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Approval Sheet

TREATING PTSD IN FEMALE SURVIVORS OF SEXUAL ABUSE THROUGH
FEMINIST PASTORAL COUNSELING: A CASE STUDY

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ABSTRACT

TREATING PTSD IN FEMALE SURVIVORS OF SEXUAL ABUSE THROUGH FEMINIST PASTORAL COUNSELING: A CASE STUDY

by Jennifer Winingder

The central underlying question to be explored in this Dissertation is as follows: are current approaches to working with female survivors of childhood sexual abuse adequate and effective? The goals of this case study will be an examination of psychotherapeutic theories of female development, socio-cultural elements that influence a woman's self-identity in modern American society, and pastoral, liberative and narrative therapeutic practices that can help a trauma survivor address past abuse and move towards healing in a healthy, holistic, and empowered manner. In order to understand the effect of childhood sexual abuse on female development and identity, exploration of the effects of trauma on the brain and body was undertaken, and observations were made about the differences between sexual assault and sexual abuse. Comparisons between various forms of therapeutic and spiritual practices currently utilized in mental health and pastoral counseling were made in order to reach helpful conclusions about the particular needs of survivors of sexual abuse in therapy. Through the exploration of available literature on treating PTSD in survivors of childhood sexual abuse, it has become clear that there is a lack of significant resources on working with this particular population of people living with PTSD.

TREATING PTSD IN FEMALE SURVIVORS OF SEXUAL ABUSE
THROUGH FEMINIST PASTORAL COUNSELING:
A CASE STUDY

by JENNIFER WININGDER

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A Dissertation presented to
The Faculty of the ATA ThD Program
Emory University Candler School of Theology
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in partial fulfillment of the requirement for the Doctor of Theology

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An inner sense of connection to others is a central organizing feature of women's development... A woman's sense of self and worth is grounded in the ability to make and maintain relationships. Most women find a sense of value and effectiveness if they experience all of their life activity as arising from a context of relationships and as leading on into a greater sense of connection rather than a sense of separation. *Dr. Jean Baker Miller*

"The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma." *Judith Herman*

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I dedicate this work to:

My father, Tom Winingder, for his steadfast, unconditional support for me and of all of
his daughters and grandchildren

Dian Winingder, who has shown me how to live and love fully and to never be afraid to
speak your truth

My mother, Lesley Ward, who showed me how to persevere and make my own
path and to be my own person

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And to my children Laila and Moustafa, my inspirations- I am so honored and proud to
be your mother and greatest cheerleader in life. You fill me with joy and continually help
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encouragement and to me and my family in order to enable me to complete this work.

FOREWORD

Sexual abuse and sexual assault affect persons of all races, classes, and cultures. They do not discriminate. They know no cultural, economic, or gender boundaries. Establishing a greater dialogue about sexual abuse and assault aids with further representing the experiences and complex narratives of those who have been victimized. Too often, other political, cultural, and social/racial issues are introduced when victims tell their stories, thus removing the focal point from the victims and onto ancillary issues that further perpetuate cycles of victim-shaming in addition to making victims and their narratives invisible. Statistically, persons of color and victims of lower economic classes have less access to legal and financial resources than victims of a majority race or higher economic status. Further, certain cultural traditions and systemic patterns of relationship enable a culture of rape and sexual assault. If we look at the incidence rate of reporting sexual assault, however, we can see that the rate does not increase among Caucasian women over women of color. This is due to a pervasive hopelessness and belief that the women would not be supported in their search for justice.

Such shaming and invisibility also perpetuate the systemic power imbalances between abusers and those whom they victimize. A culture where the burden of proof is laid on the shoulders of the survivors does not hold perpetrators accountable for their actions and achieve justice for the survivors. Further, it does not allow for systemic change. Focusing on whether a survivor of trauma is completely accurate in their recalling of events distracts from the need to examine dynamics of power on the individual and collective level that allow such abuse to happen. Our fixation on accuracy

of memory from a traumatic experience highlights our cultural and social need to value “objective” facts and provable data over subjective experience. Research shows that memory function is impaired around recalling a traumatic event, a biological phenomena that must be further explored and understood (Van Der Kolk, 2003; Felitti and Anda,1999).

Perpetrators rely on the inability of victims to accurately recall events of the abuse or assault. The ongoing public scandal involving actor Bill Cosby starkly highlights this issue. The question should not be whether or not the trauma survivors, men or women, can or cannot remember what happened to them when they have been drugged and assaulted. The question should also not be, why didn't these women, now numbering close to 30, come forward at the time of the assault? They were reluctant to do so because of the exact nature of criticism and scrutiny they have received since coming forward. One woman of a handful who pursued a legal course of action against Bill Cosby, Barbara Bowman, declared that when she told her story to a lawyer in 1985 after Cosby assaulted her multiple times, the lawyer accused her of making the story up. “Their dismissive responses crushed any hope I had of getting help; I was convinced no one would listen to me. That feeling of futility is what ultimately kept me from going to the police...I was a teenager acting in McDonald's commercials. He was Bill Cosby: consummate American dad Cliff Huxtable and the Jell-O spokesman” (Bowman, 2014). She then asks the question of why, after repeated attempts to get her story heard, did it take a man's accusations, Hannibal Burress, to cause a real public outcry.

Any improved discussion of sexual abuse and assault must address the underlying

power issues and structures. Because 75% of sexual assault victims are females,(NIH, 2013;Bureau of Statistics, 2010) issues such as gender become relevant when discussing sexual abuse. Though a court of law is the United States’ legal forum in which allegations of criminal activity are evaluated, it is evident that the court of law does not serve or support the victims adequately in their attempts to obtain justice. My position as a sexual assault advocate falls outside of the bounds of such a forum. Instead of attempting to prove or disprove allegations, I seek to hear, validate and tell victims’ stories. I hope to enable clinicians and the public to understand sexual assault, and in a broader sense, trauma and Post Traumatic Stress Disorder, so that people suffering from PTSD can get the help and treatment they need and for which they are ready. I have engaged in discussions with friends and family over the past few years around this issue and found in every discussion that there is always someone who has a story of sexual assault to share, whether it is their own or a loved one’s story. In a sense, I have become a witness and carrier of these stories, and I feel a responsibility to bring awareness to the great pervasiveness of them. There has been enough victim-blaming and attempts to discredit victims’ stories. It is time to support victims and their stories, so they both can be better understood. In so doing, we can construct a stronger, healthier, more productive, and more just society. How we treat others who are less powerful than us reflects on how just, empathetic, and considerate our society is and how well we can get along with each other. Furthermore, respect, goodwill, and good interpersonal relations are essential both to our survival and our ability to thrive.

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I

INTRODUCTION

The psychological effects of rape have been conceptualized as posttraumatic stress disorder (PTSD) in the *Diagnostic and Statistical Manual of Mental Disorders*, Third, Fourth and Fifth Editions (DSM III, DSM-IV, and DSM V). Shortly after assault, 94% of rape victims met symptomatic criteria for PTSD; 3 months after the assault, 47% of victims still suffered from the disorder (Rothbaum, Foa, Murdock, Riggs, and Walsh, 1990). An average of 17 years after the assault, 16.5% of rape victims had PTSD (Kilpatrick, Saunders, Veronen, Best, & Von, 1987). Recent studies have estimated that approximately 25% of American women experienced rape at some point in their lifetime (Koss, 1983). It is consequently imperative that effective therapeutic procedures for PTSD following rape be developed. I will argue that survivors of sexual abuse who live with PTSD, should receive specialized care and treatment appropriate to their experience.

I will show that certain traditional socio-cultural, psychotherapeutic, theological paradigms, and most commonly used criteria for diagnosis of female survivors of sexual assault and abuse do not allow for females to explore their experiences and engage in the healing process in an authentic manner. Female survivors are often blamed and held responsible for what was done to them and, more often than not, diagnosed with Axis II disorders, which are defined as characterological and therefore inherent to the personality

of the victim, with little afterthought as to the fact that a person is not merely the psychiatric diagnosis assigned to her or him. This is an oppressive approach to working with survivors, and it labels the abuse as part of who survivors are as opposed to what they experienced and what had been committed against them by others. It shifts culpability from the abuser to the abused and, more egregiously, it almost presupposes that such abuse is only a figment of the imagination of the abused.

Why a Constructivist, Feminist Approach to Therapy with Survivors of Sexual Abuse and Assault?

This Dissertation focuses on five years of pastoral counseling work with a 60 year old Caucasian woman who experienced prolonged childhood sexual abuse. She has been given the pseudonym “Billie” in order to protect her identity. The emphasis of this Dissertation will be on Billie’s current experience with coping with her trauma, identifying current patterns of behavior that stem from the abuse, and voicing, validating, and expressing parts of her experience and herself that were repressed, cut off, or denied.

I myself am a Caucasian woman working towards a doctor in pastoral counseling at Candler School of Theology at Emory University, a well known university in Atlanta, Georgia. I was born in Atlanta but I have lived in various parts of the USA and abroad in African and Egypt with my family while I was employed. My professional background is in ministry, higher education, and counseling. My ex-husband is an Egyptian Muslim, and so my children were raised in a multicultural, interreligious environment in the early stages of their lives. They live and experience their environment and community in

different ways that I do for many reasons, one of them being that they carry the names of their father's culture and share his ethnicity and skin color. I come from a background of privilege in many ways but I have sought to learn about communities and cultures that were different from my own in culture, economic makeup, and geographical location.

The opportunity to be challenged and grow in this way came suddenly in September 2011 when my husband, myself and my infant daughter were living in Brooklyn and working in New York City. I was a student at Union Theological Seminary taking a course on interfaith dialogue when 9/11 happened. Our instructor was a South African Muslim scholar and he decided on September 12 to abandon the syllabus and engage in honest, immediate dialogue about what was happening in New York City and why. That was very powerful for me and an important learning and growing moment for our class and our community. I worked at Auburn Seminary while I was taking classes at Union and participated in a women's multifaith group that was composed of women from Jewish, Christian, Hindu, Muslim, and Sikh traditions. During the period after 9/11 we organized several community gatherings to share our thoughts, feelings, fears, grief, hopes. I also had the opportunity to help organize the first interfaith memorial service for the victims of 9/11 near Ground Zero. Muslim, Christian, and Jewish leaders from New York City spoke and led the service for members of their community and for New Yorkers and Americans during that time.

I have grown from this experience and others and I believe it is important for people in a position of privilege to continue to challenge their perspective and assumptions and engage with other people from different backgrounds all over the world.

It is important to be able to identify embedded racial, cultural, and economic prejudices or attitudes that one was born and raised with through engaging with others of different races, nationalities, and religious backgrounds. I believe one must continue to do this in an effort to reach understanding, form a common humanitarian goal, and improve communication and goodwill among all cultures. I have read authors, theorists, theologians, and thinkers from various cultural and ethnic backgrounds and I embrace dialogue and communication and accept a critical stance towards the cultural, economic, and racial position I was born into. I myself seek justice, peace, and health for all people and am willing to work towards that goal. As a woman, I am drawn towards feminist perspectives and I find a feminist approach to be empowering and liberating. I find it encouraging when women empower other women of all backgrounds towards the goal of gender equality.

Regarding my work with Billie and other trauma survivors, I have developed a constructivist approach to therapy that allows the client to possess an agency in the therapy that allows authentic healing to take place. This approach encompasses different viewpoints rather than one unified theory for the clinician to follow, based on the belief that people make their own meaning out of events they experience, and that the therapist's role is to help them understand their experiences through several lenses, including a socio-cultural lens, a diagnostic lens, and a spiritual lens. As I continue to explore how a survivor of trauma processes the traumatic experience in therapy and how healing can take place, I will show how this approach is most helpful, based on research and evidence undertaken by scientific researchers, therapists, medical doctors, and

pastoral theorists alike on the nature of trauma and how humans live with it and make meaning out of it. In constructivist theory, so in the therapy there is no one objective reality and no one set treatment protocol (Berman, 2010). The conversational exchange is the medium through which meaning is constructed; the therapy becomes a dynamic enactment of expressing, creating, and re-creating meaning for the client that is given form through the act of continuous storytelling. Interpersonal connections and relationships are primary in the work (Neimeyer, 2000). This is important for therapists to recall when working with clients, particularly females, who have experienced sexual abuse. The therapeutic relationship, including the establishment of rapport, is typically affected by the diagnosis of Post Traumatic Stress Disorder with which many abuse survivors struggle. Though PTSD is a formidable diagnosis to address in therapy, it is also an umbrella diagnosis that can be perceived as open, fluid and encompassing in its cognitive and affective symptom presentation so as to enable the therapist and the client to make important connections between the experience of the trauma and past, current behavior patterns, and self-perceptions. Thus, I wish to show that PTSD, while a challenge, can certainly be framed as an opportunity to move beyond the effects of trauma in order to positively transform the individual.

With respect to the goal of this research, and to therapy that concerns sexual abuse and related trauma, I believe there is an ethical imperative to define PTSD as it manifests in female survivors of childhood sexual abuse. Furthermore, there is an imperative to identify symptoms of PTSD observed in client Billie and viewed through a critical lens in this paper that are life-inhibitive in order to explore various therapeutic modalities and to

identify therapies that are most effective for her in alleviating symptoms so she can enhance her life on her own terms. Included in this exploration is the growing understanding for Billie of what health and happiness mean for her and how she reaches that place within the context of understanding and working past her abusive childhood.

The Role of the Spiritual in Constructivist Approaches to Therapy

Though the underlying psychotherapeutic elements of therapy with female sexual abuse victims have been discussed, there is still a need for a discussion of the role of the spiritual in such therapy. The theological grounding inherent to pastoral counseling provides the existential framework for clients such as Billie, in this case, to best contextualize their experiences to move forward. Consequently, the spiritual role of the pastoral counselor as well as elements of pastoral care and theology can help to build a relationship of trust that is essential for healing work with survivors of sexual abuse and trauma. Clebsch and Jaekle's (1965) four elements of pastoral care widely used and applied in pastoral care training programs and in pastoral and practical theology programs as building blocks are useful in the therapeutic space. These are commonly understood to be healing, sustaining, guiding, and reconciling. Dr. Carol Watkins Ali added nurturing, empowering, and liberating to these pastoral care functions in her seminal work *Survival and Liberation, Pastoral Theology in African American Context* (1999) with a womanist methodology. Bonnie Miller-McLemore and others followed her lead and critiqued conventional models with which pastoral care has been routinely equated in *Feminist and Womanist Pastoral Theology* (1999). These additional models focus on social, cultural,

and political power imbalances and dynamics. Practicing the pastoral quality of sustaining in the therapeutic space- giving the client comfort, understanding and support during long or short term crisis is essential to good therapy with clients living with PTSD.

