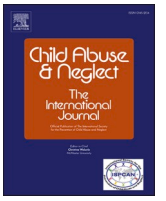
Child Abuse & Neglect 160 (2025) 107214

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg



Spirituality, self-blame, and trauma symptoms among adolescents waiting for treatment after disclosing sexual abuse

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ARTICLE INFO

Keywords:
Sexual abuse
Trauma symptoms
Spirituality, self-blame

ABSTRACT

Background: Adolescents who have been sexually abused commonly experience trauma symptoms, and many spend considerable time waiting for treatment.
Objective: This study examines the extent to which adolescent perceptions of divine spiritual support, divine spiritual struggles, and self-blame collected during a screening assessment predict trauma symptoms at the beginning of treatment.
Participants and setting: Participants were 224 adolescents (92.9 % female, Mean age = 13.46 years; 53.6 % identified as Hispanic/Latino/a and 24.1 % Black/African American). All obtained services at a Children's Advocacy Center in the southern United States.
Methods: Adolescents reported on trauma symptoms, divine spiritual support, divine spiritual struggles, and self-blame appraisals at a screening assessment (T1). Trauma symptoms were also reported a second time when beginning treatment (T2).
Results: The mean level of trauma symptoms declined over time for the total sample, $t(223) = 9.37$, $p < .001$, $d = 0.63$. Greater divine spiritual struggles ($\beta = 0.10$, $t[219] = 1.98$, $p = .049$, $sr^2 = 0.02$) and self-blame for the abuse ($\beta = 0.11$, $t[219] = 2.03$, $p = .044$, $sr^2 = 0.02$) at the screening assessment were associated with higher levels of trauma symptoms at the beginning of treatment, controlling for sex, trauma symptoms and age at the screening assessment.
Conclusions: Assessing adolescents' divine spiritual struggles and self-blame for sexual abuse may be important in triage and treatment planning for youth who have experienced sexual abuse.

Sexual abuse is unfortunately an all-too-prevalent experience for adolescents (Finkelhor et al., 2014; Stoltenborgh et al., 2011), often resulting in trauma symptoms (Chen et al., 2010; Pérez-Fuentes et al., 2013). After disclosing an experience of sexual abuse, adolescents with significant trauma symptoms are frequently referred for mental health treatment (National Children's Alliance, 2019). Fortunately, empirically supported treatments can effectively reduce trauma symptoms among those who have experienced sexual abuse (e.g., Trauma-Focused Cognitive Behavioral Therapy; Cohen et al., 2016). However, numerous obstacles can prevent adolescents from getting timely care, and some face lengthy waits before treatment can begin (Jouriles, Johnson, et al., 2022; Theimer

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https://doi.org/10.1016/j.chiabu.2024.107214
Received 2 July 2024; Received in revised form 3 November 2024; Accepted 11 December 2024
Available online 7 January 2025

et al., 2020). Understanding factors that predict adolescent trauma symptoms while on a waitlist for treatment is crucial, both for informing providers who manage waitlists for clinical services and for helping scientists better delineate sources of influence on the course of trauma symptoms over time.

Theory on the course of adolescent trauma symptoms following sexual abuse often focuses on aspects of the abuse experience and the adolescents' cognitions pertaining to it, and on adolescents' interactions with their family as well as others in their broader social environment (Celano, 1992; Finkelhor & Browne, 1985; Spaccarelli, 1994). Spirituality, which refers to a person's connection to or relationship with the divine (de Jager Meezenbroek et al., 2012; Mahoney, 2021), represents a domain of potential influence on adolescent functioning after abuse that has received scant attention in the literature on adolescent sexual abuse. Yet there are reasons to believe it warrants consideration. Most adolescents in the United States (US) believe in and pray to God or a higher power (hereafter referred to as God) at least a few times a month (Pew Research Center, 2020). Additionally, there is a large scientific literature linking spiritual variables to mental health. For example, among people in general, forms of positive religious coping, such as turning to God for support (i.e., divine spiritual support), are modestly associated with better mental health (Davis et al., 2023; Hodapp & Zwingmann, 2019). Conversely, forms of negative religious coping, such as negative thoughts and emotions about one's relationship with God (i.e., divine spiritual struggles), are associated with problematic mental health symptoms (Bockrath et al., 2022; Hodapp & Zwingmann, 2019). The current study examines how divine spiritual support and divine spiritual struggles relate to changes in trauma symptoms among adolescents waiting for treatment after disclosing sexual abuse.

