individuals may passively surrender to God in an attempt to alleviate their uneasiness around their relationship with God, rather than assertively giving control of their lives to God as defined by surrender to God.

It is also possible that those with anxious attachment styles can access and utilize positive religious coping skills in times of need. Prior research suggests that those with anxious or "preoccupied" attachment styles may be more likely to engage in religious coping mechanisms and take an active role in their faith when compared to avoidant attachment styles. An anxiously attached individual may be likely to practice surrender to God due to their assumption and perception that God is accessible rather than distant (Cooper et al., 2009). The anxiously attached Christian may simultaneously convey surrender to God as an adaptive coping skill while experiencing anxiety about their relationship with God. For example, according to the biblical text and the Christian tradition, anxious feelings and surrender to God occurring simultaneously is not new. Psalms 139:23-24 describes King David crying out to God saying,

“Search me, O God, and know my heart! Try me and know my thoughts! And see if there be any grievous way in me and lead me in the way everlasting!” (*English Standard Version Bible*, Psalm

139:23-24). The verses represent the anxious Christian seeking reassurance through their relationship with God and an attempt to soothe their anxieties via God and surrender.

The results of the current study indicated that anxious attachment to God, surrender to God, and trauma symptoms were positively associated with PTG. PTG has been described by Calhoun and Tedeschi (1996) as an individual's ability to reach positive change and significance following a traumatic event. The results of the current study contrasted with prior research that included variables such as preoccupation and rumination of a traumatic event negatively impacting PTG (Calhoun et al., 2000). While a fixation on negative experiences may hinder PTG growth, intrusive thoughts and thinking can eventually lead to PTG via purposeful attempts to reconsider the traumatic event (Brooks et al., 2019). Based on the characteristics of anxious attachment to God, anxiously attached participants may experience the positive outcome of PTG and acknowledge the intensity of their trauma symptoms rather than avoid them. Similar to previous research, those with an anxious attachment to God may view their suffering as having meaning rather than viewing their trauma symptoms as negative (Bock et al., 2018).

The current study identified possible mediation, indicating that surrender to God can help to explain the relationship between anxious attachment to God and PTG. Little research examines the relationship and impact of surrender to God on PTG and attachment to God. The results suggest that mediation may account for the possibility of anxiously attached participants reassessing their traumatic experiences through intrusive thoughts (Brooks et al., 2019). The results may reflect an anxiously attached individual's process of continuing to experience PTG via rumination and intrusive thinking while actively surrendering their will to God in an adaptive manner. Specifically, the anxious subscale of the AGI reflects a preoccupation, worry, fear of unacceptance of God, and jealousy of others' perceived closeness with God (Beck & McDonald,

2004). Whereas the PTGI-X factor IV, spiritual and existential change, describes a general "clarity about life's meaning" and comfortability of facing "questions about life and death," PTG's spiritual and existential change factor depicts an individual's ability to be comfortable with the unknown of life and lean into one's religious faith (Tedeschi et al., 2017). Similarly, individuals with anxious attachments to God may connect to PTG's adherence to question and focus on life and death, including concentrating on their faith. The PTGI-X does not measure whether the disclosure of adhering to a stronger religious faith and pondering questions about life and death indicates a more anxious attachment to God or elicits anxiety in its participants.

For example, the AGI includes items such as, "I worry a lot about damaging my relationship with God," depicting a preoccupation anxiously attached to Christians ruining their relationships with God. In the current study, it is possible Christians who were anxiously attached to God strongly identify with the tenets of PTG, including feeling connected to their faith and meaning-making, but continue to worry about how God perceives them or are preoccupied with doing "good" to please God, including responding to the PTGI-X in a way that reflects their need for acceptance and closeness with God. Additionally, surrender to God may reflect a similar process of seeking meaning by entirely depending on God but may fail to capture if surrender is an anxious response to gain favor in a Christian's relationship with God.

The Surrender Scale includes items such as, "Although I may not see results from my labor, I will continue to implement God's plans as long as God directs me to do so." Anxiously attached Christians may use surrender to cope with CSA and still maintain a preoccupation with receiving reassurance from God. As mentioned before, anxious attachment to God may leave space for Christians to contemplate the factors of PTG that lead to eventual growth by reassessing trauma, specifically using religious coping mechanisms such as surrender to God.