Guiding in therapy involves helping the client find solutions to their life's problems. Healing involves helping a person to find wellness and wholeness from injury or disease. This is a particularly appropriate pastoral function when working with survivors of sexual trauma. Reconciling can be one of the most challenging tasks of the pastoral counselor when working with clients who have been abused, because relationships with survivors of childhood abuse were so destructive and life-limiting at a developmental level instead of life giving. The process of reconciliation is different and individual for each client, and may or may not involve forgiveness. It almost always involves acknowledgement and acceptance of the abuse in some form. Reconciliation as I understood it in the therapy meant for Billie to develop the ability to reconcile parts of herself that were split off from one another that contained intense emotional memories and associations with her father, and her own understanding of him and what he meant to her. These memories and emotions around the memories were often conflicting and contradictory. In some memories, Billie's father was the fun-loving, strong, and doting father who called her his "special" daughter. He was the one who took her on camping trips and took her for ice cream. In other memories, he was the angry, repressed, strict father who could not tolerate noise or misbehavior in the house. In other memories, he was the terrifying, threatening presence whispering commands to her at night in her bedroom as he violated her. How then, could we attempt to understand these memories

to be one person and acknowledge that the man who claimed he was her favorite child do such unspeakable things to her?

Another function of pastoral care that is essential to effective therapy with Billie and clients like her is the act of liberation (McLemore, 1999; Doehring, 1993). Liberation is a function that involves a careful examination of power dynamics in relationships between the client's own self-narratives, between the client and the abuser, others in their intimate circle, and the community as a whole. Because abuse involves the exploitation of an unequal power dynamic between two people, or between two entities, this examination of the nature of exploitation is essential for the victim to release themselves from self blame and reclaim the power that was involuntarily taken from them. Billie struggled with the commitment to liberate herself. In order to be her own liberator, she had to let go of the old notion and feeling that she was Daddy's little girl, and that he would always take care of her, as he had promised. She had to let go of the fantasy that he, or someone representing him in her mind, would come rescue her from the bad guys. Liberation involved a continual, painful reminder that he would not rescue her, or anyone else, and a reminder that the abuse actually did happen.

The Role of Empathy in Pastoral Counseling and the Therapeutic Relationship

Empathy, spiritual awareness, and an understanding of how different socio-cultural factors affect a female's narrative all help to rebuild trust in a relational manner between the client and therapist, and the client and herself, and the client and her environment. As a result of working with Billie, in addition to working with other client survivors of

sexual abuse during the past 5 years of counseling work, it has become clear to me that the pastoral, collaborative relationship is the key to an effective alliance between the therapist and the client and forms the foundation on which healing can occur. An equally powerful dynamic within the therapy room allows the abuse survivor to begin to break down walls of defense and resistance and to trust both her therapist and herself.

Relatedly, feminist pastoral counseling, from a constructivist perspective, empowers the client to create and use her voice and name her experience for what it was – abuse, and to reconstruct her identity and self-agency that was taken from her through an abuse of power (Berman, 2010, Herman, 1992).

What does “pastoral” mean specific to this discussion and with respect to my work experiences with previous clients? What does pastoral counseling mean? These questions will be explored in depth and in a manner that is representative of my experiences and those of my clients and revolves around an approach to therapy that is spiritual and yet not necessarily Christocentric. My background in pastoral care arose from years of work in parish ministry, in outreach to communities here and abroad, and from a year of Clinical Pastoral Education at Northside Hospital. The approach to pastoral care in a hospital setting that cares for peoples of all races, backgrounds, and ethnicities was one of ecumenism and interfaith acceptance. Practitioners were encouraged to meet the patients and families where they were with respect to their faith. That is, irrespective of whether they were practicing Christianity, practicing a different faith, or not practicing any religion, therapists were to engage them as they were. This is not to say that pastoral care could not be provided, but rather that it needed to be

customized and framed to the uniqueness of each client. Certain qualities of pastoral care were very present in the therapeutic work accomplished with clients at the hospital.

Central among these were presence, listening, mirroring, reflecting, respect, and empathy.

Pastoral Counseling as it is taught through the Atlanta Theological Association's program, offered by Candler School of Theology at Emory University in cooperation with Columbia Theological Seminary and the Interdenominational Theological Center, is a cross-disciplinary, integrative program. The focus of the program is on how to apply theology to pastoral situations, and to effectively counsel clients in need. This focus is bolstered with psychoanalytic theory, sociocultural theory, object relations theory, and family systems theory. Such a multidisciplinary approach to counseling and therapy is enriching and fulfilling because it addresses the background and underlying elements of what makes individuals unique and thus affects each person's narratives. Each area of study informs the other in a conversation that is affirming for therapists and their clients. The ability to apply pastoral theology to counseling is a most valuable element of the approach. It is something that helps with creating faith and spirit-centered counselor-client rapport in order to allow clients the space to not only tell their stories, but also to tell them confidently, with purpose, and with a trajectory that will allow them to positively transform.

Women who have been abused and forced to keep the abuse a secret, to deny its occurrence out of fear of retaliation, are often convinced that no one will believe or support them. They often believe that because they may have lost faith in themselves and even others, that others have no faith in them, thus prematurely shutting down the paths

to positive transformation that can be traversed with the aid and companionship of others. In many cases, our culture bears out this reality when the women who endeavor to talk about their abuse come forward. The women are usually blamed, or ignored, or not believed. The number of cases of rape or sexual assault that are reported to police, educational administrators, and military personnel that go ignored, are dismissed or mishandled is astounding. The New Orleans police department is currently under investigation for ignoring thousands of reports of sexual assault by individuals dating back to the 1980s. Columbia University, the University of Virginia, and the University of Florida are one of many universities embroiled in controversy around administration's poor handling of numerous complaints filed of sexual assault. What tends to happen when these allegations are not investigated and addressed, is that the perpetrator escapes any punishment and continues to abuse. A culture of permissiveness of sexual assault is encouraged. Further, because of the nature of how our brains and bodies cope with trauma by repressing it and "forgetting" it, female survivors often do not remember all of what happened to them (Van Der Kolk, 1996, 2012). They may remember bits and pieces, or the memories may be vague. (Felitti and Anda, 1998) They may not remember the abuse at all until years after it happened. All of these factors lead to a culture of disbelief and lack of support for female survivors of sexual assault and abuse that is anathema to how people tend to treat allegations of non-sexual crimes – with faith in those making allegations and consequent support for their narratives..

Part of the liberative process for the client is the belief that someone believes the survivor's story. I have come through my work with Billie to understand my job as a

pastoral counselor is to believe his/her story, to allow the survivor to tell his/her story as he/she remembers it and not to judge him/her, or question the story. This framework or imperative is critically important to assisting clients with helping themselves because it helps clients move beyond the hurt that stems not only from abuse, but also possibly from their previous experiences of therapy in which there was never any gain that resulted from talking about their trauma because they perceived the judgment and incredulity from their therapists as palpable. Proving or disproving facts or events that occurred previously creates an atmosphere of judgment and distrust to therapeutic work and the client will not be comfortable enough to be completely open and honest with the therapist and engage in the relationship in order to ultimately heal.

When asked about why our therapeutic relationship was effective, client Billie responded that, principally, she felt that I saw her as a whole person and not as a diagnosis (Sept. 2014). Thus, from her perspective, when she felt that she was being engaged rather than treated as a diagnosis, and when she felt as if she was an active rather than passive character in her narrative, she could begin to free herself. Feminist pastoral counseling advocates this approach of treating clients as active, knowledgeable, sentient, and capable storytellers whose narratives hold weight beyond just providing clues as to how to treat a diagnosis. Such an approach enables the client to collaborate with me on what treatment methods they feel would be effective for where they are at each stage of the healing process. Inherent to such an approach is the philosophy that individuals are the experts of their internal worlds and, also that, since humans are social creatures, people can help each other make sense of their worlds so as to grow – the double

hermeneutic (Giddens, 1984).

Dangers of a Medicalized Climate in Therapy with Female Survivors of Sexual Abuse and Sexual Assault

Does the current medicalized climate of therapy of prescribing a set of treatments after a brief interview help survivors of sexual abuse and sexual assault who live with PTSD? ¹ I will look at certain cognitive behavioral approaches to working with survivors of sexual assault living with PTSD and examine the results in depth in Chapter III. If we take a brief look at a few comparative studies conducted that looked at effectiveness of reducing certain symptoms of PTSD related to rape, we can gain some insight into what therapies are most effective for clients living with PTSD.

One thing will become clear, shorter term behavioral-based approaches and methods do not allow the caregiver to get to know the client, which also translates into a deficit with respect to being able to convince clients that their narratives can be and will be believed. As previously explained, clients need to feel that someone believes them, has confidence in them, and has faith in them regardless of what has happened to them. With respect to the target population of this dissertation, women, it must be emphasized that women sexual abuse survivors are people and not diagnoses. Such a statement may seem redundant, but given the state of mental health care that focuses on treating diagnoses rather than people, it must be done. As I continue to undertake research into the effects of sexual assault and childhood sexual abuse, I come to believe more that childhood

¹ CBT, SFT, shorter term evidence based, behavioral therapies versus longer term relational therapies

² It is important to note here that my observations and experiences with Billie in

abuse survivors develop certain disorders distinct from survivors of onetime sexual assault by a stranger, and the evidence supports such a conclusion. The PTSD survivors of chronic abuse live with also has a certain character and intensity and depth that must be considered.

Furthermore, it must be emphasized that, even for women sexual abuse survivors whose struggles lead to severe diagnoses, there always exists an underlying dynamism concerning lived experiences and the potential each individual has to positively transform rather than remain in a static state – trapped in the hurt of the past (Berman, 2010). Though the current standard of treatment is such that focuses on fixing clients, the narratives provided by my clients and notably, Billie, suggest that clients do not need to be fixed. Rather, they desire and require assistance with directing their own transformations. As such, this interdisciplinary approach, which focuses on holism, is central to this work and my ability to practice faith in my work with my clients by accepting them unconditionally, by believing them, by hearing and validating their stories, and by encouraging them to reactivate their agency and power in the ways that best apply to them.

Synopsis of Case and Treatment Planning

The case study format selected for this study is appropriate because it allows for the acquisition of a thick description of Billie’s experiences (Geertz, 1973). Specifically, it allows for a thorough description of certain, directed techniques when working with female adult survivors of childhood sexual abuse who have PTSD and for allowing

observations and conclusions to emerge through the process of the therapy. Work with survivors of sexual abuse who have PTSD requires certain conditions and criteria related to the parameters of therapy, length of therapy, depth of therapy, and the quality of the therapeutic relationship in order for there to be the greatest opportunity for clients to heal. Since the therapist must commit to engaging in the journey with the client through the client's own story, emotional states, and power dynamics within the client's self and in interpersonal relationships, the process must be open-ended, in-depth, long term, and exploratory. For these reasons, grounded theory is the best way to form conclusions from this type of therapy and research. Since every person is unique, and thus each narrative is unique, an approach that accentuates detail of experience is preferable.

This dissertation seeks greater understanding of clinical applications that reduce and, in some cases, eliminate destructive behaviors associated with PTSD that result from childhood sexual abuse. This process is best accomplished as an interpretive task utilizing case study methodology and its related techniques. In the next section, attention will be directed toward the validity of the research design, its implementation, and processes.

Research Design and Methodology

The interpretive nature of this dissertation is grounded in the field of qualitative research. Denzin and Lincoln (2005) define qualitative research as:

A situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and

memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. (Denzin and Lincoln, 2005, p.3)

By focusing on the process of therapy with a client living with PTSD, via a case study presentation, the therapeutic experiences of both the clinician and client can be best understood. Qualitative research offers the opportunity to explore the directions that the participants may take as well as to gain deeper understanding through natural interaction. “Being open to any possibility can lead to serendipitous discoveries. Qualitative researchers are “trying to remain open to the nuances of increasing complexity,”(Merriam, 1998, p.121) thus affording the opportunity to optimize the concept of “progressive focusing” (Huberman and Miles, 1983; Stake 1994). As therapy progresses, the focus of the work shifts and adapts according to the client’s increasing awareness, integration, and insightfulness. Within the case study approach, as data and themes emerge throughout the course of the study, the organizing concepts change in accordance with the tenor of such progress. (Stake, 1995, p.133)

The design of this study provides guidance to accomplish the following characteristics of quality qualitative research as outlined by Garman (1994):

1. verity (intellectual authenticity)
2. integrity (structural soundness)
3. rigor (depth of intellect)
4. utility (usefulness)
5. vitality (meaningfulness)

6. aesthetics (enrichment)

7. ethics (consideration of dignity and privacy of participants)

8. verisimilitude (sufficient detail to warrant transferability)

As the research progresses, attention will return to these elements to provide a compass to avoid the traps of tangents, irrelevance, data mismanagement, or disorganization, shallow interpretation, bias, and weak analysis.

This dissertation employs a qualitative case study research approach as defined by Merriam (1998) as “an intensive, holistic description and analysis of a bounded phenomenon” (p.xiii) and Yin (2003) who provides more specific boundaries for case study. It is an empirical inquiry that,

Investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident; it copes with the technically distinctive situation in which there will be many more variables of interest than data points: and as one result relies on multiple sources of evidence, with data needing to converge in a triangulating fashion; and as another result, benefits from the prior development of theoretical propositions to guide data collection and analysis. (Yin, 2003, p.13-14)

I believe this description satisfactorily captures my intent in this case study. This case study is bounded by several contexts: the center where the counseling took place, the therapist’s experience as a counseling resident at the center, the therapist’s experience as a ThD student in the Atlanta Theological Association (ATA) program in Atlanta, the supervision the therapist received in tandem and group situations, in case conference presentations, class assignments and presentations, and in clinical staff consultation. Through qualitative research techniques, the relationships and resulting interactions between these contexts, pastoral, theological, psychoanalytic, and feminist principles, and

clinical applications will be explored. These experiences are significant to such a research endeavor because the extent to which attention is paid to these areas can facilitate or hinder the understanding of feminist pastoral counseling by therapists and give it meaning.

The case study is written in narrative form and is primarily concerned with providing the reader with insight and understanding of the unique case or situation. According to Stake (1995), “Qualitative research tries to establish an empathetic understanding for the reader, through description, sometimes thick description, conveying to the reader what the experience itself would convey” (Stake, 1995, p.39). Thus, the outcome of a rich narrative text describing the experiences of the therapist and the client, with pastoral theological perspectives, feminist viewpoints, psychoanalytic insights, and medical and clinical applications, is dependent on organized, flexible, and careful data collection.

The purpose of this dissertation then is to generate grounded theory based on an examination of my work with Billie through the lens of certain pastoral, theoretical, and clinical frameworks and by applying recent medical and scientific research on the effects of trauma on the body and brain and the effects of self-reflective practices on the same. Billie is a prime candidate for this examination, as she committed to 5 years of therapy, received several neuropsychological evaluations, and engaged in several therapeutic and reflective practices in an effort to heal.