1. Divine spiritual support and divine spiritual struggles after sexual abuse

Many adolescents turn to God during times of stress (Cotton et al., 2005; King et al., 2021). Theoretically, seeking divine spiritual support after stressful experiences can be conceptualized to function similarly to turning to a caring friend or attachment figure, to the extent that it provides comfort, hope, or a sense of security (King & Boyatzis, 2015). Additionally, feeling supported by a benevolent God may give adolescents a sense that healing is possible and help them to create meaning out of adversity (Bryant-Davis et al., 2012). Evidence from cross-sectional studies among adolescents in general suggests that divine spiritual support may have mental health benefits, but many of the documented associations are weak (Hardy et al., 2019). Notably, a couple of studies conducted with relatively large samples ($n > 400$) of adolescents who have disclosed sexual abuse have documented such associations. For instance, the extent to which adolescents more often seek solace in God after experiencing sexual abuse has been found to correlate with greater resilience (Gower et al., 2020) and less anger (Sigurvinsdottir et al., 2021).

Divine spiritual struggles reflect the extent of one's negative thoughts and emotions about one's relationship with God (Exline et al., 2014). Survivors of childhood sexual abuse sometimes grapple with such thoughts and emotions (Jouriles et al., 2020; Kane et al., 1993). Theoretically, adolescents who experience divine spiritual struggles following sexual abuse may be particularly vulnerable to heightened distress and slower recovery. For instance, an adolescent who previously relied on God for protection, comfort, and support may wonder how a powerful, benevolent God allowed the abuse to happen. They may question their faith altogether if they feel God has abandoned or betrayed them, potentially intensifying their distress and compromising the recovery process (Jouriles et al., 2020). For adolescents who previously relied heavily on God for comfort and support, that sense of divine abandonment or betrayal might feel like the end of a relationship or loss of a loved one. Given that betrayal and powerlessness are theorized to be among the core dynamics by which abuse inflicts psychological injury (Finkelhor & Browne, 1985), perceived divine betrayal and abandonment may intensify the adverse effects prompted by these dynamics. Consistent with this theorizing, adolescents' experiences of divine spiritual struggles following sexual abuse have been found to relate positively to their adjustment problems in cross-sectional research (Jouriles et al., 2020).

It is important to recognize, however, that research linking divine spiritual support and divine spiritual struggles to adolescent mental health after sexual abuse is sparse and has thus far been limited to cross-sectional studies (Gower et al., 2020; Jouriles et al., 2020; Sigurvinsdottir et al., 2021). Although the findings from these studies are consistent with theory asserting a directional effect – that turning to God for support can result in mental health benefits, while struggling with one's relationship with God may lead to adjustment problems – the direction of effects cannot be concluded from cross-sectional research. Longitudinal research on links between spiritual and religious variables and mental health has been conducted mostly with adult samples and focuses primarily on potential mental health benefits. A meta-analysis found that participation in religious activities and beliefs about the importance of religion lead to modest, positive mental health benefits over time (Garssen et al., 2021). Unfortunately, longitudinal studies examining relations between spiritual/religious variables and adolescent mental health after a traumatizing event are rare.

2. Self-blame after sexual abuse

Perceiving sexual abuse as a form of divine punishment may go hand in hand with the belief that one is somehow responsible for the abuse or for failing to stop it. That is, beliefs that human suffering reflects punishment from God may pave the way for adolescents to blame themselves for the abuse, especially if they also believe God's motives and acts are beyond question (Frechette, 2017). In other words, the more adolescents believe in a God who is judgmental and punitive, who allows bad things to happen only to bad people, the more they may conclude there must be something about themselves or their actions that caused the sexual abuse to occur. Additionally, adolescents may have heightened vulnerability to feelings of self-blame in response to greater perceived divine punishment, given that adolescents often turn to God in the search for identity and for meaning in times of adversity (King & Boyatzis, 2015).

Self-blame for adverse events may be more detrimental during adolescence than other developmental periods, in part because adolescence is an important period for the development of self-image, and self-blame appraisals for sexual abuse are theorized to foster

the development of a negative self-image (Aaron, 2012; Celano, 1992; Finkelhor & Browne, 1985; Spaccarelli, 1994). In other words, adolescents who feel more responsible for their abuse may start to believe that they are more flawed or have negative characteristics. In line with this thinking, greater self-blame for sexual abuse has been linked to higher levels of trauma symptoms among adolescents in dozens of cross-sectional studies (e.g., Bal et al., 2009; Daigneault et al., 2006; Melville et al., 2014; Rancher et al., 2022), and several longitudinal studies (Alix et al., 2020; Feiring et al., 2002; Feiring & Cleland, 2007; Manion et al., 1998), including one that assessed adolescent trauma symptoms while waiting for treatment after disclosing sexual abuse (Jouriles, Johnson, et al., 2022). In short, self-blame may help explain associations between divine spiritual struggles and adolescent trauma symptoms following sexual abuse.