**Avoidant Attachment to God**

In contrast with the hypothesis, the current study found that avoidant attachment to God positively correlated with PTG and trauma symptoms, differing from past research (Bock et al., 2018; Murphy et al., 2016). In other words, avoidantly attached participants reported higher levels of PTG and more trauma symptoms following the experience of childhood sexual abuse. Prior psychological research suggested that PTG does not indicate a lack or erasure of trauma symptoms; instead, it is a complex relationship between trauma and recovery (Tedeschi & Calhoun, 2007). The complexity between trauma symptoms, PTG, and avoidant attachment to God may explain the results concluding that PTG is positively associated with avoidant attachment to God.

In the current study, surrender to God did not mediate the relationship between an avoidant attachment to God and PTG. Instead, the study concluded there was a negative association between surrender to God and avoidant attachment to God. Prior psychological literature indicates those with avoidant attachment styles appear more vulnerable to developing posttraumatic stress symptoms than those with anxious or secure attachment styles, contrasting with the current study's results (Murphy et al., 2016). Avoidantly attached individuals may adopt maladaptive coping styles and mechanisms, ultimately sustaining trauma symptoms and inhibiting healing (Brooks et al., 2019).

In general, an individual with an avoidant attachment to God may struggle to depend on God, require self-reliance, and have the unwillingness to be emotionally vulnerable with God (Beck & McDonald, 2004). The characteristics of an avoidant attachment to God may explain the negative relationship between avoidant attachment to God and surrender to God. Surrendering to God requires an assertive and intentional abdicating of control to God (Wong-

McDonald & Gorsuch, 2000), contrasting with avoidance coping styles. Individuals with CSA in their background and an avoidant attachment may demonstrate difficulties trusting others or engage in social isolation (Briere, 1989; Kobak & Sceery, 1988; Wooley & Vigilanti, 1984). The current study's results may reflect the avoidantly attached individual's tendency to minimize and avoid expressing emotions, leading to the appearance of growth following trauma, despite the participants demonstrating a maladaptive attachment style (Alexander, 1992; Aspelmeier et al., 2007).

The utilization of surrender to God as a coping skill is connected to spiritual well-being and adaptive coping efforts (Clements & Ermakova, 2012). Similarly, avoidant attachment to God depicts a general unwillingness to depend on God, suggesting difficulty for avoidantly attached participants to assertively give control to God in times of distress (Beck & McDonald, 2004). In general, surrendering to God as a coping skill requires individuals to collaborate with God and allow God to intervene in their distress. This action may prove inherently difficult to an individual with an avoidant attachment to God.

The current study indicated that avoidant attachment to God was positively associated with trauma symptoms and PTG. Surrender to God did not mediate the relationship between avoidant attachment to God and PTG. Prior psychological research indicated that when PTG is not developed correctly following a traumatic event, it may encourage detachment rather than viewing the negative experience as an opportunity for positive change. Lahav and Spiegel (2020) suggested that if individuals are detached from their trauma and cannot achieve positive change following trauma, they may not have experienced PTG; instead, they may not have processed their trauma appropriately. Previous psychological research also indicates that childhood trauma

survivors make greater use of avoidance coping (Simons et al., 2003), which may be used as a survival strategy to maintain a relationship with an abusive caregiver (Freyd, 1996).

In contrast with prior studies using an avoidant attachment, the current study indicated that avoidant attachment to God was positively correlated with PTG (Yu et al., 2016). In preceding psychological literature, avoidant attachment hinders the development and experience of PTG (Yu et al., 2016). While avoidantly attached individuals may isolate themselves from support and use maladaptive coping skills, the current study may reflect a theological underpinning. The results do not illuminate the participants' perceptions of God, religious socialization, and conceptions of God (Smith & Cooperman, 2016).

In other words, avoidantly attached participants may not have been socialized to need to believe in a "close" or proximal relationship with God. For some Christians, avoidant attachment to God may not necessarily reflect an emotionally invulnerable relationship with God; instead, they may not find it helpful or essential to cultivate a close relationship with God to maintain spiritual wellbeing (Henderson & Kent, 2022).This understanding of closeness with God may explain the positive association between avoidant attachment to God and PTG (Henderson & Kent, 2022). Similarly, the result of surrendering to God, failing to mediate the relationship between avoidant attachment and PTG, may also be explained by a distal conception of God or mixed results of legitimate emotional avoidance of God and an understanding that God does not need to be close.