Relevant Factors in the Case of Billie

Billie was chosen as the subject of this case study because of the fact that 1) her history of childhood sexual abuse is extensive 2) she has personal and professional knowledge of therapeutic techniques, psychoanalytic theory, theology, and medicine 3) she was and remains deeply committed to the therapeutic process, and 4) she came to the Care and Counseling Center of Georgia (CCCG) when she was destitute and homeless, and her progress towards health and stability can be marked by her commitment to therapy and to self-reflection. 5) She is unique in that she is a single, well-educated Euro-American female who temporarily became part of a public health care/welfare system as a statistical minority living among people of other races and socio-economic and educational backgrounds. As such, the selection of Billie as an individual with unique sexual abuse history and intercultural and intrasocietal experiences was demonstrative of a purposeful sampling, which is “based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned” (Merriam, 1998, p. 61). For the purposes of this dissertation, going forward, the term “client” describes the research participant Billie.

Throughout this dissertation, my role is one of both researcher and therapist. Billie is both my client and the participant. The potential conflict between these dual roles has been handled in such a way that the material collected during the time I was Billie’s therapist serves as the foundation for the research. However, Billie and I have at this point terminated our therapy. Since the termination of our therapeutic relationship, a series of exit interviews with Billie regarding the research have been conducted.

In contemplating one’s role as a researcher, especially in descriptive, exploratory,

and phenomenological work, Stake's (1995) conception of case researcher as interpreter is most fitting. According to Stake,

The case researcher recognizes and substantiates new meanings. Whoever is a researcher has recognized a problem, puzzlement, and studies it, hoping to connect it better with known things. Finding new connections, the researcher finds ways to make them comprehensible to others.(Stake,1995, p.97)

Through this approach, it is the aim of this research, in part, to apply the lessons learned by working with Billie, and other clients, and explain them in such a way as to allow other therapists to understand the effect of sexual abuse on female identity and emotional, physical, and psychological makeup.

Approach to Treatment

I approached the work with Billie with the following understanding and expectation: if her behaviors and thoughts did not improve or mimic or mirror the model of behavior determined to be healthy by Billie, myself, and my colleagues and supervisors in the counseling program I was participating in, then the therapy would be considered ineffective. My primary professional goal was to be able to be present with the client and open in the moment to engaging in a "relational" and authentic manner so as to strengthen the therapeutic alliance and to understand the most visible and powerful transferences and countertransferences going on so as to form an effective, honest, and healing relationship.

Pete Walker (2002) states that prolonged abuse causes deep distrust among clients who have PTSD. It can take months for the client to trust the therapist enough, or anyone close to them, to engage in effective work. This was expressed by Billie, and it became

clearer to me as the therapy progressed that before there could be any client progress, there had to be a deep and unfailing therapist-client rapport in which the client feels not only comfortable, but also empowered to speak honestly. Similar trust issues were present in working with other female survivors of childhood sexual abuse.² By the ninth month working with this population, I began to notice a shift in the dynamic and a more open, direct, present and honest discussion around certain subjects. It was around this time that I also began to notice a pattern of shifting “states” or personas that Billie and other clients would inhabit or exhibit. Davies and Frawley (1994) and Schwartz (1997) focus on how the therapist can engage and help the client survivor of abuse acknowledge, integrate, and inhabit these repressed states without getting caught in the internal conflict that the client is projecting. Billie and I talked about this and undertook the exercise of naming these states, and then trying to get to know them and understand them. She was aware of these shifts in emotional states, but was not completely aware of when or why she would make a shift and why she would choose to allow the state or part to emerge in the manners in which it did. In the second year of therapy, we were able to get closer to understanding why she would shift into particular states and what triggers, ongoing or immediate, would cause a shift. Gradually, Billie became increasingly mindful of her thoughts (automatic), emotions, and behavior.

Therefore, in the first year of therapy, I was not completely aware of the multiple parts or self-states that Billie actually possessed and with which she lived. She admitted

² It is important to note here that my observations and experiences with Billie in therapy were mirrored, influenced, and validated in my work with other survivors of childhood sexual abuse occurring during the same timeframe that this study encompasses.

to being “dissociated” at times in therapy. There were a few instances in which she was particularly affected and deeply buried in an emotional state. She would then go home and explain, via journaling, where she was emotionally. In some cases, she would reveal that entire sessions were a blank or that she did not remember a significant conversation after the fact except to recall that it was significant. Following Billie’s emotional and therapeutic revelations, I felt responsible to learn how to detect and identify which emotional self-states Billie was in when she came to see me. I chose to do this through a) inquiring with her and asking her a series of friendly questions about how she was feeling, tracing her activity from the time of the last communication until that session, and documenting my impression of her presentation and affect and repeating back to her what she was expressing in order for her to verify that this was true for her.

Based on my work with Billie, the danger perceived by engaging in Cognitive Behavioral Therapies (CBT) or Solution-focused Therapies with clients exhibiting Cptsd, or chronic PTSD, is that it is very difficult at the outset of such therapeutic approaches to determine if a) the client is appearing to be thoroughly engaged and open in the therapy but is in fact in a dissociated or traumatized state or b) the trust and alliance between the therapist and client is strong enough for the client to open up and engage effectively to effect lasting change. Both of these challenges require longer term therapy and the ability for the client and therapist to develop such a strong alliance. Neither can be found in CBT or Solution-focused approaches because they are inherently occupied with an expeditious rather than transformational and existential examination of issues.

Billie and I discussed related modes of therapy as possibilities for engaging in

together. She was eager to read about them and she was open to exploring different models and modes, which enabled us to freely discuss the possible benefits and drawbacks to such therapies. She participated in an eight week Dialectical Behavior Therapy group that provided her with some basic knowledge and techniques to employ to better alleviate the severe anxiety she experienced while being outside of the home and traveling on public transportation. Billie was also having dissociative episodes that left her with chunks of time that were unaccounted for. After the DBT group work, Billie remarked that the exercises and techniques that she learned helped in a few circumstances to alleviate some anxiety but that the anxiety would return or be reduced to a lower level.

The case material collected consists of more than 350 hours of therapeutic interaction, observations, consultation with colleagues concerning this case, and artifacts related to the case including letters, drawings, and psychiatric and medical evaluations. Data will be analyzed simultaneously with data collection and the result will be a narrative text describing the experience of the therapeutic relationship infused with historical thinking and socioconstructivist pedagogy.

Chapter I provides a rationale for the use of a feminist approach when working with female adult survivors of childhood sexual abuse. Such an approach has been contextualized with respect to Billie's experiences, since she is the focal point and participant of this case study. Chapter II provides an overview of the study's research questions as they relate to therapeutic and clinical understandings of Post Traumatic Stress Disorder (PTSD) and the use of poststructuralist thinking with respect to sexual abuse and trauma. Also provided is a brief case study methodology overview that is

employed in this dissertation. Chapters III and IV describe in detail the conceptual framework for this dissertation. Additionally, they provide a detailed application of the research methodology. Chapter V summarizes the findings and conclusions of the case study and evolution of therapy.

II

UNDERSTANDING TRAUMA AND PTSD

In order to provide effective treatment when working with survivors of sexual assault and sexual abuse in different forms, it is important to understand various ways trauma is defined. I provided a brief look at how PTSD can be defined in various diagnostic settings and practices in the previous chapter. Here, I would like to expand that description and also define it in the way that is most useful to this discussion and to female survivors of childhood abuse living with PTSD.

There are different causes and forms of trauma. The two most recognized forms prevalent today are physical and sexual trauma occurring on an individual, intimate level, and combat trauma experienced by military engaged in active combat. There are different forms of sexual trauma. I will broadly highlight some similarities and differences between sexual abuse and sexual assault and how they are defined in the mental health field. Both survivors of sexual abuse and sexual assault can develop PTSD from the traumatic experience. However, the experience of sexual abuse implies certain particular conditions and dynamics for a survivor that may not necessarily apply for a survivor of assault, and vice versa. I will go into further detail in the following chapters about how the nature of sexual abuse affects a survivor. I would like to pay attention to two factors in particular; 1) How the onset and termination of abuse –at what age the abuse began and ended- influences the intensity and long-term effects of PTSD on the

survivor. 2) The effect of the dysfunction of the parent/caregiver- child relationship on the development of a child whose parent is abusing them. Because the parent/child bond is the strongest bond between humans in the early stages of life, abuse of a child by the parent can be particularly devastating for the psychological, mental, emotional, and spiritual development of a child. After working with this particular population, I am left wondering if survivors of childhood sexual abuse are able to repair and overcome such extensive damage to the point of being able to function and be happy. The ego development and characterological development is so deeply damaged that the odds against finding a “normal” life seem overwhelming. Studies done on the effects of adverse childhood experiences (ACEs) support this question. (Felitti and Anda, 1999). The question then becomes, what are “normal,” “health,” and “happiness” for these clients? Do those terms need to be redefined?

For the sake of this dissertation, I will focus on aspects of defining trauma particularly as they apply to sexual trauma, and I will draw comparisons and contrasts to other forms of trauma for the sake of clarification.

Definition of Trauma

The American Psychological Association (2015) defines trauma as the following:

Trauma is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives. Psychologists can help these individuals find constructive ways of managing their emotions. (APA, 2015)

Causes and Effects of Trauma

It is important to make connections between the possible causes of trauma and how they affect persons, particularly women. Different traumatic events can have a range of effects on an individual. Additionally, the duration, intensity, and age of onset of the trauma influences the long term effects and affects the possibility of healing and recovery. This dissertation is interested in looking at how sexual trauma, particularly that experienced at a young age and taking place over a long period of time creates long lasting symptoms and coping behaviors that are dysfunctional and life-limiting. Some of these symptoms are more obvious and easily diagnosable through the DSM IV and DSM V, and some are not as visible or easily categorized.

It is also important to draw connections and make comparisons between different forms of trauma to better understand chronic PTSD developing from long-term abuse. Trauma as it is widely recognized in the psychological, social, political, and economic spheres, can be misdiagnosed and misunderstood. Survivors of trauma are often stigmatized and judged and therefore suffer re-traumatization when attempting to tell their story. Therefore, many report a strong reluctance to share their story and attempt to get help because of the judgment and misunderstanding surrounding traumatic experience. They face judgment and ostracism from friends and family who may choose to support the perpetrator if they are known, and they face diagnosis through a medical model formed by health professionals who may choose to prescribe a set treatment protocol that addresses the surface symptoms and who may choose to medicate the presenting symptoms which provides partial relief but does not get to the heart of the

problem. As a social group that is overwhelmingly discriminated against and oppressed economically, socially, politically, and psychologically, women are doubly afraid of seeking healing and justice against a perpetrator for sexual crimes. The majority of my clients who are survivors of childhood sexual abuse report that a family member abused them. Further, they report that the abuse was an accepted, covert pattern in the family that occurred over generations.

One African American female client, after telling her mother about the abuse she suffered at the hands of her stepfather, found out that her mother was abused by an uncle when she was a young teenager. After investigating this pattern and inquiring with other female relatives, the client found out that her grandmother was also abused by an older male relative. This client's daughter was later abused by the client's second husband. This event was particularly devastating for my client because she felt she worked hard to break an intergenerational pattern and failed.

Billie told me her father was physically abused as a young boy. She is not aware if he was sexually abused. Yet another client, who belongs to an Asian culture where one's elders are honored and revered and where children have no voice or ability to resist authority, lived with the secret of abuse by an older male cousin for years for fear of confronting him and her family system that supported his authority over hers. Yet, she was seized with panic and guilt at the thought of her brother's children spending time with this cousin and her own children as well. This family pattern of abuse highlights a social and cultural acceptance of abuse and creates an atmosphere that makes it more difficult for a survivor to tell their story, get the support and healing they need, and to

break an intergenerational pattern.

People who have endured horrible events suffer predictable psychological harm. There is a spectrum of traumatic disorders, ranging from the effects of a single overwhelming event to the more complicated effects of prolonged and repeated abuse. Established diagnostic concepts, especially the severe personality disorders commonly diagnosed in women, have generally failed to recognize the impact of victimization. (Herman, 1992, p.2- 3

Sexual Abuse and Sexual Assault, Similarities and Differences

There is more literature on sexual assault, there is more public discussion about sexual assault than sexual abuse, and more research has been published regarding sexual assault than sexual abuse. The Encyclopedia of Psychology (2015) defines sexual abuse, a particular form of trauma, as unwanted sexual activity, with perpetrators using force, making threats or taking advantage of victims not able to give consent. Most victims and perpetrators know each other (EOP, 2015). Immediate reactions to sexual abuse include shock, fear or disbelief. Long-term symptoms include anxiety, fear or post-traumatic stress disorder. While efforts to treat sex offenders remain unpromising, psychological interventions for survivors — especially group therapy — appears effective. According to this definition, there are several evident commonalities in the experience of sexual assault. First, the perpetrator uses force, i.e. . . . the activity is non-consensual. Second the perpetrator makes threats or takes advantage of an imbalanced power dynamic due to physical, social, economic differences between the perpetrator and victim. There is some form of manipulation of power. Therefore, sexual abuse is not just a sexual act, it is an act of control, or power of one person over another. Third, most victims and perpetrators

know each other. In cases of childhood sexual abuse, this is overwhelmingly true. This fact influences and shapes the abusive dynamic or relationship and the effects of such a relationship on the victim in a very particular way.

Though there are some similarities to sexual abuse in terms of effects on the survivor, there are differences. For instance, with respect to abuse, in contrast to rape or sexual assault, there is a presumed frequency of unwanted sexual activity. Whereas demographic factors such as age of the victim or relationship to the perpetrator may be relevant in individual instances of rape or sexual assault, such factors are that much more relevant to understanding the dynamics of abuse, since abuse can be described as continuous and thus, trauma can occur and reoccur, resulting in PTSD in the surviving individual of such extreme mistreatment (Walker, 2002). Moreover, such demographic factors, age and relationship to the abused, in particular, can greatly help in explaining how abusers decide on whom to prey. I will discuss this in further detail in the case discussion. To be abused or assaulted by a stranger is devastating as well, but it is not the same as being abused by a family member, parent, cousin, sibling, or neighbor.