3. Current study

The current study examines how divine spiritual support, divine spiritual struggles, and self-blame for the abuse relate to changes in adolescent trauma symptoms over time. Hypotheses were pre-registered with the Open Science Framework (XXX). Adolescent trauma symptoms were measured at two time points: an agency screening assessment conducted after the disclosure of the abuse (T1), and a clinical assessment conducted just prior to the beginning of treatment (T2). Trauma symptoms often diminish over the time shortly after the trauma-inducing event (Hiller et al., 2016), including after a child sexual abuse disclosure (Jouriles, Johnson, et al., 2022), and this pattern is consistent with clinical guidelines that assume some natural recovery after a traumatic event (American Psychiatric Association, 2013). Thus, we hypothesized that (H1) trauma symptoms would decline between T1 (screening) and T2 (beginning of treatment).

Based on the extant literature on spirituality and mental health, we hypothesized that (H2) greater perceived divine spiritual support at T1 would be associated with lower levels of trauma symptoms at T2 after accounting for trauma symptoms at T1, and (H3) greater divine spiritual struggles at T1 would be associated with greater levels of trauma symptoms at T2 after accounting for trauma symptoms at T1. We also hypothesized that we would be able to replicate prior findings (Jouriles, Johnson, et al., 2022) that: (H4) greater self-blame for the abuse at T1 would be associated with greater levels of trauma symptoms at T2 after accounting for trauma symptoms at T1. Additionally, we hypothesized that (H5) greater self-blame at T1 would mediate the hypothesized association between greater divine spiritual struggles at T1 and greater levels of trauma symptoms at T2. Because adolescent age and sex have been associated with trauma symptoms in past research (Tolin & Foa, 2006; Zink et al., 2009), they were included as control variables in analyses for hypotheses 2–5.

4. Method

4.1. Participants and procedure

Adolescents brought to an urban Children's Advocacy Center (CAC) in the southern United States from August 1, 2017 through May 30, 2019 completed the study measures as part of the CAC's routine assessment protocol. Study inclusion criteria for adolescents were: (1) age between 11 and 17 years, inclusive, (2) disclosed an incident of sexual abuse, (3) completed the CAC screening assessment subsequent to disclosure of the abuse, (4) referred for treatment at the CAC and duration between screening assessment and clinical assessment for treatment initiation was $\geq$10 days (to avoid overlap in the reporting period for trauma symptoms), (5) clinical assessment for treatment initiation included assessment of trauma symptoms, and (6) adolescent provided assent and a non-offending caregiver provided consent for the data to be used for research. Exclusion criteria included: (1) family declined the offer of CAC clinical services, and (2) incomplete data on measures of spirituality, self-blame, or trauma symptoms.

All individuals were informed that their decision to allow or disallow their data to be used for research would not affect their access to CAC services in any way. All study procedures were approved by the institutional review board of the corresponding author's institution.

During the study period (August 1, 2017 to May 30, 2019), data for 469 adolescents met the first three eligibility criteria for this study. During this period, in regular triage meetings, CAC staff reviewed screening assessments and made decisions pertaining to treatment. Generally, adolescents were referred for treatment at the CAC if they were experiencing elevated levels of trauma symptoms related to the sexual abuse and were not in treatment elsewhere. However, there were other considerations as well. For example, if there were concerns about self-harm or severe impairment linked to the adolescent's trauma symptoms (e.g., school refusal), and no CAC service providers were immediately available to pick up new cases, adolescents were referred to other mental health service agencies.

Of the 469 adolescents that met the first three inclusion criteria for the study, 224 also met the final three criteria for this study, and did not meet either of the two exclusion criteria. Of the 245 families who were excluded: 72 of the adolescents were not referred for treatment at the CAC or the duration between the screening and pre-treatment clinical assessments was $<$10 days; 53 adolescents were not assessed for trauma symptoms during the pre-treatment clinical assessment, and in 6 families either adolescent assent or caregiver consent for use of the data for research was not provided. Additionally, 103 families were excluded because they declined the offer of clinical services by the CAC or the CAC was unsuccessful in reaching and scheduling the families for services after multiple attempts to do so, and 11 families provided incomplete data on the study measures of spirituality, self-blame, or trauma symptoms.