The current study indicated that in avoidantly attached participants, surrender to God was positively correlated with PTG. The Surrender Scale's items contain statements reflecting finding meaning in hard times through God, choosing God's plan or solution when in distress, and finding hope by following God's way. The premise of surrender to God contrasts with the

characteristics of an avoidant attachment to God in that it requires Christians to adhere to God's plan assertively and willingly. PTG's tenets, such as the "personal strength" and "relating to others" factors, relate to surrender to God in that it highlights an individual's ability to rely on others in times of need and accept the result of events than avoid it. Surrendering to God may encourage and foster Christian survivors of CSA to adhere to the tenets of PTG and, ultimately, find meaning from their trauma.

**Clinical Implications**

The results of the current study have implications for clinical settings and psychologists working with Christian clients with backgrounds of CSA. Specifically, clinicians working with Christian clients who may demonstrate an avoidant attachment to God may require further exploration of the client's religious socialization and perception/need for closeness to God. As the results of the study show, those with an avoidant attachment to God may require further intervention and assistance in processing their trauma related to CSA. Similarly, a low surrender to God score may serve as a risk factor or screener to identify possible avoidant tendencies or maladaptive coping strategies in Christian clients.

Avoidantly attached clients may struggle to emotionally engage in therapy, which can lead to poorer outcomes following therapy. Avoidant clients may also reject therapeutic interventions that are perceived to be emotionally overwhelming or require emotional disclosure. Due to this, clinicians may fail to properly challenge the avoidant client’s defenses (Mikulincer et al., 2012). Specifically, avoidantly attached Christians may require intervention to turn outward and allow God into their lives, rather than turning inward and focusing on the self. Avoidantly attached Christians may require interventions that challenge their tendency to withdraw to the self and disallow a relationship or attachment with God. They may need

guidance to begin to slowly invite God into a relationship with them. Avoidant patterns of attachment towards others and God can be challenged via the therapeutic relationship by employing corrective attachment experiences meant to move an avoidantly attached individual towards a more secure way of relating to others and God (Mikulincer et al., 2012).

The current study's results also affect those with anxious attachments to God. If those with anxious attachments to God continue to experience trauma symptoms while simultaneously maintaining PTG, other variables that the current study did not include, such as intrusive thinking or rumination, may significantly impact growth following trauma. The results also indicate that while anxious attachment to God may suggest individuals fear abandonment and fixate on their relationship with God (Beck & McDonald, 2004), it may not necessarily inhibit the ability to reach PTG following CSA. Furthermore, religious coping skills such as surrender to God may be beneficial when working with Christian clients, particularly those who identify as anxiously attached to God.

Surrender to God may be helpful when working with anxiously attached Christians due to their willingness to engage in positive religious coping skills in times of distress (Cooper et al., 2009). Although anxiously attached Christians may be inclined to utilize positive religious coping skills, it is important for clinicians to understand and identify when skills such as surrender are being used incorrectly. A secure and assertive surrender to God describes a collaborative, trusting, and confident submission to God's will. In contrast, an insecure surrender to God includes a passive preoccupation with letting go of one's control in an attempt to alleviate internal distress or anxiety about one's perceived closeness or relationship with God. Clinicians attempting to decipher between secure and insecure expressions of surrender to God should seek clarification of their client's motivation to surrender to God.

Similar to avoidant attachment, anxious attachment can be challenged and reorientated through corrective attachment experiences by the therapeutic relationship (Mikulincer et al., 2012). Clinicians working with clients with anxious attachments must be mindful of demonstrating consistency and reliability as the therapist. In contrast with the avoidantly attached client's refusal to emotional exploration, the anxiously attached client may need assistance in adopting and learning cognitive skills to avoid intensifying their tendency to perseverate on past traumatic experiences (Berry & Danquah, 2015). Working with a Christian's anxious attachment to God entails tailoring interventions to encourage looking outward rather than focusing on the self. This encouragement to look outside of the self may challenge the anxiously attached Christian's tendency to worry and focus on their relationship on God. Rather than preoccupy the self with one's standing with God, an anxious Christian can begin to turn outward, focusing on living in a collaborative relationship with God.

**Limitations**

The current study has limitations, which should be considered when interpreting results. The present study relied on self-report measures and data, leaving room for response bias and under- and over-reporting symptoms. The study's limited sample size to Christian adults with a CSA background restricts the findings' generalizability to other populations and religious groups. Similarly, the current study utilized the Attachment to God Inventory, whose measure was primarily normed on Christians. The present study's demographics revealed that the majority were Catholics rather than Protestants, possibly impacting the way the current study's participants responded to the Attachment to God Inventory.