In addition to employing and drawing from on definitions of sexual abuse, I will refer to Dr. Amelia Stinson Wesley's definition of sexual assault and rape, something which she describes as a traumatic event. Dr. Stinson-Wesley, founder of Religious Response to Violence against Women and Children, defines rape as "any sexual act that is attempted or completed by force, threat of force, or coercion against another person's will"(Stinson-Wesley, 1996, p,236). If she says no, it is rape. Rape is not sexually motivated; it is neither sex nor love, it is violence, and it tends to be about power and

control, the use of the body in a violating way, for one person to dominate another. Almost all rapes involve the threat of physical harm or the use of force (Stinson-Wesley, 1996). Because females tend to be less physically powerful than men, women and children (females and males) tend to be the majority of victims of sexual violence. Dr. Stinson-Wesley articulates that the majority of rapes are planned; the attacks are premeditated, and the victims are made to believe that the rapes are their fault. After an attack, the survivors often wonders what they did to provoke the attack or what they could have done to prevent it. Often, the impact of the rape is minimized, and the victim will not report it for fear of retaliation and out of shame over the event. The FBI reports that 25-33% of women will be raped (Stinson-Wesley, 1996) in the U.S. at some point in their lives. Understanding this helps with demonstrating how prevalent such occurrences are and how systemic violence such as rape continues to oppress women like client Billie.

Often, survivors of rape are not only the victims of the physical crime of rape, but also of the ethical and psychological crimes of mistreatment and social lack of consideration after the fact. One could imagine a social environment in which rape, for all of its physical and psychological horrors, could become less stigmatized and even more psychologically bearable if only individuals rallied around those victimized instead of ostracizing them. Pamela Cooper-White (1995) asserts that violence against women is too often called something else: “just a little joke,” “flirting,” “she asked for it,” “being in the wrong place at the wrong time,” thus further burdening those in need of greatest support and assistance because they, rather than their predators, are the innocents.

How We React To Trauma

Various forms of trauma can have varying and lasting effects on people (DSM V, 2013, Van Der Kolk (2006, 2014), Felitti and Anda (1999)). The DSM V states that some people can develop PTSD and symptoms related to it from the sexual causes already discussed. Some people who experience the same type of trauma do not develop PTSD, however. Why do some people develop PTSD and some do not? The answer to this question is too complex to answer in a simplistic manner. If we assess different factors including the age, gender, ethnicity, culture, family environment, and economic class of the person who experienced trauma, as well as the length of the trauma, then we can see how these factors influence a person's reaction to a traumatic event (Walker, 2002).

Comprehensive studies on the effects of stress and Adverse Childhood Experiences (ACEs) overwhelmingly show that stress has a physical effect on the body (Felitti and Anda, 1998). Acute stress, which triggers the release of cortisol into the brain and the fight-flight response, enhances the immune system, memory, and cardiovascular function. Chronic stress, such as repeated sexual trauma or abuse, suppresses the immune system and memory, promotes bone mineral loss, muscle loss, slows down the metabolic system, raises blood pressure, increases insulin resistance and decreases restful sleep patterns (Felitti and Anda, 1998). A study by Drs. Christine Heim, Mayberg, Nemeroff, Preussner, and Mletzko published in the *American Journal of Psychiatry* (2013) showed how childhood trauma causes long lasting changes in brain architecture. In survivors of childhood sexual abuse, MRIs of the brain showed decreased cortical

representation of genital somatosensory field after childhood sexual abuse. Basically, the brain shut down or decreased any connection between genital touch and the brain's recognition or response to that touch. What is clear here is that repeated trauma causes a disconnect between sensory input and processing in the brain and body. If the body and brain are like a system that in a healthy person, act in harmony and self-regulate, then repeated trauma disrupts that harmony and does not allow the body to self-regulate. The brain is no longer able to communicate with the body in a healthy and responsive manner and vice versa. The body becomes a strange, unfamiliar, painful, and scary place for trauma survivors. Instead of feeling pleasure, control, positive feelings and emotions, survivors feel pain, fear, lack of control, and despair.

It is true that individuals are unique, but it also true that populations and sub-populations tend to experience certain phenomena in similar ways. This is important knowledge that has arisen out of a wealth of psychosocial studies relating to how adversity, including traumatic events, impacts individuals, especially at various life stages. This is also an asset to those concerned with assisting those struggling with moving past trauma because it can help in creating robust frameworks with which to help people heal in a manner that reaches out to many. For instance, Billie experienced prolonged trauma or sexual abuse over a period of eight years, which began for her at the age of five.

For Billie, and others who experience sexual abuse during this third state of psychosocial development – the Initiative vs. Guilt State (Erikson, 1950)-, her ability to make sense of what was happening to her was complicated by the fact that

developmentally she was preoccupied with determining her worth in the world, specifically with regard to whether she was a good or bad person. Though older youth and adults appreciate that humans are not intrinsically either good or bad, children between the ages of three and five must figure this out for themselves (Erickson, 1950, 1963). When something as traumatic as sexual abuse occurs, the tendency to blame oneself and feel guilty complicates a child's ability move forward and understand the complexity of who he or she is beyond a good-bad dichotomy (Bradshaw, 2002). This is consideration of the power of psychosocial resilience that children innately possess. In contrast, their shame typically makes them feel bad and thus answer the question of "am I good or bad" in the negative, increasing the likelihood of developmental turmoil in adolescence and beyond (Bradshaw, 2002). We should also consider psychoanalytical and theological discussions around human nature, and whether it is inherently hopeful, positive, benevolent, and resilient. For the purpose of this dissertation, discussion around this topic will be brief and pointed. The question that concerns me is: are humans somehow inherently good, loving, and compassionate? And if there are humans who are not compassionate, why is this so? I will look at studies done on the biological responses of humans to trauma and to each other a little further in this work to show that yes, humans are inherently compassionate, supportive, and relationship-seeking. Meaning, they strive for harmonious relationships rather than violent, harmful ones. We can assume that someone who abuses a young child then disrupts or affects this child's inherent nature to trust, seek love and care and to seek harmonious relationships. How then does abuse affect a child's nature? How does it change a child's beliefs about life,

people, the world, and their ability to trust at a deep level? These are important questions that Billie and I explored over the five years of our work together, questions that she struggled with on a daily basis.

Is there a key to understanding how this inherent, biological and spiritual need to seek harmony in relationships and in the world is developed, enhanced, and fostered, and conversely, broken down or destroyed? I believe one way of identifying and tracking this process is through somehow looking at or measuring a person's level of empathy and compassion: for themselves and for others. Frans deWaal (1987-present) of Emory University, conducted a series of studies on mammals' ability to empathize and express compassion through examining behavioral cues such as facial recognition, contagious emotional expression, and reactivity to pain witnessed in other mammals. It has been documented that elephants react to the death of another elephant by expressing grief.

Billie struggled with expressing empathy primarily for herself and her own dysfunctional behaviors. She described feeling no love or empathy for herself. She constantly blamed herself for what happened to her, and particularly in the beginning stages of our therapy, would talk about her father the abuser as if he were not to blame at all for what happened. Did the sexual abuse somehow disconnect Billie's ability to feel empathy and compassion? As we will see explained in this chapter and the following chapters, studies (Van Der Kolk (2006), Felitti and Anda (1999), Heim (2013)) on the effect of trauma on the brain show that people who have experienced prolonged trauma have an overactive amygdala, and broken synapses between the amygdala and limbic system and the prefrontal cortex, the latter of which is the area of the brain that can

process impulses, external information, and emotions in a logical manner. We can make a conclusion then, that persons who have been abused possess a diminished ability to perceive, experience, or possess empathy and compassion. Billie has continually stated that she has extreme difficulty in reading social cues and facial expressions. This diminished capacity to read and process social cues and interactions would correspond with the observation that abusers and the ones they abuse experience a diminished ability for compassion and empathy for themselves and others. This diminished capacity for empathy then can be included in the definition of chronic PTSD. The literature indicates that the age of onset of childhood sexual abuse is a significant factor in the development of PTSD and chronic PTSD and in the effects of trauma on the body, both long term and short term as discussed above. (Felitti and Anda, 1999) As noted, this can have varying effects depending to which psychosocial developmental stage the individual corresponds.

Definition of PTSD

We can now turn our attention to looking at different definitions of PTSD and if they are effective in treating survivors of trauma. We can also look at how the causes of trauma and effects of trauma, particularly sexual trauma, are categorized in the primary diagnostic manual for mental health professionals, the DSM IV and DSM V. I am including both versions of the most recent DSM editions because I was utilizing the DSM IV for most of my work with Billie. The professionals who are most likely the ones that undertake to work with and treat survivors of trauma and sexual abuse can include physicians, psychiatrists, psychologists, marriage and family therapists, social workers,

pastoral counselors, professional counselors, as well as pastors, educators, and community leaders.

DSM-IV and DSM-V Criteria for PTSD

In 2013, the American Psychiatric Association revised the PTSD diagnostic criteria in the fifth edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V). Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific conditions and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition. Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of which is new to DSM-V. In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted. I will refer to portions of the criteria in the following paragraphs for the purpose of highlighting symptoms that were present with Billie and how they were addressed.

A) PTSD Criterion A: Stressor (DSM-V, 2013)

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (DSM V, 2013). Billie's memories of her father coming into her room late at night included sensations of something cold and hard being held against her back while lying in bed facing the wall with him next to her. She still feels pain in her lower back at the point where her memories connect the sensation to her

father's voice talking to her while next to her. She believes the cold object was probably a gun or metal object used to keep her still and silent. Another memory she has of her father is of him using a belt to spank her while reciting the Apostle's Creed.

B) Criterion B: intrusion symptoms: the traumatic event is persistently re-experienced in the following way(s): (one required) (DSM-V, 2013)

1) Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play (DSM-V, 2013). Because Billie was so young when the abuse first started her early memories are at times hazy and more sensate than visual. However, she does have some specific memories of early childhood and interactions with her father and other members of her family. She experiences intrusive memories related to terror of her father in the form of panic attacks and extreme anxiety when in close proximity to a large male, or when she hears a low, husky male voice similar to her father's. She also reported for the first three years, a regular startled awakening in the early morning hours between and 3 and 4 AM and an inability to fall back asleep soundly. She reported some sound or sensation awakening her. Her quality and length of sleep improved over the five years of therapy but she still experienced early morning insomnia.

2) Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness (DSM-V, 2013). One of Billie's primary and most dysfunctional symptoms that pervaded her daily activity were dissociative reactions or episodes. These occurred in the form of extreme anxiety particularly out in public and

during interactions with others, to the point where Billie would not retain any recollection of movement or interactions for periods of time during her day. These dissociative episodes would either result in a blank fuzzy haze or she would in fact re-experience a traumatic moment from her childhood in different forms. How we were able to make connections from present day stimuli to particular memories and flashbacks will be covered in Chapter IV.

3) Intense or prolonged distress after exposure to traumatic reminders (DSM-V, 2013).

Billie would feel incapacitated when she experienced panic or a dissociative episode, so she became very reluctant to venture out and engage in daily activity. We worked on finding ways for her to empower herself in the moment of panic or incapacitation by forming a “safety protocol” or plan for her to remove herself from the stressful situation and find a place where she felt safe. This procedure did bring Billie some relief, and enabled her to feel as if she had choice and control over her reactivity and anxiety. However, she still felt frustration at not being able to anticipate when she would go into a panic or experience a dissociative episode.

C) Criterion C: avoidance. This includes persistent effortful avoidance of distressing trauma-related stimuli after the event. (DSM-V, 2103). As I remarked above, Billie’s coping mechanism in dealing with her extreme anxiety was and remains avoidance. She reports such constant reactivity to triggers in her daily activity that her default instinct is to isolate and avoid going out altogether. Loud noises, crowded spaces, even mildly aggressive actions or behavior is capable of sending her into a panic. She feels overwhelmed, helpless, and vulnerable. Her family history reveals that she grew apart

from her family, and her parents after she left home at 17, and kept a distanced, strained relationship with them until her father's death in the Spring of 2007 and her mother in 2008. Because of her strict Baptist upbringing, she also reports that certain aspects of visiting church, including attending services, reciting the Apostle's Creed, or reading certain Scriptures, can trigger anxiety.

D) Criterion D: negative alterations in cognitions and mood: (DSM-V, 2013)

1) Negative alterations in cognitions and mood that began or worsened after the traumatic event. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs (DSM-V, 2013). Billie's memories of the abuse she endured were at times vivid and detailed, and at other times, more of a sensation or focused around a smell, a voice, an image, or a feeling. The primary indicator that she was making an association of something occurring in the present to her experience of abuse was through a pervasive anxiety or certain sensations that would appear and that she would feel, including a dull roar in her ears, so that she could no longer hear someone talking to her, or formulate coherent thoughts and follow a conversation.

2) Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous"). Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences (DSM-V, 2013). This symptom was pervasive in Billie's daily life and something she would revert back to and repeat on a regular, consistent basis. Her negative self-narrative was so ingrained in her that it overshadowed any other narrative. Our task then became to uncover and trace the origins and foundation of such a negative, self-critical, and limiting

narrative that was almost ingrained in her personality, and see how to uncover and dissect the causes and origins. This is a continual process, one that she struggles with today and probably will for the rest of her life. I go into further detail on this in Chapter 4. Her reading of John Bradshaw's (2006) writing on shame helped her to make the connection between toxic shame and a negative, self-critical, unforgiving attitude, primarily towards herself. Her ability to experience compassion and empathy for herself and what she endured and experienced and survived was almost nonexistent on coming into therapy, and it has improved slowly over the years. These persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame) permeate Billie's existence. She lives with these emotions on a daily basis and they seem at times undiminished by time.

Markedly diminished interest in (pre-traumatic) significant activities (DSM-V, 2013).

3) Feeling alienated from others (e.g., detachment or estrangement) (DSM-V, 2013).

4) Constricted affect: persistent inability to experience positive emotions. Both of these symptoms were markedly present with Billie on a daily basis and still remain present and influence her daily activities and interactions with others (DSM-V, 2013).

E) Criterion E: alterations in arousal and reactivity. Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: Irritable or aggressive behavior, self-destructive or reckless behavior, hypervigilance, exaggerated startle response, problems in concentration, and sleep disturbance (DSM-V, 2013). Billie experienced all of these symptoms and continues to experience them on a regular basis. I have discussed some of the symptoms above and will continue to discuss them in further detail in Chapter IV.

F) Criterion F: duration. Persistence of symptoms (in Criteria B, C, D, and E) for more than one month (DSM-V, 2013). I would categorize Billie as having chronic PTSD based on the length, duration, and intensity of her symptoms.

G) Criterion G: functional significance. Significant symptom-related distress or functional impairment (e.g., social, occupational). In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli: (DSM-V, 2013).

a) Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream) (DSM-V, 2013)

b) Derealization: experience of unreality, distance, or distortion (e.g., "things are not real"). Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately (DSM-V, 2013). Billie described experiencing all of these symptoms described above at various points during our work together, not only in the present but in her history as well. I observed her experiencing certain symptomologies that indicated chronic PTSD. I will discuss this further in Chapter III.