In the final sample, adolescents were 13.46 years old (SD = 1.60) on average at the time of the screening assessment and 92.9 % (n = 208) reported their sex as female. Adolescents reported their race and ethnicity as follows: 53.6 % Hispanic/Latino/a (n = 120), 24.1 % Black/African American (n = 54), 16.1 % as non-Hispanic white/European American (n = 36), and 3.6 % multi-racial (n = 8), and 2.7 % (n = 6) failed to report race or ethnicity.

The average duration between the screening and pre-treatment clinical assessments for the 224 study participants was 46.57 days ($SD = 35.72$, median = 38.47). Because preliminary analysis indicated that time on the waitlist for services was not associated with any of the study variables, it was not included as a control variable in analyses testing the hypotheses.

Most youth (91.1 %, $n = 204$) reported believing in God, a universal spirit, or a higher being, but analyses were conducted with all adolescents because there is evidence that individuals who declare themselves to be atheist still turn to God for support and/or experience divine spiritual struggles (Sedlar et al., 2018). Religious affiliation was 26.3 % ($n = 59$) Protestant or non-denominational Christian, 40.2 % ($n = 90$) Catholic, and 12.1 % ($n = 29$) other (e.g., "Christian," "spiritual, not religious," "Jehovah Witness"). About one-fifth (20.5 %; $n = 46$) reported no formal religious affiliation.

4.2. Measures

All measures were completed at the screening assessment (T1) and the trauma symptoms measure was also completed at the pre-treatment clinical assessment (T2). Different CAC staff members administered the measures at T1 and T2.

4.2.1. Divine spiritual support and divine spiritual struggles

Items from the RCOPE (Pargament et al., 2000), a multi-dimensional measure of religious coping, were used to measure divine spiritual support. Instructions were: "It might be that you believe in one God or many, or none at all. In the questions below, when we use the word 'God' you should feel free to use whatever word and meaning that fits for you. And if you do not believe in a God, that is OK too, just answer each question the best you can." The language for all the items was simplified for adolescents, and items were anchored to the experience of sexual abuse. Specifically, for *divine spiritual support,* participants responded to 4 items asking how often, when thinking about the sexual abuse in the past month, they: "Turned to God for love and care"; "Looked to God for strength, support, and guidance"; "Did my best and then turned the situation over to God"; "Did what I could and put the rest in God's hands." Responses were made on a 4-point scale (0 = *not at all*, 1 = *somewhat*, 2 = *quite a bit*, 3 = *a great deal*) and summed to create a total score. In the present sample, $\alpha = 0.88$. This 4-item measure has been found to relate positively with resilience in prior research with adolescents who have been sexually abused (Gower et al., 2020).

Four items from the Brief RCOPE (Pargament et al., 1998) were used to measure *divine spiritual struggles*. Following the same instructions as for the measure of divine spiritual support, adolescents reported how often, when thinking about the sexual abuse in the past month, they: "Wondered what I did for God to punish me"; "Felt punished by God for my lack of faith"; "Wondered whether God had abandoned me"; "Questioned God's love for me." Responses were made on a 4-point scale (0 = *not at all*, 1 = *somewhat*, 2 = *quite a bit*, 3 = *a great deal*) and summed to create a total score. In the present sample, $\alpha = 0.80$. This 4-item measure of divine spiritual struggles has been found to relate positively with adjustment problems in prior research with adolescents who have been sexually abused (Jouriles et al., 2020).

4.2.2. Self-blame appraisals

Adolescents completed the 8-item self-blame subscale of the Negative Appraisals of Sexual Abuse Scale (NASAS; Spaccarelli, 1995). They reported the frequency of self-blame appraisals when thinking about the sexual abuse in the past month (e.g., "You did something bad or wrong"). Responses were made on a 4-point scale (0 = *not at all*, 1 = *a little*, 2 = *somewhat*, 3 = *a lot*) and summed to derive a total score. For the current sample, $\alpha = 0.88$. The NASAS has been shown to relate to psychological adjustment in adolescents who have been sexually abused (Spaccarelli, 1995; Spaccarelli & Fuchs, 1997).

4.2.3. Trauma symptoms

Adolescents reported their trauma symptoms on the general trauma subscale of the Trauma Symptom Checklist for Children Screening Form (TSCC-SF; Briere & Wherry, 2016). Responses to 12 items (e.g., "can't stop thinking about something bad that happened to me") were recorded on a 4-point scale (0 = *never,* 1 = *sometimes*, 2 = *lots of times*, 3 = *almost all of the time*) and summed, with higher scores indicating more trauma symptoms. Scores on the TSCC-SF can be converted to indicate clinically elevated levels of trauma symptoms based on adolescent age and sex. In the present sample, Cronbach's α was 0.90 at Time 1 and 0.88 at Time 2. The TSCC-SF has been shown to differentiate between youth who have and have not been abused (Briere & Wherry, 2016; Wherry & Herrington, 2018).