Furthermore, the current study did not control for demographic variables in both mediation models which may have impacted results. Specifically, the study did not control for

gender differences despite prior research suggesting gender may impact development of trauma symptoms following abuse (Breslau, 2009; Tolin & Foa, 2008). Lastly, while the current study concluded that surrender to God mediated the relationship between anxious attachment to God and PTG, no mediation relationship was found between avoidant attachment to God and PTG. Instead, several of the results concluded opposite relationships than what were initially proposed in the hypotheses. These results suggested other variables may be involved with or account for the relationship between avoidant attachment to God and PTG, such as coping styles, demographic variables, religious socialization, etc. Likewise, the current study collected a sample of primarily Caucasian participants, limiting the generalizability to other demographic groups.

**Future Research Directions**

Future research should determine the number of CSA experiences and if the type of CSA impacts attachment to God. The current study outlined multiple types of CSA. Still, it did not utilize the results to determine if the type of CSA or relationship to the perpetrator would impact attachment style to God. Furthermore, further exploration of CSA within church settings or by church leaders should be studied as to its impact on attachment to God. The violation of trust and relationship between a church leader and child may have an additional negative psychological impact.

Due to religious socialization's impact on avoidant attachment to God, future research should explore the importance and need for perceived "closeness" of God for Christians. The avoidant attachment to God subscale may not capture the lack of inherent need or want for a close relationship with God. Further research would better illuminate the nuanced features of avoidant attachment to God. Furthermore, most participants were Catholic, highlighting a

possible need for further investigation into any unique aspects of Catholicism versus Protestantism when measuring attachment to God. While both Catholicism and Protestantism adhere to the same core tenets of Christianity, the historical backgrounds and traditions of each branch or denomination of Christianity are inherently different. Protestants and Catholics may differ on how they perceive their salvation including whether or not good deeds and church teachings or traditions are needed to attain salvation from God (Pew Research, 2017). In 2017 Pew Research suggested Catholics believed in the need for additional church teachings, traditions, and church guidance alongside the usage of the Bible to attain salvation, whereas Protestants were split on this issue. The differences, traditions, and perceptions of how salvation is attained may impact how a participant responds when reflecting on their attachment to God.

Additionally, further research should examine how surrender to God and other religious coping skills relate to and impact the different tenets of PTG. Surrender to God was positively associated with anxious attachment to God and PTG, suggesting a possible unique variable connecting them. PTG's multidimensional tenets may highlight different aspects of religious coping that may benefit anxious attachment to God in individuals. Lastly, although beyond the scope of this study, future research should continue to research attachment to God within different religious belief systems.

**Conclusion**

In conclusion, this study contributes to the current literature by providing insight into the unique relationships between anxious and avoidant attachment to God, PTG, surrender to God, and trauma symptoms in Christian adult survivors of CSA. Surrender to God mediated the relationship between anxious attachment to God and PTG. In contrast, surrender to God did not mediate the relationship between avoidant attachment to God and PTG. However, other factors

such as religious socialization and perception of the relationship with God may impact how individuals who are avoidantly attached to God view their relationship and distress. The unique characteristics of avoidant and anxious attachment to God and the negative psychological impact of CSA encourage the need for future research into this population.

**Figure 1**

*The Theoretical Model for the Relationship Between Anxious Attachment to God and Posttraumatic Growth, Mediated by Surrender to God*