Pete Walker (2002) offers a definition of a type of PTSD that develops in the lives of survivors of prolonged abuse that according to him, includes neglect and abandonment. He says:

Cptsd, or chronic or complex PTSD is a more severe form of Post-traumatic Stress Disorder. It is delineated from this better known trauma syndrome by five

of its most common and troublesome features: emotional flashbacks, toxic shame, self-abandonment, a vicious inner critic, and social anxiety. (Walker, 2002, p. 12-13)

I am convinced that Billie has Cptsd based on the criteria listed above and from Walker's elaboration of that definition. It is very important to make a more specific distinction between PTSD and chronic PTSD due to the length of abuse or assault, and other factors that create a form of PTSD that is a pervasive part of daily life and can be responsible for the survivor developing chronic mood disorders or other types of disorders as long term coping behaviors.

Over the 5.5 year period I have been practicing pastoral counseling in a clinical setting, I have worked with 14 women who have experienced childhood sexual abuse and/or sexual assault. Over this period of time, I began to observe similar patterns of behavior and coping with the effects of past assault or abuse among these women. There were also some differences between how these women lived with the experience and how they were able to process it. The female clients with whom I worked for a period of longer than six months, including Billie, all qualify as having Cptsd. They had a history of prolonged childhood sexual abuse and/or emotional abuse, physical abuse, or neglect. They exhibited and expressed features in their lives that correspond to the elements that Walker outlines. In order to help them with these often crippling behaviors, thoughts and feelings, they needed to understand where these coping mechanisms came from and why they developed. Together we began to form connections between prior traumatic experiences and life-inhibiting coping behaviors, thoughts, and feelings. Typically, there was a "trigger," or present event that reminded the client of the past trauma and that

unconsciously and consciously set in motion the coping reactions.

Goals for Therapy

The goals for therapy for client Billie at intake in January 2014 were listed as follows:

- 1) Find housing
- 2) Decrease depressive symptoms, including suicidal ideation
- 3) Decrease anxiety, panic attacks, and dissociative episodes particularly in public settings
- 4) Increase general level of well-being and happiness
- 5) Increase cognitive ability and productivity
- 6) Finish doctoral degree and become ordained
- 7) Be employed
- 8) Improve quality of relationships, both intimate and casual

These goals were revisited over the five year period time and again. At our last interview session, Billie said she reviewed the goals she had written down initially and decided that on the whole, they remained the same (November, 2014). Effectiveness of the therapy towards these goals is always a factor to be considered. Determining effectiveness of therapy was an ongoing process that was a collaborative effort between Billie and myself. Considering that she was my first client with whom to engage in therapy for longer than three months, and I was new in the ThD and residency program through CCCG, feedback from her was as helpful to me professionally as it was to our

therapeutic relationship. Even so, I was initially unsure of how to measure progress of therapy for Billie. One way, which many proponents of CBT and Solution-focused therapy would support, would be to engage in observation of the client and their behaviors, thoughts, and expressions over a clearly measured period of time, e.g. ten sessions (name the theorists/therapists). However, an argument should be made that the effectiveness of therapy for clients like Billie, who express a desire for improved quality in relationships, comes from the quality of the therapist/client relationship rather than the quantity of meetings. The quality of a therapeutic relationship typically improves over a period of time. And the quality of therapeutic alliance and relationship is directly related to the effectiveness of therapy.

Spiritual Elements of the Healing Process for Trauma Clients

How do victims of abuse understand what happened to them? How are they able to make sense of the trauma in their life story? Was it an act of evil? If so, why did it happen? How does the client accept the effects of an “evil” or “bad” act in their lives without feeling judgment, shame, and some sense of responsibility for the act? If evil is allowed to exist, why do they have to experience it? Where was God when it happened, and where is God now? Why would a benevolent God allow such a horrible thing to happen to an innocent person? Why do people do horrible things to one another?

In asking such questions, humans reveal that they believe themselves to be more than bodies; they reveal themselves to be spiritual beings whose existence encompasses more than their biology (Jones, 2009; Levinas, 1969). Individuals are spiritual because

we find meaning in our lives. However, part of finding such meaning is allowing oneself to seek connections with others. For instance, Billie expressed a deep desire to find a spiritual life or religious community that could support her. A spiritual foundation has been essential to her continued work and her goal of being happy and finding acceptance.

Religion and Abuse

What happens when someone uses religion and God to abuse another? Because most religions give God an ultimate power over us, or ascribe ultimate power within us to a higher being, there is a possibility for someone claiming the power of God to abuse that authority to satisfy their own desires, wants, or needs (Poling, 1991; Means, 2000). The Catholic and Protestant Churches have come under intense scrutiny in the past several decades due to the abuse of power of clergy over parishioners, particularly young people (Cooper-White, 2012) Again, in these cases, as in many sexual assault cases, the first wave of survivors to come forward and talk about what happened to them were silenced, discredited, shamed, ignored and blamed for what happened. The accused clergy were not punished but simply relocated if too many people came forward (Cooper-White, 2012).

Billie's case demonstrates this reality. Billie grew up in a strict Baptist household, where God was viewed as a judgmental, angry, punishing God, and she and her siblings were routinely compelled to pray for their salvation, to do better works, and to always try harder if they wanted to avoid going to Hell. Consequently, Billie always felt bad, dirty, shameful, and that she could never be good enough. Her family environment predisposed

her to thinking she was bad and this predated the onset of her abuse which compounded such feelings. Compounding such issues was the fact that Billie's mother did not show Billie or her older sibling's affection, and was neglected by her husband. Combined with a lack of affection and attention from her mother who had three older children to take care of, who had a husband who did not give her any attention, and was distressed by a lack of finances, Billie was in the middle of a confluence of factors – a perfect storm – that lead to an environment in which she was subjected to long term sexual abuse by her father.

Billie's only form of affection and attention came from her father, who insisted that they had a "special" relationship. He would take her camping and on trips to the lake nearby and to the woods where she received the kind of attention she craved. In our sessions, she recounted to me how she always had memories of these special outings and camping trips, and she remembered the temperature of the lake when they went swimming, the boat they would take out on the water, the kind of bathing suit she wore that he had bought for her, the candy and treats he would bring her. On the one hand, the vivid descriptive nature of such memories can be considered merely part of a bucolic childhood experience except for the obvious abuse. On the other hand, such memories can be considered indicative of Billie normalizing the trauma and making it more a part of herself than it was previously. Once the memories of the abuse came back to her in 2007, she began to remember that her father would take her to their lake house and abuse her there and take off her favorite bathing suit. She remembered that he did not want her dog, Lucy to come along because Lucy was very protective of her. She remembered that

at the age of ten or eleven, she no longer wanted to go on camping trips with her Dad and she told her mother this.

Around this time in 2007, Billie also began to remember that her father would come upstairs into her room late at night and take off his belt and hit her. He would use language that Billie had been a bad girl and she needed to be punished, that God was punishing her so she would no longer be a bad girl and that she would have to pay for her sins so she could be a good girl and go to Heaven. He would recite the Apostle's Creed while he beat her or pointed a gun in her back and then raped her. Billie was indoctrinated into a patriarchal, externalized, punishing God distortion of Christianity in order for her father to rationalize the abuse in Billie's eyes and arguably in his, though that is speculation that can neither be verified nor refuted through this dissertation. Billie felt deeply conflicted over the fact that as a young woman, she could no longer unconditionally accept this belief system and for her own survival, she began to question the religion of her upbringing. She began to explore other religions, and to defy the homeostasis of her family system. Her mother never went to college and married out of high school. Her sister Betty did the same. Billie decided she was going to go to nursing school and, at the age of seventeen, during the psychosocially turbulent stage of adolescence, she left home permanently. However, the family narrative was strong and she still longed for approval from her parents. She developed a strong attachment to a young woman who was three years older than she and who acted as mentor and mother figure to Billie. Billie followed her to nursing school. When the young woman met someone and got married, Billie had her first thoughts of suicide. She reacted to her

infatuation with this woman by agreeing to marry Mark, a young man in seminary who was studying to be a minister. Billie's lifelong love/hate relationship with the Church continued as her new husband finished his degree and accepted a pastorate in Virginia and then North Carolina. Billie worked as a nurse while her husband worked until their oldest child was born.

Trauma and the Brain and Body

A traumatic event, while uniquely experienced by every individual, and in some ways uniquely experienced by women in different ways than by men, is part of the human condition (Herman, 1992, 1997). As discussed above, the rapidly growing field of neuroscience and psychology has shown through studies how trauma and the perception of danger affect the human brain (Van Der Kolk, 2010, 2012, 2014 Ziegler, 2012; Porges and Siegel 2011; Heim, 2000).

Childhood sexual abuse is form of trauma that is a major public health problem. It affects 16% of females in this country at some time before they reach their eighteenth birthday, and it is a common cause of Post Traumatic Stress Disorder (PTSD) (Anderson, Martin, Mullen, Romans, Herbison, (1993), Berliner and Saunders (1996)). More is becoming known about possible changes in brain structure and function in abuse-related PTSD. In addition to symptoms such as nightmares, hyperarousal, impaired social functioning, and sleep disturbance, alterations in several facets of memory are a prominent part of the presentation of patients with PTSD (Felitti and Anda, 1998). These memory alterations include amnesia, flashbacks, impaired learning and concentration,

and intrusive memories. These observations have led to the hypothesis that brain regions involved in memory, including the hippocampus and prefrontal cortex, mediate symptoms of PTSD (Bremner, Vythilingam, Vermetten, Southwick, 2003). All living creatures have a certain survival mechanism that reacts to danger or stress. The fight-flight instinct is a deep, intrinsic part of our biological, spiritual, and psychological makeup (Felitti and Anda, 1997). The limbic system is the oldest system wired in our brain and can be triggered without desire, will, or control (Van Der Kolk, 2014). When this happens, our bodies react to the manifestation of danger, causing increases in heart rate as well as adrenaline in addition to elevation in anxiety levels (Felitti and Anda, 1980). People react to triggers that they believe threaten their survival, especially after sometimes near-automatic consideration of prior experiences of harm or pain. When individuals experience intense or repeated pain, physical harm, or emotional trauma, they begin to dissociate, or isolate or compartmentalize the painful experience in order to survive and continue to live (Herman, 1992). Basic and advanced psychosocial functioning often depends on this. The emotional, psychological, and physical states that are embodied during a traumatic event are also repressed, cut-off, and pushed away (Messler Davies, 1996). However, because they are a part of the individual who experienced the initial trauma, they cannot stay repressed forever, and will resurface when a similar external event or trigger or emotional experience reminds the survivor of that original abuse. The survivor is flooded with painful memories that are emotionally terrifying and physically painful (Ziegler, 2011).

Drs. Christine Heim et al (2000) published an article in the *Journal of the American Medical Association* that illustrates a link between early adverse life experiences and the development of mood and anxiety disorders through studying how early-life stress results in a persistent sensitization of the hypothalamic-pituitary-adrenal axis to mild stress in adulthood, thereby contributing to vulnerability to psychopathological conditions. Women with a history of childhood abuse exhibited increased pituitary-adrenal and autonomic responses to stress compared with controls. This effect was particularly robust in women with current symptoms of depression and anxiety. (Heim, Newport, Heit, Graham, Wilcox, Bonsall, Miller, Nemeroff, 2000). One study composed of almost 2000 women revealed that those with a history of childhood sexual or physical abuse exhibited more symptoms of depression and anxiety and had more frequently attempted suicide than women without a history of childhood abuse (McCauley, Kern, Koloder, *JAMA*, 1997 vol. 277:1362-1368). Women who have been abused in childhood are 4 times more likely to develop syndromal major depression in adulthood than women who have not been abused, and the magnitude of the abuse is correlated with the severity of depression (Mullen, Martin, Andersen, 1996). Childhood abuse also predisposes to the development of anxiety disorders in adulthood, including panic disorder and generalized anxiety disorder (Stein, Walker, Anderson, et al, 1996). In addition, posttraumatic stress disorder (PTSD) may be a direct consequence of childhood abuse, and, moreover, such trauma early in life also appears to increase an individual's risk of developing PTSD in response to other traumas in adulthood (Bremner, Southwick,

Yehuda, Charney, Johnson, 1993). Depression and anxiety disorders, including PTSD, are often comorbid in individuals with a history of diverse early adversities.

There is evidence that central nervous system (CNS) corticotropin-releasing factor (CRF) systems are likely to mediate the association between early-life stress and the development of mood and anxiety disorders in adulthood. Corticotropin-releasing factor neurons are found in the hypothalamus, and in the neocortex and the central nucleus of the amygdala, which are believed to be involved in cognitive and emotional processing and in brainstem nuclei that contain noradrenergic and serotonergic perikarya that project to the forebrain. These CNS CRF systems have been implicated in the pathophysiology of both depression and anxiety disorders (Owens, Nemeroff, 1991). When administered directly into the CNS of laboratory animals, CRF produces many physiological and behavioral changes that closely parallel symptoms of depression and anxiety, such as elevations of peripheral adrenocorticotrophic hormone (ACTH), corticosterone, and catecholamine concentrations, increases in heart rate and mean arterial pressure, changes in gastrointestinal activity, decreased reproductive behavior, decreased appetite, disruption of sleep, increased grooming behavior, increased locomotor activity in a familiar environment, suppression of exploratory behavior in a novel environment, potentiation of acoustic startle responses, facilitation of fear conditioning, and enhancement of shock-induced freezing and fighting behavior.(Sutton et al, 1982; Britton et al, 1982).

Females can experience threats in a gendered or gendered-constructed way due to their biological makeup and emotional construction (Herman 1992, Baker Miller, 1987).

They inhabit and relate to their bodies in a unique way and perceive danger through assessing physical threat, emotional threat, and psychological threat. Numerous socio-cultural norms allow for and encourage the destructive physical, emotional, and sexual violation of females, something that is demonstrated by Billie's story (Herman 1992, Cooper-White, 1992). Women, in particular, develop a conflicted relationship with their bodies, which are traditionally perceived in a societal context as objects of desire, and also as invitations for violation via rape, abuse, molestation, or assault (Herman, 1992, Cooper-White, 1992, Baker Miller 1987). Historically, women have not been able to fully own or inhabit their bodies and express themselves authentically because male-dominated society has owned their bodies and dictated how they should feel, dress, act, behave, and even experience pain and pleasure (Baker Miller, 1989-1993). Female sexuality is a particular locus of this conflicted battle and a complex arena for a woman when she is attempting to heal from sexual trauma. After such a trauma, a woman's body becomes her enemy, including her sensations (Heim, et al 2000). Tactile sensations, and the emotions that result from them are often intertwined with painful rather than pleasurable experiences, further perpetuating the conflict that exists between women, their bodies, and society. Case in point: Billie's childhood sexual abuse not only spoke of the dysfunctional and abusive interpersonal relationship that her father forced upon her, but also how patriarchal attitudes are routinely interjected in how males dominate and can terrorize females by violating their bodies.