4.3. Attrition analysis, data analysis plan, and power

Data for adolescents included in the study ($N = 224$) were compared to data for the 245 who were excluded. There were differences in the level of trauma symptoms at T1 (included $M = 17.27$, $SD = 8.33$, excluded $M = 14.21$, $SD = 7.89$; $t[467] = 4.09$, $p < .001$), divine spiritual struggles (included $M = 4.50$, $SD = 3.58$, excluded $M = 3.73$, $SD = 3.64$; $t[459] = 2.29$, $p = .023$), and self-blame (included $M = 11.68$, $SD = 7.05$, excluded $M = 8.99$, $SD = 7.03$; $t[460] = 4.11$, $p < .001$). Differences did not emerge on divine spiritual support or adolescent age, sex, or race, $p > .05$.

None of the distributions of the variables were skewed (i.e., skewness for all variables was $< |1|$); however, two distributions were kurtotic (kurtosis $> |1|$: divine support = −1.17; self-blame = −1.16), indicating a flatter distribution that can lead to underestimated variance (Tabachnick & Fidell, 2019). Square root transformation resulted in divine support kurtosis = −0.80 and self-blame kurtosis = −0.71); thus transformed scores for these two variables were used in analyses.

To test our first hypothesis, we conducted a paired-samples *t*-test to examine within-participant change from T1 to T2 in trauma

symptoms. To test hypotheses 2–4, we conducted a series of multiple regression analyses with T2 trauma symptoms as the dependent variable. The predictor variables for each of the models were: (H2) divine spiritual support, (H3) divine spiritual struggles, (H4) self-blame. For H5, we examined whether the relation between divine spiritual struggles and T2 trauma symptoms was mediated by self-blame. We specified a path model using the PROCESS macro, specifying bias-corrected 95 % confidence intervals and boot-strapping estimation ($n = 5000$) (Hayes, 2017). In all models we controlled for trauma symptoms at T1, adolescent age, and sex. We report the *partial* η^2 as a measure of effect size. It reflects the unique variance accounted for by each statistically significant predictor in the model.

A priori power analyses were conducted to determine estimated minimum sample sizes to detect a specified effect with alpha set at 0.05 and 0.80 power. For hypotheses 2–4 (which contained one predictor and three control variables), the program G*Power 3.1.9.7 indicated that a sample size of 138 was needed to detect a small-to-medium effect ($f^2 = 0.09$). For hypothesis 5, simulation data from Fritz and MacKinnon (2007) indicate that with alpha set at 0.05, power at 0.80, and using bias-corrected boot-strapping to assess mediation, a sample size of 148 was needed to detect a small-to-medium indirect effect ($\alpha = 0.26$ and $\beta = 0.26$).

5. Results

5.1. Descriptive analyses

Table 1 summarizes the means, standard deviations, and correlations among the study variables. Using age- and sex-adjusted formulas for determining clinical cutoffs (Briere & Wherry, 2016), 46.4 % ($n = 104$) of youth reported trauma symptoms above the clinical threshold at T1, and 27.2 % ($n = 61$) did so at T2.

5.2. Hypothesis tests

Consistent with H1, a paired samples t-test revealed a reduction in mean trauma symptoms from T1 to T2, $t(223) = 9.37$, $p < .001$, Cohen's $d = 0.63$ (see Table 1 for the means and standard deviations). Table 2 summarizes the results of the analyses for H2, H3, and H4. In each of the three analyses, T1 trauma symptoms and adolescent age and sex were included as control variables. Divine spiritual support did not relate to T2 trauma symptoms (H2), but greater divine spiritual struggles and self-blame for the abuse at T1 (H3 and H4, respectively) were associated with higher levels of trauma symptoms at T2. Thus, the data were not consistent with H2, but were consistent with H3 and H4. In our final analysis, (H5) self-blame did not mediate the association between divine spiritual struggles and T2 trauma symptoms, indirect effect = 0.03, SE = 0.03, 95 % CI [−0.006, 0.091] (Fig. 1), which was not consistent with H5.