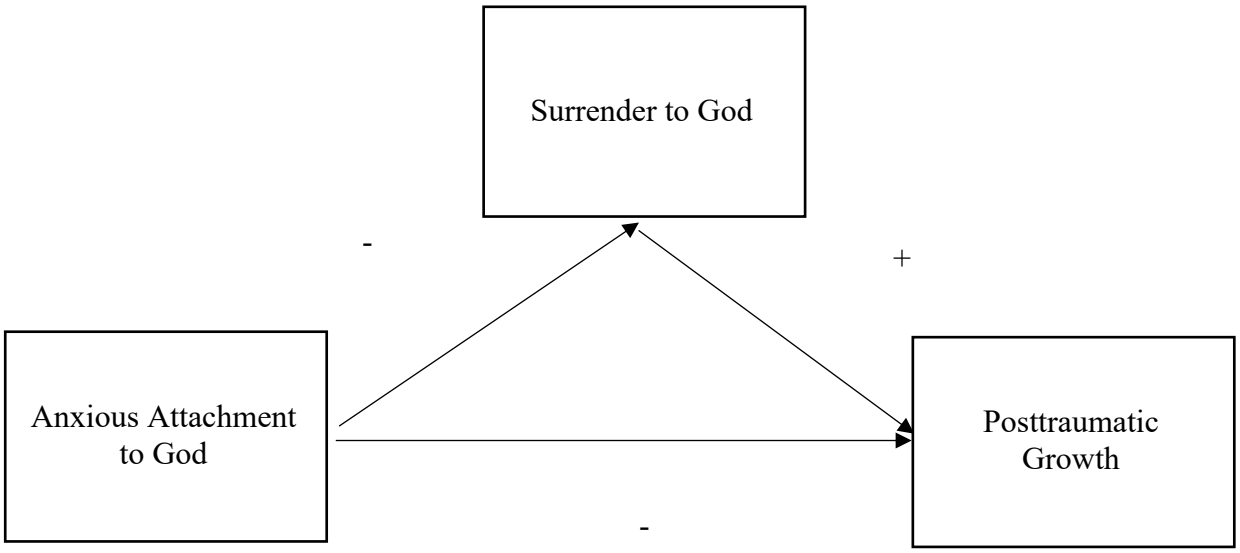


**Figure 2**

*The Theoretical Model for the Relationship Between Avoidant Attachment to God and Posttraumatic Growth, Mediated by Surrender to God*

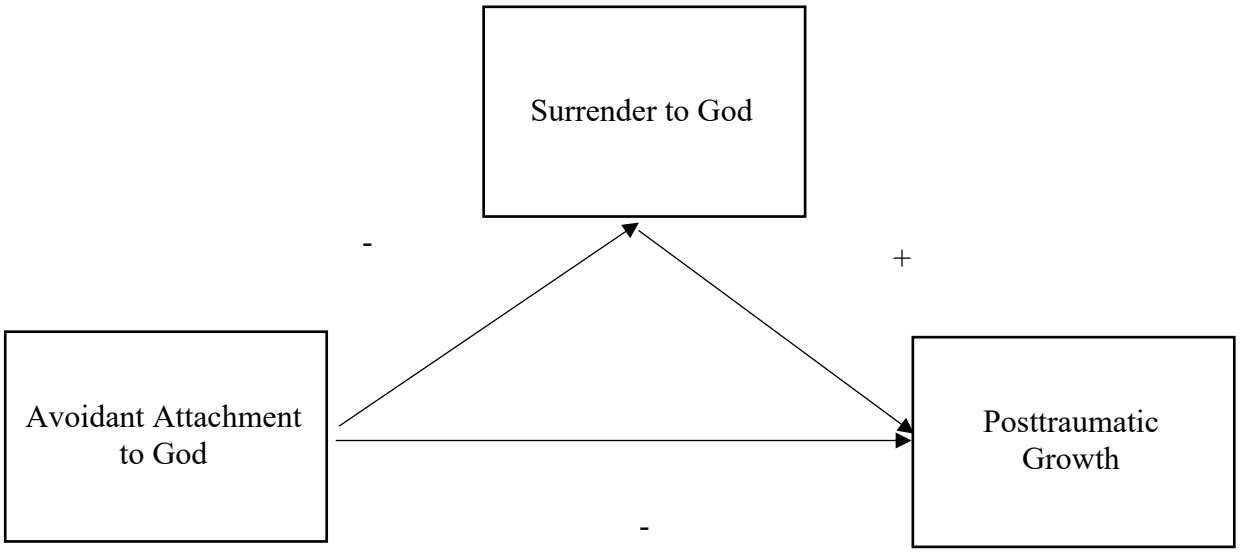
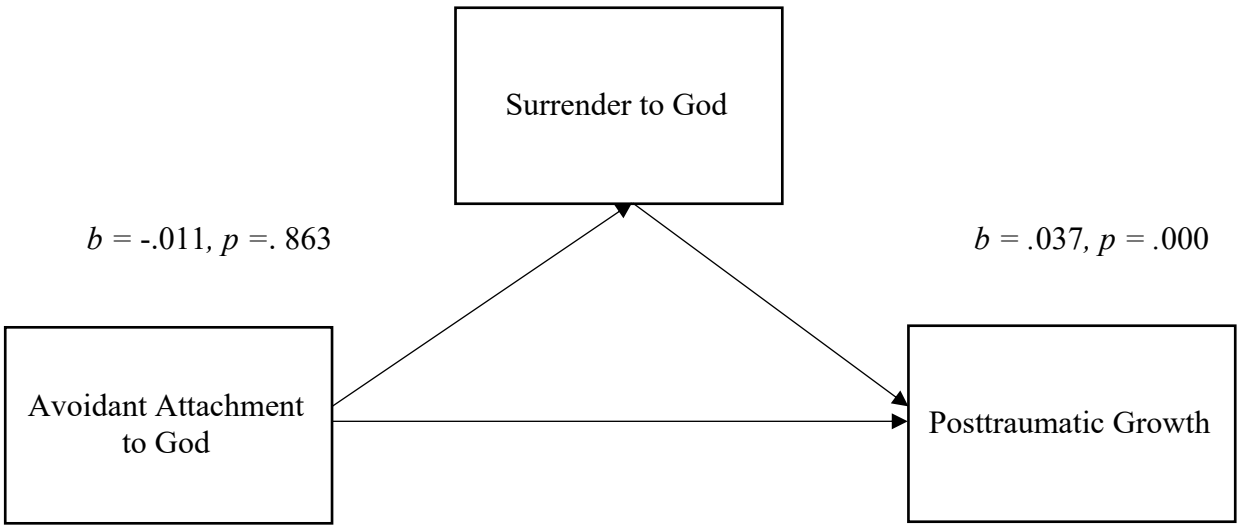