Billie's story speaks to the pain, fear, and loneliness that can envelop one following such sexual trauma and abuse. For women who have experienced sexual trauma, sexual

activity, something evolutionarily designed to be enjoyable and demonstrative of romantic love, is loaded with terror, pain, traumatic memories, anger, silence, coercion. In Billie's case, the abuse by her father bastardized filial love into romantic love in terms of physical affection. When such occurred, there was no safe place for her to go because her body was a scary and threatening place to inhabit. Clients who are survivors of sexual abuse express such a conflicted and painful relationship with their bodies. It is a continual, internal battle that they wage with their physical needs, feelings, and how they attribute meaning to their sensations (Felitti and Anda, 1998, Davies, 1994).

For healing to occur, the survivor of abuse must open up and allow the traumatized, repressed parts of herself to surface, and to re-inhabit or re-experience the physical, emotional, and spiritual body-states that were enacted during the abusive event (Davies, 1994). This requires courage and strength, and trust on the part of the client towards the therapist. Once the survivor is able to do this, she is encouraged to name the feelings, the memories, and the physical sensations, and to give voice, validity, and meaning to them that they were previously not allowed to have. If pastoral counselors and psychotherapists have a compassionate, life-giving, and close-to-home understanding of female development and experience, and of sexual trauma and its various effects on self-identity and expression, therapists can formulate and utilize therapeutic techniques and methods that are effective in helping women work towards healing themselves and becoming empowered following sexual abuse. "The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma" (Herman, 1997). In this vein, this research utilizes recorded

interactions, interviews, process notes, personal communications by the participant, journal entries, writings by Billie, direct and physical observations, and case studies.

Previously mentioned, it is estimated that one out of three women is sexually abused, typically by someone she knows, and often by a family member (Stevenson-Moessner (1996), Cooper-White (2004), Stinson-Wesley, 2008), something highlighted by Billie's case. Sexual abuse is rarely talked about and perpetrators utilize a variety of manipulative tactics to justify and continue the abuse. Abusers rely on an imbalanced power dynamic to force their victims to endure the abuse rather than try to stop it. Victims are told it must remain a secret, threatened with further harm to themselves or family and other loved ones, or that no one will believe them. Over time, such threats become dehumanizing. For the victims, the lack of situational power renders them feeling helpless, hopeless, and full of despair.

Since Western society is male-centered and male-oriented, males are able to utilize the socio-cultural power dynamics to their advantage in abusive situations more often than females (Baker Miller, 1987). Additionally, their physical strength is a natural intimidator and threatening to someone of a smaller size. Parents and older relatives, possess innate as well as societal power over younger children and other individuals with whom they have relationships (Winnicott 1956, Klein, 1934.) This underscores the facilitation of potentially abusive situations.

Comparing a Feminist Postmodern, Pastoral Approach to Other Treatments for Sexual Abuse and PTSD

Historically, psychoanalytic treatment for childhood sexual abuse and sexual trauma has operated out of a diagnostic paradigm that does not allow individuals to re-shape their structural self(ves) to let go of what is no longer useful or helpful, and form new self-identities and behaviors that are more positive, useful, and healthy. More contemporary psychonanalytic theorists help shed light on object relating, splitting, attachment theory, dissociation, multiplicity and internal parts specific to individual survivors of childhood sexual abuse.³

A broad range of theorists in this field, including Pamela Cooper-White, Jody Messler-Davies and Gail Frawley O-Dea, Christie Cozad-Cozad-Neuger, Richard Schwartz, and pioneers in the field of neuroscience and PTSD such as Dr. Bessel Van Der Kolk, and researchers of the mind-body connection through the Emory University offer helpful ways to work with clients who have survived childhood sexual trauma. Employing a “feminist” perspective when working with women can be profoundly liberating for female therapists and female clients alike because it can create an environment of support, understanding, and collaboration. In so doing, it can assist clients with figuring out how to reach an awakening of consciousness around recognition of behavior patterns in self-destruction, self-criticism, perpetuating abuser/abuse cycles so as to create better self-understandings and healthier relationships. Furthermore, it can assist clients who have suffered abuse to push forward and participate in therapy in order

³ Please see the work of Melanie Klein regarding object relating and splitting, Donald Winnicott regarding object relating, object usage, attachment theory, and Richard Schwartz, Pamela Cooper-White, and Jody Messler Davies and Gail Frawley O’Dea on multiplicity, dissociation, and internalized objects or parts specific to individual survivors of childhood sexual abuse.

to overcome self-destructive behaviors and self-concepts (Cozad-Cozad-Neuger, 2001). The willingness to exhaustively explore personal history, uncover, revisit and remember abusive experiences, to research and explore new modes of self-identity and behavior that are healthier, more true for the client, and liberating is often dependent on the therapist's level of commitment to the client and to therapy, her attentiveness, patience, and ability to successfully act as a guide to clients while also being a fellow traveler within clients' narratives.

The liberating power of speaking the truth of trauma can be summarized in the following statement:

Clinicians know the privileged moment of insight when repressed ideas, feelings, and memories surface into consciousness. These moments occur in the history of societies as well as in the history of individuals...the power of speaking the unspeakable and witnessed firsthand the creative energy that is released when the barriers of denial and repression are lifted. (Herman, 1997 ,p. 2).

There is a therapeutic engagement spectrum on the part of the therapist and client alike, and each is reflective of the other. Through my work with Billie, I will show how together, we were able to help her uncover the abuse, to re-examine her childhood experiences, her relationship to the abuser, to herself, and to validate her experience in such a way that was previously not accomplished. Further comparison between a feminist, postmodern approach to therapy and other methods of treatment for clients living with PTSD will be made in Chapter III.

This case will demonstrate how Billie has consciously been able to re-claim her experiences and past to validate her feelings, re-define herself and her feelings towards her body, towards intimacy, and self-love and acceptance. It will also demonstrate how

we have been able to examine her family system, socio-cultural influences, gender roles, and her patterns of relating, communicating, and interacting with those around her to better identify her needs, to accept and forgive herself, and to create a stable life. We identified triggers and defensive behaviors resulting from PTSD and fear of further invasion of boundaries in order for her to create better coping mechanisms and to establish safety and control in her immediate environment. Establishing trust and safety is the primary step to creating effective therapy. The client must trust the therapist in some manner in order to feel comfortable sharing shameful, painful, and terrifying memories and feeling states, and to even re-experience them in the therapy room in order to heal and re-integrate dissociated and split parts.

Billie came to me in severe crisis. She was not aware of why she was experiencing the symptoms she had and could not understand or explain her behaviors. She was terrified of herself, her environment, the future, of the homelessness she faced and of death. Due to the acute situation I was forced to stabilize her and address her immediate needs of housing, shelter, food, and safety to the best of my abilities. As her situation slowly stabilized, we were able to look at what precipitated the crisis and delve into her history to make connections between familial and parental interactions and current emotional states, behaviors, and parts.

III

FOUNDATIONS OF PASTORAL COUNSELING: PASTORAL THEOLOGY AND CLINICAL PRACTICE

A Brief History of the Field of Pastoral Theology

Students of pastoral theology appreciate the fact that it is a discipline that is an “ongoing, corporate inquiry with more or less agreed upon topics of investigation and principles of research” (Doehring, 2006). There is also the understanding that it is an interdisciplinary effort that demands insights from other fields, including feminism, intercultural and global perspectives, theology, psychology, psychoanalytic theory, religion, spirituality, philosophy, literature, and medicine in order for the practitioner to most effectively assist clients. There is a reciprocal relationship between good theology and practice; each informs the other. The term *pastoral theology* was first used in the mid-eighteenth century (Farley, 1990, 934; E. Graham, 1996b, 56; Mills, 1990, Doehring 2010, p. 865) among Protestants to refer to the pastoral care functions of ministry—preaching, education, and worship. In the 1920s and 1930s, the spreading influence of psychodynamic psychologies (i.e. Freud and Jung) began to infiltrate understandings of religious experiences and pastoral care of persons. Advanced studies in this discipline have several names: psychology of religion, pastoral psychology, pastoral theology, pastoral counseling (Townsend, 2013, Denton, 1997; Pruyser, 2005; Ramsay, 1998).

Scholars such as, Clebsch and Jaekle, (1967) Seward Hiltner, (1949) and Wayne Oates, (1981) articulated its theological nature. Practitioners and theorists of the 1960s-1970s emphasized a therapeutic paradigm (Holifield, 1983; Hunter, 1995; Hunter and Patton, 1995). Therapeutic techniques were adapted to form bases for models of care in what Gerkin (1997, 84) named a toolbox approach. In the 1980s, pastoral theology began to define itself more as practical theology and less in terms of therapeutic practice (Holifield, 1983; Doehring, 2006). This occurred because of a growing awareness of the contextual nature of pastoral care and the extent to which the therapeutic paradigm arose out of a middle-class Western context (Holifield, 1983). Wimberly's (1979) *Pastoral Care in the Black Church* is a timely example of contextual pastoral theology.

“An awareness of this contextual nature pushed pastoral theologians to move from second-order reflection on practice to third-order reflection on methodologies for relating psychology and theology. Using the term third-order reflection is a definition Jennings (1990, 862-864) used to describe pastoral theology. (Wimberly, 1979, 36)

First-order language is the description of the practice of pastoral care and counseling. Second-order language uses various disciplines such as theological and psychological studies to reflect theoretically on practices. In cross-disciplines such as pastoral theology, third-order reflections concern methodologies that relate psychology and theology (Farley, 1990; E. Graham, 1996b; Holifield, 1983, Jennings, 1990; Loder, 1990; Miller-McLemore, 1996; Pattison, 1994). The discipline of pastoral theology proposes methods for relating cross-disciplinary perspectives (such as theology, psychology, and gender studies) to practice in order to effectuate a comprehensive methodology to working with clients that is consistent with treating clients as the

complex beings that they are as opposed to simple and static diagnoses.

The pastoral theological method that I utilize, which acts as an umbrella for other methodologies with which I engage, is a feminist, postmodern pastoral theology proffered by several contemporary scholars.⁴ According to Cooper-White (2004, 2011), poststructuralist or postmodern implies an assumption that there are no “core” meanings or deep structures to life experiences that are singularly, absolutely, or universally true. Rather, there are multiple meanings to life experiences. Additionally, I also explore pastoral theological methodologies that complement feminism, meaning that they all move towards a positive, shared goal. These are postmodern pastoral theologies of relationality and multiplicity argued by Cooper-White (2004, 2011), as well as by David Tracy (1975, 1994, 1996, 1998) with respect to the revised correlational method.

Building Bridges Between the Present and the Past, and between the Living Community

David Tracy (1975, 1994, 1996, 1998) provides a bridge between multiple constructivist, relational theological, and pastoral psychotherapeutic orientations with the long tradition of Christian pedagogical, dogmatic, institutional, and writings on pastoral theology via his Revised Correlational Method. Rebecca Chopp (1995) provides a feminist interpretation of the Revised Correlational Method that is particularly helpful for this work.

⁴ Carrie Doehring, Brita Gill-Austern, Bonnie J. Miller-McLemore, Pamela Cooper-White, and Christie Cozad-Cozad-Cozad-Neuger.

The clash between traditional Christian theology and scientific rationalism is the understanding that the orthodox Christian practices a morality of belief and obedience to a tradition and loyalty to a set of beliefs. The modern scientist and historian is loyal not to a tradition but to only a set of methodological procedures of inquiry which her particular scientific community has developed in order to ascertain or arrive at a “truth” (Tracy, 1998). Tracy emphasizes the importance of this contrast by asking the following questions: What is truth to a Christian, to a non-Christian, to a scientist, and how is it ascertained? At what point are the standards by which it is examined to be considered a valid truth? Tracy moves to bring forward a postmodern method of inquiry into the nature of truth, God, and reality for the moral committed Christian to be able to use and therefore “defend” herself, or utilize in order to effectively communicate with members of different communities of faith and practice. The modern theologian must be critical of her own tradition and use such a set of rational critical questions to do so in order to be relevant. This is a fidelity to “open-ended inquiry, a loyalty to defended methodological canons, a willingness to follow evidence wherever it may lead.” (Tracy, 1998, p. 186)

The committed Christian must examine the Christian tradition’s past and present claims to meaning and truth since doing so is a prerequisite of authentic Christian self-understanding. Tracy explains that postmodern critiques of rationalism and autonomy, as vehicles and paths to Enlightenment that Freud, Marx, and Nietzsche put forth, shifted the tides of philosophical thought towards the search for true human authenticity and liberation.

The revisionist theologian's fundamental claim is not that she happens to be Christian...her claim is that not less than a proper understanding of those central beliefs in "revelation," in "God," and Jesus Christ can provide adequate understanding, a correct 'reflective inventory,' or an existentially appropriate symbolic representation of the fundamental faith of secularity (Tracy, 1975, p. 182).

Tracy incorporates methods and techniques that secular thinkers and philosophers have created because they do have much to offer, including the following insights:

Firstly, contemporary and postmodern quests are quests for self-transcendence. As such, they are instinctively concerned with a search for the spiritual in such a way that it helps to make sense of the mundane aspects of the human experience.

Secondly, there is a desire to understand the individual's vulnerability in relation not only to humanity being a mortal creature, but also in relation to what such fragility means for spiritual considerations. Many contemporary writers and thinkers seek to find a way to transcend the individual and collective present state in order to more clearly identify illusions and limitations that prevent us from gaining understanding, insight, knowledge, and action. This is demonstrative of Calvin's and Barth's salvific theology because there is an underlying acceptance that man's fallenness is a given. Additionally, there is the belief that humans are only able to transcend this fallen sinful state of illusion and confusion through admission of our individual and collective guilt and ultimate faith and trust in Jesus Christ (Tracy, 1998, p 123).

Thirdly, the Age of Enlightenment's failure to save the world and enlighten humankind was partly due to its complete dismissal of tradition and history (Tracy, 1998, p.167). Humans are historical beings. Consequently, history is critically important to the construction of our individual and collective identities, and to ignore such history is

similar to self-destruction). Tradition cannot be eliminated, it is part of who we are – we do not transcend by ignoring, leaving behind, or walking away from- we transcend through continuous revision and restoration. Traditions and their “permanent achievements” can and must be won over again and again through a hermeneutics of restoration and inquiry (Tracy, 1998, p.54).

Lastly, Rationalism led to the horrors of the 20th century through its system of conformity, its dismissal of the power of protest and negation, the memory of history and human suffering and existence and the possibility of liberation. Tracy seeks to reclaim other aspects of rationality – the “emancipatory power” critical rationality – in order to affirm and enforce human liberation. Faith in the worth of human life, which is the basic faith common to the committed secular thinker and the committed Christian, is clarified and deepened by postmodern critique (Tracy, 1998, p, 23).