6. Discussion

The current study evaluated hypotheses pertaining to trauma symptoms among adolescents screened and referred for clinical services after having disclosed sexual abuse. The replication of earlier findings that adolescent trauma symptoms decline during the time they are waiting for mental health treatment after a sexual abuse disclosure (Jouriles, Johnson, et al., 2022) bears consideration by researchers and by those treating youth who have been sexually abused. It should be recognized, though, that while mean levels of trauma symptoms declined over the waitlist period, about a quarter of the sample (27.2 %) nonetheless were at clinically elevated levels throughout. The observed decline in trauma symptoms may be attributed to several factors. For example, for some adolescents, there is likely a natural recovery process, which might include using effective coping strategies in the aftermath of the abuse (Yancey et al., 2011). Coming off the waitlist and anticipating meeting with a mental health provider to begin treatment may also cause some adolescents to experience some relief and hopefulness, which may influence their report of trauma symptoms before their first therapy session. The observed decline might also be explained by common measurement artifacts, such as regression toward the mean (Nesselroade et al., 1980), a tendency to report fewer negative symptoms on repeated assessments due to boredom or rushed responding (Sharpe & Gilbert, 1998), or wanting to appear more favorably to their clinician. It is also possible that as time passes, adolescents become accustomed to their symptoms, perceiving them as less remarkable, memorable, and reportable.

To better understand the course of trauma symptoms among these adolescents waitlisted for services, the current study examined whether divine spiritual support, divine spiritual struggles, and self-blame predicted adolescent trauma symptoms during the waitlist

Table 1
Correlations, means, and standard deviations for study variables ($N = 224$).

	1.	2.	3.	4.	5.	6.	*M (SD)*
1. T2 Trauma symptoms	–						13.31 (8.16)
2. T1 Trauma symptoms	0.71***	–					17.27 (8.33)
3. T1 Divine spiritual support[a]	−0.12	−0.09	–				6.20 (3.99)
4. T1 Divine spiritual struggles	0.38***	0.42***	0.15*	–			4.50 (3.58)
5. T1Self-blame[a]	0.44***	0.52***	−0.11	0.30***	–		11.68 (7.05)
6. Age	0.06	0.11	−0.13	-0.05	0.23***	–	13.46 (1.60)
7. Sex (1 = male, 2 = female)	0.25***	0.28***	-0.05	0.10	0.12	0.02	92.9 %

[a] Correlations computed on square-root transformed scores. Means and standard deviations are raw-score values.
* $p < .05$.
*** $p < .001$.

Table 2
Spiritual support, spiritual struggles, and self-blame as predictor of trauma symptoms at the beginning of treatment (T2), (N = 224).

						95 % CI		
Variables	*B*	*SE B*	*β*	*t(219)*	*p*	Lower	Upper	sr^2
Hypothesis 2								
T1 Trauma symptoms	0.67	0.05	0.69	13.83	**< 0.001**	0.579	0.771	0.47
T1 Divine spiritual support[a]	−0.57	0.46	−0.06	−1.22	0.224	−1.478	0.348	–
T1 Age	−0.12	0.25	−0.02	−0.47	0.635	−0.600	0.367	–
Sex (1 = male, 2 = female)	1.75	1.56	0.06	1.12	0.265	−1.334	4.827	–
Hypothesis 3								
T1 Trauma symptoms	0.63	0.05	0.65	11.91	**< 0.001**	0.530	0.740	0.39
T1 Divine spiritual struggles	0.24	0.12	0.10	1.98	**0.049**	0.001	0.470	0.02
T1 Age	−0.03	0.24	−0.01	−0.12	0.905	−0.509	0.451	–
Sex (1 = male, 2 = female)	1.85	1.55	0.06	1.19	0.235	−1.213	4.914	–
Hypothesis 4								
T1 Trauma symptoms	0.62	0.06	0.64	11.17	**< 0.001**	0.513	0.732	0.36
T1 Self-blame [a]	0.84	0.41	0.11	2.03	**0.044**	0.023	1.657	0.02
T1 Age	−0.18	0.25	−0.04	−0.73	0.468	−0.666	0.307	–
Sex (1 = male, 2 = female)	1.88	1.55	0.06	1.21	0.229	−1.186	4.938	–

Note. Statistically significant *p* values are in bold.
Hypothesis 2: $F(4, 219) = 56.19$, $p < .001$, $R^2 = 0.51$.
Hypothesis 3: $F(4, 219) = 57.41$, $p < .001$, $R^2 = 0.51$.
Hypothesis 4: $F(4, 219) = 57.51$, $p < .001$, $R^2 = 0.51$.
[a] Scores were computed using square-root transformation of raw scores.