**Figure 3**

*Relationship Between Avoidant Attachment to God and Posttraumatic Growth, Mediated by Surrender to God*

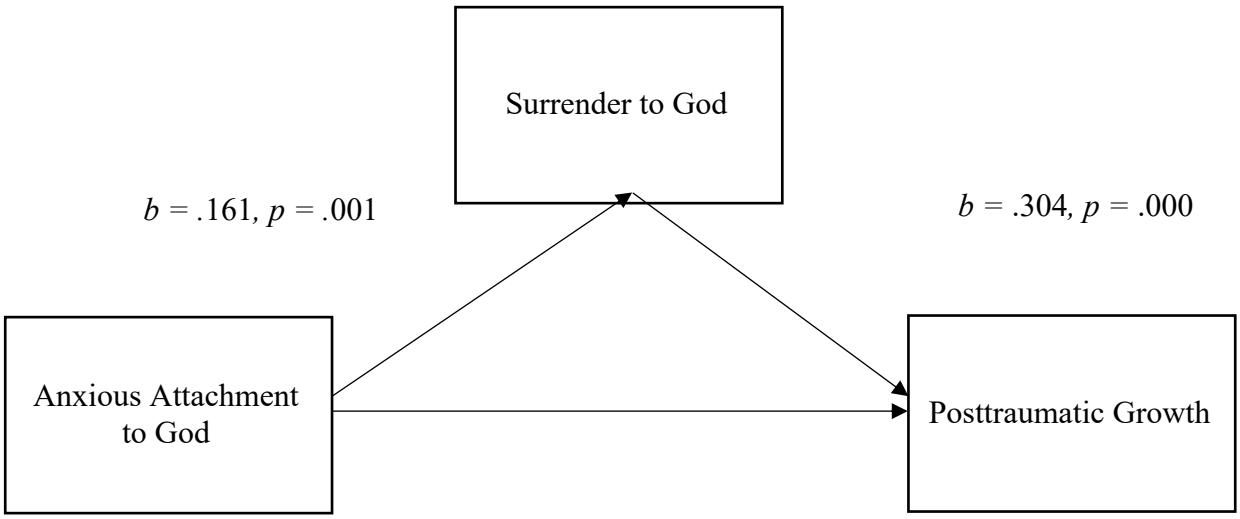



Direct effect, $b = 0.05$, $p = .86$
Indirect effect, $b = -.0004$, 95% CI [-.0055, .0057]

*Note.* $N = 201$. The CI is based on 5,000 bootstrap samples. $b$ = unstandardized regression coefficient. CI = confidence interval.

**Figure 4**

*Relationship Between Anxious Attachment to God and Posttraumatic Growth, Mediated by Surrender to God*




Direct effect, $b = 0.03$, $p = .02$
Indirect effect, $b = .0049$, 95% CI [0.0010, .0097]