Rahner, Barth, and Tillich were writing in reaction to the disillusionment of the failure of the modern, liberal Enlightenment worldview to prevent war, violence, atrocities, and genocide. Tracy categorizes these theologians as neo-orthodox because they accept the failure of romanticism and dismantle the illusion of ultimate confidence in human technology, rationality, and production to create a better society. In so doing, they highlight the need to return to ultimate dependence on a transcendent, all-powerful, mysterious God (Tracy, 1998, p.89). For Tracy, the gap in discourse was widened again into a chasm between Christian theological discourse and understanding and contemporary experience and social/political systems at work. For him, this is not acceptable. Thus, the postmodern theological revisionist must continue to engage with

contemporary discourse and common experience no matter how painful and difficult and diverse and complex and challenging it becomes. Further, individuals must use the techniques of self-examination in a historical and hermeneutical critical examination of one's religious tradition in order to clarify and determine how one's religious and spiritual symbols can be meaningful in today's society (Tracy, 1998, p.172).

Neither partner of the correlative conversation can be abandoned, dismissed, or discriminated against (Tracy, 1998, p. 192). Both sides must undertake self-reflective exercises as informed by interaction with each other. This is Tracy's basic assertion; all humans generally and continuously make meaning out of their lived experiences. They make meaning out of their lived experiences through transformation. This is the foundation of that in which pastoral counselors must engage with clients, in correlative conversations that are reciprocal, and involve making meaning out of such lived experiences.

Meaning-making, along with other common human activities, is a point of intersection between theological dialogue and dialogue of writers and thinkers from other disciplines. Humans are innately self-reflective and therefore, it is our moral duty as humans to engage in such a process of revised correlation or interdisciplinary dialogue and not to retreat into our own ideologies or dismiss one representation of experience as lesser or not as valid. Though, indeed, this duty is a challenge because humans are often keen on self-preservation and protection, particularly at the psychological and emotional levels, something that has been highlighted in literature on the topic of cognitive dissonance, for example. In our self-reflection, and also their quest for power for

instance, humans can manipulate symbols and meanings for immoral ends. This revised correlational approach is applicable in many ways in today's pluralistic society. Tracy outlines a clear though complex way in which people can determine points of conversation and intersection for peoples from different cultures, religions, societies, and nations to help build greater connections.

If people are able to agree on common denominators for dialogue and apply a belief or meaning that one dialogue partner described to another's belief system, albeit in a different form or phrase, then people can engage in constructive dialogue (Tracy, 1998, p. 186). If we operate out of the understanding that humans have distinct and valuable processes and experiences, despite background, and that we can grow and learn from one another through dialogue, then we can also work together instead of working from the assumption that one's faith and worldview is superior to others and therefore it is not necessary to be open and willing to be changed by interactions with cultures, symbols, or people with different faiths and worldviews (orthodox position) (Tracy, 1998, p. 54).

An important orientation for pastoral theologians when talking about our work on a global and communal scale is to operate out of the belief that truth and good practice lie in the tension between opposing positions (Lartey, 2003). Collapsing opposite tensions into one pole or another loses the importance that each contributes to the whole. The global task of the pastoral theologian is therefore to maintain these tensions in creative ways by recognizing that truth lies not in one pole, but in finding the contributions of both (Tracy, 1996; Cooper-White, 2011). The "either-or" attitude encourages exclusion, suppression, or annihilation of the other, whatever the other is defined to be. It is a part

of human nature to tend to polarize in order to locate or define security and comfort in a world full of insecurity, ambiguity, and the unfamiliar. Such polar thinking is at the root of extremism and intolerance.

The Field of Feminist Pastoral Theology

Practical theology has long been a male-dominated discipline (Doehring, 2006; Ramsay, 2004; Cozad-Cozad-Neuger, 2001; Bennett Moore, 2003; Graham, 2002; Gill-Austern, and McLemore, 1999). The prominence of the male clerical paradigm excluded women as actors and subjects. Many feminist pastoral theologians engage in third-order reflections upon methodology, defining gender as positional, relational, contextual, pragmatic, and political⁵ (Doehring, Cozad-Cozad-Neuger, Bennett Moore, Graham, Gill-Austern, McLemore). A poststructuralist feminist perspective means that meanings are contextual, shaped by the particularities of life experience, and they are always political, seen or unseen, depending upon the status conferred or deferred by aspects of one's identity in terms of age, gender, sexual orientation, and race (Ramsay, 2004). Bonnie Miller-McLemore (1995) states: that feminism is far more than a movement to achieve equal rights, individual freedom, and economic and social equity for middle class White women. Instead, a feminist perspective demands a critical analysis of structures and ideologies that rank people as inferior or superior according to various traits of human nature, whether gender, sexual orientation, class, color, age, physical ability, and so forth, in order to contextualize how issues arise.

⁵ Carrie Doehring, Christie Cozad-Cozad-Neuger, Carol Watkins-Ali, Zoe Bennett Moore, Elaine Graham, Brita Gill-Austern, Bonnie Miller-McLemore, Pamela Cooper-White.

Feminism strives to eradicate sexism and related exploitative classificatory systems and to allow those silenced to join in the cultural activity of defining reality (Baker Miller, 1983; Herman, 2002; Gill-Austern, 1999). To assess the study of religion from this perspective demands an analysis of structures and ideologies that rank academic study as superior or inferior depending on its distance from or proximity to religious faith, concrete lives, emotions, and women's activities. To assess practical theology from the vantage point of feminist theory requires a forceful challenge to systems of stratification and domination within the academy and to systems of power and authority within society and religious life, particularly those that rank men and male activities over women and female activities (Baker Miller, 1983; Herman, 2002).

With a feminist, postmodern methodology, Watkins-Ali (1999), Miller-McLemore (1995, 1999) and others critique conventional models with which pastoral care has been routinely equated- healing, sustaining, guiding, and reconciling, as also articulated by Seward Hiltner (1958) and amended by William Clebsch and Charles Jaekle (1964). Watkins Ali (199) adds three other pastoral practices: empowering, nurturing, and liberating, and McLemore adds resisting to this list (McLemore, 1999). These additional models focus on social, cultural, and political power imbalances and dynamics. By fostering redefinition in all three spheres of religious study, practical theology, and pastoral theology, feminist theory participates in undercutting primary assumptions of modernism, including the universality of certain pastoral "cultural, and political power imbalances and dynamics (McLemore, 1999). Postmodernism signals the

breaking up of the hegemony of modern Western culture and a receptivity to other perspectives. However, this does not mean that feminist theory means the deconstruction of all knowledge (Ramsay, 2004). Feminist arguments for shared, if not universal assumptions about truth, justice, and other matters must be made (Ramsay, 2004).

We can apply a useful feminist critique to David Tracy's hermeneutical model discussed above. Beginning with understanding traditional texts and traditional interpretations of those texts, we engage in a dialogue between these texts and our lives. This is useful for feminist theologians through the process of creative revisioning of the Christian tradition (Chopp, 1995). There are two differences to consider however. Hermeneutical theology according to Tracy views the Christian tradition to be the written tradition. This written tradition was primarily formed and shaped by men. Feminist theology understands Christianity to be the "activity of emancipatory praxis as much in the present and future as in the past." (Chopp, 1995, p.81) Feminist theologians view the tradition in terms of how texts functioned in historical situations as often counterproductive and even harmful to the ongoing truth of the survival and flourishing of men and women.

The recognition that the past is represented too often through only the texts of those in power, with almost total silence from women and those deemed 'others,' tends to increase the suspicion that hermeneutical models can be used to protect the dominant cultural and political arrangements (Chopp, 1995, p.82).

This is something feminist theologians and feminist pastoral counselors need to be aware of when incorporating Christian texts, practices and traditions into theological discourse and the practice of counseling men and women.

Chopp (1995) emphasizes the importance of praxis in feminist theology, and how praxis can form the interpretative activity of Scripture and Christian tradition. The norms of theology come out of arguments and efforts aimed at present and future emancipatory activity. Theology should undertake as one of its primary tasks, a goal of change, transformation, recognizing suffering and oppression and criticizing dysfunction. Theology should be ethical, anticipatory of future possibilities, and be contextual. It is an individual as well as a collective activity and helps persons to interpret, analyze, and transform their worlds, and gives them the power to speak.

Female Lived, Bodily Experience Informing Pastoral Theology

Gynocentric feminists locate women's oppression not in femininity but in a masculinist culture's denial of the female body, nature, and other modes or relational knowing and deciding, including maternal thinking, and in broader structures of oppression (Baker Miller, 1987). Women in Western culture are carriers of the female body, nature, and other modes or relational knowing and deciding, and development of others. Women require their own individual and collective voices to contribute to the expansion of current developmental theory, a theory written of men, by men, and for men (phallogocentric model) (Baker Miller, 2004; Herman, 2002). Women's development has been seen as parallel to or mirroring men's development- see the work of Freud, Erikson, Sullivan, Kohlberg, Kohut- it has led to what Jean Baker Miller describes as the exclusionary, model of female psychology. That is, women, using male models, begin to

define themselves as lacking something critical- whether it be a true or firm, 'separate' sense of self. There is no separate model that concerns the nature and autonomy of the female form (Baker Miller, 1987, p.36).

Pastoral psychotherapy includes a psychodynamic understanding of human beings (Cooper-White, 2004, 2011). Feminist pastoral theologians and feminist psychoanalytic theorists would agree that biologically, emotionally, hormonally, and spiritually, women are defined by and identify with nurturing, by relating and inter-relating, with themselves, the children that they may or may not grow inside their bodies and feed from their breasts, and others in their communities who help raise those children (Baker Miller, 1989, 1992; Chopp, 1995, Stevenson-Moessner, 1996). As such, women are intrinsically relational beings. For example, many but not all women literally experience being two selves through pregnancy as they live for themselves and for and through the lives they carry within them. They also experience the precursor of dual life as a result of their menstrual cycles that hold the potential for life beyond their own. In contrast, though, they also experience, though it is an accepted aspect of the reproductive cycle, the loss of potential each month that a pregnancy does not occur. This is not necessarily tragic, but rather reality. In addition, women must move between multiple identities, between many roles such as those of wife, mother, daughter, sister, teacher, and friend. As victims and recipients of injustice, of violence, of disruption and disconnection, women sometimes internalize that disconnection and cut off parts of themselves in order to survive and belong (Baker Miller, 1987, 1998). Women, and other

oppressed and disenfranchised groups in our society, must develop skills of flexibility, adaptability, compatibility, in order to survive, grow, and protect the ones they love as they nurture them into maturity (Cozad-Cozad-Neuger, 2003). All people have parts of themselves that are cut-off, disavowed, repressed, because for one reason or another, these parts were not acknowledged or nurtured by their caregivers when they were young (Klein, 1921-1945; Cozad-Cozad-Neuger, 2003; Cooper-White, 2004). Melanie Klein skillfully demonstrates how the need of a child to attach to his or her primary caregiver supersedes any attempt at wholeness or recognition of certain basic needs and behaviors that a child can experience (Klein, 1937). Infants and toddlers' experiences will be subsumed under their need to retain the bond with their caregivers (Klein, 1937). The young child will reject the part of himself or herself that may threaten or contradict what his or her mother/caregiver is telling him or her, communicating with them in order to ensure that they will be cared for. If a mother communicates to her child that the child will get what he or she needs only if he or she is, good, and does not demand anything of her, then the child will not vocalize his or her needs (Klein, 1921-1945).

Applying Theory to Practice- Postmodern Practical Applications

Are there historical qualities in pastoral theology, pastoral care, and pastoral counseling that remain necessary and important to pastoral counseling today? Yes, there are. In my work with Billie, I have come to realize how important these qualities of pastoral care are, especially in terms of strengthening the therapeutic relationship. Empathy, pastoral presence, community, and understanding and relationship between

person and self, person and others, person and community, and person and environment, as Bonnie McLemore (1999) calls the Living Human Web, are provided in quality and invested pastoral counseling. In such counseling, relationships are valued and there is reciprocity.

The main challenge that people face in relation to living with each other concerns how relations should be carried out, especially when there are often such stark differences. Thus, the following questions are routinely asked among lay people as well as pastoral psychotherapists: how do we relate to difference, to the “Other,” to “them,” to a being or concept that is less powerful, lower in status, dismissed, rejected? How do we incorporate and acknowledge those emotions, attitudes, parts of ourselves that for some reason we wish to reject, dismiss, repress, disown? How do we help our clients to do so?

Psychoanalytic theory and pastoral theologians would agree to an extent that it is part of human nature to strive, to belong, to be accepted by the dominant power, which is typically the caregiver in one’s earliest years because it is she who is the one who nurtures, grows, feeds, and provides a person in order to survive. Freud referred to this phenomenon as drive, Klein referred to it as splitting and idealizing, and Winnicott focused on the mother-daughter bond and on the parent-child relationship as formative in a toddler’s development, and how the toddler then relates to the world and “objects” outside of himself/herself: “object-relating.” (Winnicott, 1943). Kohut referred to it as self-object transference (Kohut, 1996).

However, there is a crucial piece missing in this understanding of human nature; the Freudian human, the Kleinian human, and the Kohutian human are largely isolated, self-

concerned individuals whose identities are formed after a certain age, unable to grow and be changed through relationship (Baker Miller, 1987). Growth occurs through insight and internalization. Feminist theorists would say this is a masculine model of identity and development (Baker Miller, 1987; Cozad-Cozad-Neuger, 2003). It ignores the mutuality inherent in intimate, primary relationships, namely the mother-child relationship, a mutuality that Winnicott (1936) highlighted in his work. The caregiver and the individual have the ability and power in assisting the dependent to value relationship, acceptance, give-and-take, and community, as “we,” rather than an “I.”

By respecting and appreciating the “Other,” whether it be community, an individual, or a part of oneself, and by not dominating it, subjugating it, or assimilating it, but by valuing it and holding it in relationship as “different,” we give it an integrity and value system of its own (Levinas, 1973). We can tolerate a mystery and ambiguity about the world, our life, and ourselves that is not fully known and may never be fully known.

A relational conceptual approach can be a way forward, because it can hold differences, ambiguities, tensions, and polarities together in a type of dialogical relationship (Cooper-White, 2003, 2011). There is a holding, containing activity that takes place within a relational framework that is essential to creating constructive, liberating realities (Cooper-White, 2003). The Christian theological construction of the Trinity holds tensions in a tripolar reality- unity-in-diversity, which is also alive and visible in human experience (Cooper-White, 2011). Pamela Cooper-White assesses the interrelated nature of the Trinity as crucial to understanding one’s relationship to a God that is multiple and interdependent, as well as lifting up a concept of self that is multiple,

dynamic, and in relationship. “The pastoral theological task-and it is a crucial one in the twenty-first century- is to assist in the formation of persons and communities that are adept at living creatively and constructively within the tensions and extremes of life” (Cooper-White, 2011, p.185).