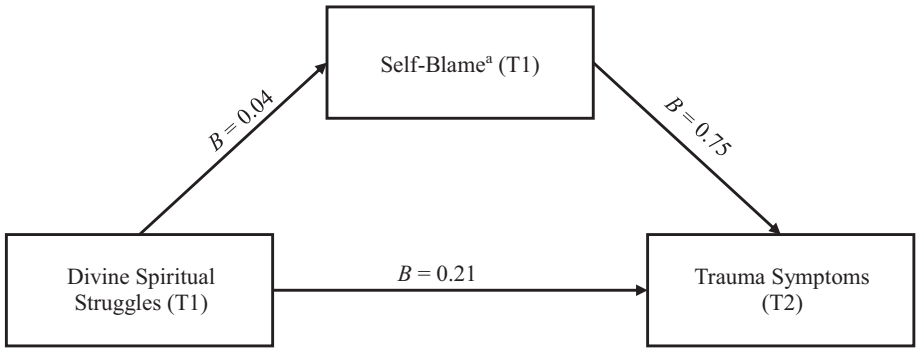

Fig. 1. Indirect Effect of Divine Spiritual Struggles (T1) on Trauma Symptoms at the Beginning of Treatment (T2) via Self-blame (T1). Note. Indirect effect = 0.03, SE = 0.03, 95 % CI [−0.006, 0.091]. Model included trauma symptoms at T1, adolescent age, and sex as control variables. [a] Scores were computed using square-root transformation of raw scores.

period. Divine spiritual support did not predict T2 trauma symptoms; nor was there a cross-sectional, bivariate correlation between divine spiritual support and trauma symptoms at T1. One interpretation of these results is that divine spiritual support, as conceptualized and measured in this study, simply does not relate to change in trauma symptoms among adolescents who have experienced sexual abuse. A second interpretation is that they reveal counteracting effects. That is, for some adolescents, experiencing greater trauma symptoms after sexual abuse may prompt them to turn to God even more than usual for support, which may result in divine spiritual support being positively associated with trauma symptoms, both cross-sectionally and longitudinally. For other adolescents, seeking God's comfort and perceiving that God is responsive may reduce trauma symptoms. For these adolescents, divine spiritual support would be negatively associated with trauma symptoms, both cross-sectionally and longitudinally. These two different responses may effectively cancel one another out and thus yield no overall cross-sectional or longitudinal associations.

Consistent with our third hypothesis, greater divine spiritual struggles predicted higher levels of trauma symptoms at T2, after accounting for trauma symptoms at T1 and adolescent age and sex. It should be emphasized that while this longitudinal finding was statistically significant, the lower-bound confidence interval was close to zero and the effect size was small. As a result, caution needs to be exercised in interpreting this finding. It is noteworthy, however, that this longitudinal finding is consistent with theory and the results of prior cross-sectional research linking divine spiritual struggles after sexual abuse with adolescent adjustment problems (Jouriles et al., 2020), and it further highlights the potential value of considering how divine spiritual struggles may pose challenges for adolescents who have been sexually abused.

A possible explanation for this finding is that divine spiritual struggles are stressful for adolescents at a time when they are already stressed; the accumulation of stressors may adversely influence trauma symptoms over time. Another explanation is that the divine spiritual struggles interfere with behaviors that facilitate recovery. For example, it seems plausible that divine spiritual struggles

inhibit participation in religious activities, which have been shown in longitudinal research to result in positive mental health benefits (Garssen et al., 2021). Similarly, divine spiritual struggles may intensify the effects of other processes linked to childhood sexual abuse. That is, theory suggests childhood sexual abuse leads to psychological harm through experiences of betrayal, powerlessness, and stigmatization (Finkelhor & Browne, 1985). Adolescents who previously relied on God as a source of support may now feel betrayed by God and powerless without divine protection. This could magnify feelings of betrayal and powerlessness already brought about by the sexual abuse, thus worsening mental health. Moreover, believing that sexual abuse has been a punishment from God could trigger feelings of stigmatization and related maladaptive cognitive processes, further contributing to trauma symptoms. Consistent with this latter idea, in the current study, divine spiritual struggles and self-blame were positively correlated with one another.