**Table 1**

*Demographic Characteristics*

| Variable ($N$ = 204) | |
|---|---|
| Education (%) | |
| High school graduate | 8.8% |
| Some college | 16.2% |
| Trade/technical/vocational training | 2.0% |
| College graduate | 61.3% |
| Some postgraduate work | 5.4% |
| Postgraduate work | 6.4% |
| Gender (%) | |
| Male | 43.6% |
| Female | 56.4% |
| Other | .5% |
| Marital status (%) | |
| Married | 67.6% |
| Single | 25.5% |
| Divorced | 3.9% |
| Widowed | 1.0% |
| Separated | 1.0% |
| Other | 1.0% |
| Ethnicity (%) | |
| Black | 8.3% |
| White | 78.9% |
| Hispanic | 5.4% |
| Native American | 3.9% |
| Asian American | .5% |
| Arab American | .5% |
| Multiracial | 2.0% |
| Other | .5% |
| Denominational affiliation (%) | |
| Catholic | 59.3% |
| Baptist | 6.9% |
| Lutheran | 0.5% |
| Methodist | 1.0% |
| Presbyterian | 0.5% |
| Church of Christ | 16.7% |
| Pentecostal | 2.0% |
| Nondenominational | 9.8% |
| Evangelical | 2.0% |
| Seventh-Day Adventist | 2.0% |
| Other | 1.5% |
| Sexual abuse type before the age of 18 years [a] | |
| Fondling/kissing of private areas | 68.6% |

| | |
|---|---|
| Penetration | 29.9 % |
| Oral Sex | 29.9% |
| Sex Trafficking | 14.2 % |
| Exposure to sexually explicit images | 23.5% |

**Table 2**

*Correlations, Means, and Standard Deviations of Variables*

| Variable | 1 | 2 | 3 | 4 | 5 | *M* | *SD* | α |
|---|---|---|---|---|---|---|---|---|
| 1. TSCL | – | .43** | .52** | .20** | .43** | 62.1 | 25.1 | .96 |
| 2. AGI AV | – | – | .60** | -.012 | .46** | 51.4 | 10.0 | .77 |
| 3. AGI AX | – | – | – | .28** | .51** | 63.3 | 16.2 | .92 |
| 4. SS | – | – | – | – | .38** | 39.9 | 9.5 | .91 |
| 5. PTGI-X | – | – | – | – | – | 3.9 | 1.1 | .97 |

*Note*. $N = 204$. * $p < .05$. ** $p < .01$. α = Cronbach's alpha coefficients. TSCL = Trauma Symptom Checklist-40; AGI AV = Attachment to God Avoidant; AGI AX = Attachment to God Anxious; Surrender to God= SS; PTGI-X = Posttraumatic Growth Inventory-X.

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# APPENDIX B

# IRB APPROVAL

**CC: Institutional Review Board**

**RE**: IRB Review
**IRB No**.: 005-2223-FULL

**Project**: Posttraumatic Growth and Child Sexual Abuse Among Christians: The Association Between God Attachment, Surrender, and Trauma Symptoms

**Date Complete Application Received**: 8/30/22
**Date Final Revision Received**: 9/29/22

**Principle Investigator**: Jaimee Stutz-Johnson
**Co-PI**: NA
**Faculty Advisor**: Joshua Knabb

**College/Department**: CBSS

**IRB Determination**: Full Application **Approved** – Doctoral student research using anonymous survey questionnaires collected via MTurk; no minor participants; risk appropriately communicated and appropriate resources provided; no deception utilized; acceptable consent procedures and documentation; acceptable data protection procedures. Data collection may begin, in accordance with the final submitted documents and approved protocol.
**Future Correspondence**: All future correspondence about this project must include all PIs, Co-PIs, and Faculty Advisors (as relevant) and reference the assigned IRB number.

**Approval Information:** Approval is granted for one year from date below. If you would like to continue research activities beyond that date, you are responsible for submitting a Research Renewal Request with enough time for that request to be reviewed and approved prior to the expiration of the project. In the case of an unforeseen risk/adverse experience, please report this to the IRB immediately using the appropriate forms. Requests for a change to protocol must be submitted for IRB review and approved prior to implementation. At the completion of the project, you are to submit a Research Closure Form.

**Researcher Responsibilities**: The researcher is responsible for ensuring that the research is conducted in the manner outlined in the IRB application and that all reporting requirements are met. Please refer to this approval and to the IRB handbook for more information.

**Date**: October 7, 2022

# APPENDIX C

## CURRICULUM VITAE

**Jaimee Stutz-Johnson, MA**
**Jaimee.Stutz@calbaptist.edu**

## EDUCATION

**Master of Arts, Forensic Psychology**
California Baptist University
Degree conferred: 2018

**Bachelor of Arts, Psychology**
York University
Degree conferred: 2016

**Master of Arts, Clinical Psychology** ,
California Baptist University
Degree conferred: 2021

## ANTICIPATED GRADUATION

**Doctor of Psychology, Clinical Psychology**
California Baptist University
Anticipated degree year: 2024

## SUPERVISED CLINICAL PRACTICA

**STARVIEW ADOLESCENT CENTER: PSYCHIATRIC HEALTH FACILITY**
Aug. 2022-Current
*Supervisor: Dr. Erin Linn*
Torrance, CA

- 20-25 hours a week
- Inpatient psychiatric hospital
  - Severe mental health including psychosis, depression, anxiety.
  - Crisis stabilization
- Retain a case load between 3-4 clients
  - Clients meet twice a week
- Clients present a range of ethnicity, SES, gender, age, and sexual identity
  - Client referrals from probation, family services, and school systems.
- Individual and group supervision weekly
- Crisis intervention implementation
- Weekly interdisciplinary treatment teams

**STARVIEW ADOLESCENT CENTER: COMMUNITY TREATMENT FACILITY**
Aug. 2021-Aug.2022
*Supervisor: Dr. Erin Linn*

- 20-25 hours a week

- Locked residential group home
- Retain a case load between 3-4 clients
    - Clients meet twice a week
- Clients present a range of ethnicity, SES, gender, age, and sexual identity
    - Client referrals from probation, family services, and school systems.
- Individual and group supervision weekly
- Crisis intervention training
- Monthly interdisciplinary treatment teams
- Inservice trainings:
    - Cognitive behavioral therapy for psychosis

**PSYCHOLOGICAL SERVICES OF RIVERSIDE**

Aug. 2020-Aug. 2021
*Supervisor: Dr. Raymond Kim*
Riverside, CA

- 12-15 hours per week
- Retain a case load between 5-7 clients
- Clients present a range of ethnicity, SES, gender, age, and sexual identity
- Individual supervision weekly
- Group supervision weekly for two hours
- Telehealth services
- Inservice trainings:
    - Psychopharmacology
    - Acceptance and Commitment Therapy
    - Motivational Interviewing

## GRANTS, HONORS & SCHOLARSHIPS

**YORK UNIVERSITY, NE**

| | |
|---|---|
| Alpha Chi National College Honor Society | 2016 |
| Magna Cum Laude | 2016 |
| Dean's List | 2012-2016 |
| Track and Field Athletic Scholarship | 2012-2016 |

## RESEARCH EXPERIENCE PEER REVIEWED RESEARCH:

Vazquez, V., Stutz-Johnson, J., & Sorbel, R. (2021). Black-White Biracial Christians, Discrimination, and Mental Health: A Moderated Mediation Model of Church Support and Religious Coping. *Psychology of Religion and Spirituality*.

- Assisted in research of peer-reviewed articles, editing of manuscripts, and gathering data.

**DOCTORAL SECOND YEAR RESEARCH TEAM:**

Supervisor**:** Dr. Kristin Mauldin

The Lived Experiences of NCAA Athletes with One or More Concussions.

- Assisting in research of peer-reviewed articles,

editing of manuscripts, and gathering data.

## PROFESSIONAL PRESENTATIONS

- Stutz, J. (2018, May). Public Perceptions of Female Sex Offenders Through Media Word Usage and Media Outlet Comments. Paper presented at the Western Psychological Association. Portland, Oregon.
- Vazquez, V., Stutz-Johnson, J., & Sorbel, R. (2021, March). Black-White Biracial Christians, Discrimination, and Mental Health: A Moderated mediation model of church support and religious coping. *Psychology of Religion and Spirituality*. Paper presented at the Christian Association for Psychological Studies. Virtual.
- Schwegler, J., Racin-Anderson, K.,Hotetz, A., Stutz, J.,Manya, L., Davis, K., Sorbel, R., Estrada, M., Gernes, J., Mauldin, K. (March, 2021). The lived experiences of NCAA athletes with one or more concussions. Paper presented at the Association for
- Applied Sport's Psychology. Virtual.

## PROFESSIONAL AFFILIATIONS

- Student member of the American Psychological Association (APA) International Association for Correctional and Forensic Psychology

## COMMUNITY SERVICE

- Volunteer at Grace Children's Home

  Henderson, NE

  2014-2016
  - Planned and engaged in activities with the group home residents.
  - Activities included interactive games to foster better communication between the staff and residents

## PROFESSIONAL DEVELOPMENT AND TRAININGS

## RELEVANT WORK EXPERIENCE

- Wicklander – Zulawski & Associates Interviewing and Interrogation Techniques Training 2018
- Patton State Hospital Forensic Mental Health Conference 2017

**ONTARIO CHRISTAN SCHOOLS**

July 2017- June 2019

*Track and Field Coach, Head*
*Hurdle Coach Assistant Cross*
*Country Coach*

- Dual cross-country coach for middle school and high school
- Plan specialty practice plans for hurdlers
- Maintain organization of hurdle practice