Consistent with our fourth hypothesis, greater self-blame at T1 was associated with greater trauma symptoms at T2 after controlling for T1 trauma symptoms. This result converges with ample prior findings substantiating links between self-blame and trauma symptoms, including one study that also assessed adolescent trauma symptoms while waiting for treatment after disclosing sexual abuse (Jouriles, Johnson, et al., 2022). Self-blame and divine spiritual struggles were positively correlated, but self-blame did not mediate the association between divine spiritual struggles at T1 and trauma symptoms at T2, as predicted in our fifth hypothesis. One explanation for this pattern of results is that other variables are creating both divine spiritual struggles and self-blame. For example, those adolescents who are experiencing both divine spiritual struggles and self-blame may be more likely to have family members and friends who imply directly or indirectly that the adolescent bore some responsibility for the abuse or for failing to stop it (Jouriles, Sitton, et al., 2022). That is, non-supportive responses from family members and friends may be creating heightened levels of both divine spiritual struggles and self-blame.

This study's findings point to the utility of assessing self-blame for sexual abuse and divine spiritual struggles when making clinical decisions for adolescents who have been sexually abused. Since many providers serving these adolescents must manage waitlists for services, identifying adolescents with risk factors that predict heightened trauma symptoms while waiting for treatment can help ensure adolescents at higher risk have more rapid access to care. The study findings also indicate the importance of developing a better understanding of the mechanisms by which self-blame and divine spiritual struggles are linked to trauma symptoms, and the conditions under which divine spiritual support might facilitate resilience. Further research in this area could inform how practitioners could compassionately and directly explore the spiritual resources and challenges that adolescents may face when they experience sexual abuse. Clinicians may need to become better educated about exploring adolescents' spiritual beliefs and struggles with self-blame for sexual abuse. Such exploration may enhance treatments for trauma symptoms for adolescent survivors of sexual abuse.

Several aspects of the current study limit the conclusions that can be drawn. First, data on divine spiritual struggles and self-blame were collected at the same time point, which limits inferences about mediation. Studies in which data on both divine spiritual struggles and self-blame are collected at multiple time points would shed greater light on this. Second, other unmeasured variables might function as predictors of trauma symptoms among adolescents waiting for treatment after sexual abuse, and it is possible that divine spiritual struggles and self-blame would fail to emerge as predictors if additional variables were considered in our regression models. Third, the variables in this study were all based on adolescent self-report. A different method of measuring at least some of the variables (e.g., caregiver report of adolescent trauma symptoms) could help rule out measurement artifacts such as common method variance that might partially explain the associations. Fourth, as with all research, caution needs to be exercised in the generalization of findings. For example, most of the adolescent participants were female, most believed in God, and the sample predominantly identified as Catholic or Protestant and Latino/a or African American. Thus, the extent to which the findings generalize to adolescents of other genders, spiritual beliefs, religious affiliations, or racial and ethnic backgrounds is unclear. Also, adolescents had to meet several criteria to be included in the study, and adolescents who did not meet these criteria reported lower levels of trauma symptoms at T1, lower levels of divine spiritual struggles, and less self-blame. Additionally, the sample was recruited from a single, urban CAC, but CACs differ in their setting (e.g., rural vs. urban), and how they manage waitlists and treatment referrals in a manner that could impact the course of trauma symptoms for adolescents waiting for treatment. In short, it is unclear how well the findings generalize to other treatment settings.

In conclusion, this study advances knowledge on cultural and cognitive factors relevant to the course of trauma symptoms for adolescents who have disclosed sexual abuse and await treatment. The findings replicate those of previous research demonstrating that trauma symptoms generally decrease while adolescents are on the waitlist for treatment, and that greater self-blame for sexual abuse at an initial assessment predicts greater trauma symptoms at the start of treatment. Additionally, the findings indicate that a greatly understudied cultural factor, spirituality, is relevant to the course of trauma symptoms among adolescents following sexual abuse. Specifically, greater levels of divine spiritual struggles at a screening assessment predicted higher levels of trauma symptoms at the beginning of treatment. Further research is needed to better understand the mechanisms by which self-blame and divine spiritual struggles impact the course of trauma symptoms among adolescents who have experienced sexual abuse.

CRediT authorship contribution statement

Ernest N. Jouriles: Writing – original draft, Methodology, Conceptualization. **Melissa J. Sitton:** Writing – original draft, Validation, Formal analysis. **Caitlin Rancher:** Writing – review & editing, Validation, Formal analysis. **Jeanine Johnson:** Writing – review & editing, Investigation. **Madeline Reedy:** Resources. **Annette Mahoney:** Writing – review & editing. **Renee McDonald:** Writing – review & editing.

Funding

This work was supported by a collaborative research grant between the Dallas Children's Advocacy Center and Southern Methodist University.

Declaration of competing interest

None.

Data availability

The data that has been used is confidential.

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