What is our ethical responsibility as pastoral counselors in therapy towards each client? If the “we” are to be seen as “the self” and “they,” “the other,” according to Emmanuel Levinas, or “we” as subject and “they” as object, how can this Other be seen when Western culture and Western psychoanalytic attitudes encourage a suppression, the “other,” and an appropriation of the other, or swallowing of the other into ourselves and our values? Levinas argues that when difference is perceived between a self and something else, this difference is only temporarily tolerated- it cannot be tolerated for long because it becomes a threat to the identity of the self. Therefore, there is a tendency to eliminate any sign of otherness and to try and force a reduction of something truly unique and different to sameness (Levinas, 1969, 2008).

Levinas urges the importance of recognizing and accepting the reality that otherness cannot be reduced, and that it is beyond one’s comprehension- otherness should be recognized in its *irreducible strangeness*. The aggressive impulse of the self to reduce something to sameness must be contained so that the other can be protected in its uniqueness (Levinas, 1995, 2005). This is a difficult challenge- relating out of one’s own integrity to that of the other that can never be fully understood or known (1995). This entails a certain reverence for the mystery of God at work in our lives and in relationships with one another. This requires hope, courage, and wonder.

The seduction of the power of collective unity is evidenced in the drive towards sameness that ultimately can cause self-destruction. Levinas differs from an object-relations oriented model of Being, switching emphasis from a priori existence to the formation of a self out of relationship to an other- the infant comes to know itself through its relationship to his/her mother. It is in being oriented towards the other that the Self finds its own identity (Levinas, 1969, 1995;Cooper-White 2001). Orientation towards the Other is the motivation behind agape love – love that emanates from God and is the essence of love subsequent to – and pastoral care. However, Object relations Theory is based on internalizing the Other, or the image of the mother and subsuming that perception within oneself and carrying on a relationship to that internalized object internally. Humans act in relation not just to other individuals, but also based upon drives that must be addressed or fulfilled, whether as a result of intrinsic or extrinsic motivation. Although the Other is never fully present to a person, he or she is known by empathy and assimilated because it is conceived as a reflection of oneself (Levinas, 1969). The relationship with the Other is therefore out of reach for the conscious self. Nevertheless, people still have real and meaningful encounters with others, which are, in fact, demonstrative of genuine knowledge because they are examples of interpersonal relations (Levinas, 1969).

How can pastoral counselors relate critically, crucially, and responsibly with Others in a way that respects and preserves their authenticity as Other? For preservation of the Other to occur, counselors must not treat the Other as an object of knowledge or experience, and they must resist the impulse to reduce the Other to the Same (Levinas,

1969, 1995). Truth is reaffirmed, and the mystery of the Other reinforced through face-to-face encounters, not through solitary thought (Levinas, 1969, 1995). Since women in Western thought have been historically perceived and labeled as the Other, the re-evaluation of the Other by Levinas invites feminist appreciation.

If we understand the Western concept of selfhood, which is remarkably discreet, isolated, and unitary when compared to African notions of personhood that are far more communal, we can glean useful insights as to how beneficial the Western concept of selfhood is for different populations and the global community as a larger entity (Lartey, 2003). Lartey asserts that in African thought, the person is a community of selves in community with others. To feminist pastoral theologians, and to relational psychologists, the person is a community of parts or selves. There is a congruency between the schools of thought. When examining how whole societies subsume the Other into the collective concept of the Self through colonialism and slavery, African American womanist scholar Barbara Holmes (2002) points out that communal responses to collective oppression on the part of the African American community have revolved around the devastating long-term effects of institutionalized racism and oppression. Consequently, she argues that many African Americans still struggle with various issues related to identity (Holmes, 2002, p. 18). She uses the term “multiple consciousness,” to identify a state of being that includes fluctuating life perspectives (Holmes, 2002, p.89). The term also recognizes the negotiated aspect of human interactions that include varied influences contributed by gender, race, sexuality, and class. “We have yet to reintegrate fractured spirits and psyches, because we are only beginning to understand the personal consequences of

oppression” (Holmes, 2002, p. 18-19).

Psychoanalytic feminists have influenced pastoral theology powerfully, perhaps more than other feminist views because they have helped to provide an interdisciplinary framework for insights into the psychoanalytic and sociopolitical issues that women face. Nancy Chodorow (1974, 1978) explored the prominent role of the mother in reproducing patterns of female fear of separation and male fear of relationship. The rationale for moving beyond psychoanalytic feminism lies in the broader moral and communal concerns of pastoral theology. Since pastoral theology is an integrative discipline that works at the intersection of personal experience, tradition, culture, and community, a feminist approach can be particularly useful and appropriate for pastoral theologians, especially with respect to resisting labels and deconstructing social structures that harm people (McLemore and Gill Austern, 1999; Ramsay, 2004; Doehring, 2004). Gynocentric feminists locate women’s oppression not in femininity, but in a masculinist culture’s denial of the female body, female nature, and other modes of relational knowing and deciding, including maternal thinking, and in broader structures of oppression (Baker Miller, 1998, 2004; Herman, 2002). A nascent ecological feminism combines elements of both humanistic feminism and gynocentric feminism (McLemore, 1999).

Self in Relation

Women in Western culture are carriers of certain aspects of human experience—emotionality, vulnerability, and fostering growth and development of others (Baker Miller, 1987). “Only through describing women’s experience can we begin to map out a

theory of full human development” (Surrey, 1998, p. 35). Women need their own individual and collective voices, a point previously made and yet which still demands repeated emphasis. Women’s development must be remedied by a model that moves the Deficiency-based Freudian model of female psychology into a more postmodern, integrative and life affirming understanding of who women are and how they function and make meaning out of their lives (Miller, 1987). That is, a model is needed in which women can move beyond using male models as the primary means of defining themselves as people lacking something crucial, whether it be a penis or a firm, separate sense of self.

The notion of separation-individuation as the basis of human development implies that the person must first disconnect from a relationship in order to form a separate, articulated firm sense of self or personhood (Mahler, 1965; Baker Miller, 1987; Chodorow, 1974,1978). The process of male development is defined as the disconnection and differentiation from the mother early in childhood (Chodorow,1974,1978; Baker Miller, 1987; Freud, 1911-1923). According to Erikson (1950,1963), only later in life do intimacy and generativity become tasks to be mastered. Intimacy, empathy, and relatedness can be experienced as threats to autonomy, agency, self-determination if one is not developmentally ready (Erikson, 1963). New construction theory of relationship-differentiation describes a dynamic process that encompasses increasing levels of complexity, structure, and articulation (accountability) within the context of human bonds and attachment (Baker Miller, 1987, 1998).

There has been a recent shift in theological literature from “categorical, biologically

based sexual difference to gender as ambiguous social construct ” (Gorsuch, 2000, p. 108). A more fluid, contextual, postmodern view of gender does not mesh with the concrete experiences of many women in families, communities, and nations where gender roles are more rigid, fixed, and categorical (Gorsuch, 2000, p. 125). Gorsuch believes pastoral theologians “are finding a way to explore gender differences without reinforcing opposition or stabilizing notions of essential nature...through careful attention to the ambiguities of gender in human experience” (Lartey, 2006, p. 108). Lartey is most concerned with investigating and figuring out how pastoral theologians and can live respectfully with difference and ambiguity. Moreover, he is concerned with understanding how people can change and improve their relationships and live with others in peace. Lastly, he seeks to find out how people can learn from the past in order not to repeat the same mistakes.

Consequently, there is an ethical and professional imperative to for pastoral counselors to best understand their ethical responsibilities in therapy towards clients. Levinas (1995) voices a concern that when difference is perceived between a self and something else, this difference is only temporarily tolerated- it cannot be tolerated for long because it becomes a threat to the identity of the self. In order for therapeutic relationships to flourish, at a minimum, counselors must be aware of this threat and work to address rather than suppress it.

Clinical Approaches

The goal of my work in pastoral counseling is to 1) identify the issues that

challenge clients 2) utilize a therapeutic and pastoral approach via a firm understanding of who it is that pastoral counselors are in order to enter into a healing relationship with female clients 3) assist the client in working through challenges through identifying treatment goals, addressing injustices and achieving justice through the therapeutic relationship 4) help the client deconstruct and let go of false stories, dehumanized, unhealthy, and self-destructive self-perceptions and to 5) co-journey, co-suffer with clients on their paths towards fullness, wholeness, self-respect, and respect for others.

Bromberg (2001), Stolorow (2000), and Atwood (2000) emphasize the relationship between conscious and unconscious processes and how they affect the unsaid, the unformulated, and the preconscious as being as crucial to therapy as that which is vocalized. What people disavow, do not acknowledge, and repress is done for a variety of reasons. However, if people continue to repress the “other,” they invariably project those unwanted parts onto something or someone else, an external object, thus increasing the chance of having interpersonal challenges and issues (Freud, 1901-1921; Winnicott, 1931-1963). Sitting with a client in the therapeutic space and allowing ourselves to be open to a multitude of experiences and emotions is foundational to therapeutic rapport, growth, and ultimately, the growth of clients.

Foundations of Relational Approaches to Psychotherapy

As articulated by Klukhohn and Murray (1948) and elaborated by Cooper-White (2011) and Lartey (2003), “Human beings are like all others, like some others, and like no others” (2011, p. 11). For instance, twins may be raised in a similar environment and

may have more in common genetically and physically than any other two people, but studies show that they often grow up to be unique individuals with different perceptions of what their similar home environment was like (Cooper-White. 2011). Relatedly, Donald Winnicott's (1957, 1965, 1971) observation that a "good enough mother" has some genetic or physical capability to attune adequately to one baby, but she may not also be as attuned to another baby, due to various factors and circumstances, underscores the phenomenon that that crux of human relationships is based on how we relate to each other at the individual level. Using the example of twins and their mother, one baby may be able to adapt and attune to his/her environment more easily and readily than his/her twin or another baby (Winnicott, 1957, 1965, 1971).

Melanie Klein (1921-1945), WRD Fairbairn (1946), and Winnicott (1960) articulated an internal process related to an infant's fantasy life that paves the way for a relational understanding of the psyche. According to Klein, a child, through a process called internalization, internalizes interactions with significant others into an active fantasy life and begins to relate to these fantasied objects and interpret experiences through them in a significant way (Klein, 1921-1945). The real objects are always informing and changing these fantasies and the more nurturing, loving, and attuned the caregivers are in influencing a child's development, the more outward-looking the child becomes (Klein, 1921-1945). Winnicott provides a useful set of definitions to describe the dynamic that a child engages in while interacting with significant others and continuing to grow and develop. A child engages in two related but distinct processes, object-relating and object usage. (Winnicott, 1957, 1965, 1971).

In object-relating, the child internalizes something of the object (caregiver), so that the object becomes meaningful to the child. Object-relating is an experience of the subject; projections about the object and identifications with the object are at work in the subject. Interacting with this process is object-usage. In object-usage, the behavior of the object is also involved and influences the object-relating. If the object is used, then reality influences and affects the projections going on in the child. In order to use an object, the subject must develop the capacity to do so- this is developed through a facilitating environment. When the external environment is destructive, the child withdraws and retreats from reality, and he or she also begins to interact and relate with his or her internal fantasy world and internal objects more exclusively. Ultimately, this understanding of the inner world of human beings is a marked departure from Freud's drive theory. It allows for a more relational understanding of human development (Cooper-White, 2011, Greenberg and Mitchell, 1983).

For Kleinians, babies experience trauma by being alive; life is scary and traumatic. Growth, development, maturity is not necessarily a harmonious, positive process; it is painful. A person who experiences stress, overwhelming events, or trauma will regress to a more infantile, primitive state (Klein, 1921-1945). Excessive pressure and stress exaggerates survival strategies and reduces or altogether eliminates relating, reciprocal, and mutual ways of relating. A person splits into a paranoid-schizoid position, and repression, disavowal, and psychic disintegration occurs. This means that an individual will retreat into an internal world and redirect orientation, thus turning away from relating to people in the external world. Such an individual will begin relating to

internalized, introjected objects or representations of significant others instead of maintaining an openness to real relationship with others, thus inhibiting his or her ability to move forward and grow. When factors seem overwhelmingly threatening, especially during traumatic experiences, or in times of great loss, a person can retreat to paranoia, and engage in the splitting of the bad object which is present, and the good object, which a person may conjure from which to draw strength (Klein, 1921-1945).

A major weakness of this position, as it concerns development and trauma, is that it presumes that a person is always struggling, and always on the verge of slipping into psychosis, splitting, or turning away from reality. Is this as good as it gets for a Kleinian person? What is the possibility of happiness, of fullness of life, and where is the hope? Later Object Relation oriented clinicians reshaped the understanding of infant and child development to be more relationship-oriented (Winnicott, 1957, 1965, 1971; Greenberg and Mitchell, 1983). A child experiences trauma either through lack, or deficiency, of a good-enough mothering, or holding environment, or lack of attention and mirroring on the part of the mother (Winnicott, 1965). A child also experiences trauma through absorbing or being a repository for repressed, rejected impulses and repressed parts of the parents that they do not acknowledge (Fairbairn, 1954).

Object relationists posit that each child bonds to his or her parents through whatever forms of contact the parent initiates, and those forms become patterns that endure throughout the child's life with respect to his or her ability to attach and connect with others in healthy ways. On this point, Harry Stack Sullivan (1953) argued that

One has information about one's experience only to the extent that one has tended to communicate it to another or thought about it in the manner of

communicative speech. Much of that which is said to be repressed is merely unformulated (Sullivan, 1953, p 62).

Pleasure is one form of connection with others; if the child experiences pleasure as an encouraged and nurtured emotion through the parent/caregiver relationship, the child then becomes pleasure-seeking in relationships with others. If the parental relationship inflicts pain on the child, then the child will not avoid pain (Freud, 1923) and avoid others, but will continue the painful patterns. This was first observed by Freud who named this blind attachment instinct by a child with a caregiver “repetition compulsion” (Freud, 1914).

Donnel Stern (1993, 2005) concerns himself with investigating the essence of unformulated experience. Stern’s article “Unformulated Experience: From Familiar Chaos to Creative Disorder” marks a shift from an emphasis on repression as the prototypical defense to dissociation, which is a more interpersonal understanding of the contextual nature of the mind, as well as a shift from the Freudian view of memory as static, linear, and archaeological to one of memory as continually informed and transformed as it is accessed in the present. Philip Bromberg (1999) notes Jay Greenberg and Stephen Mitchell’s (1983) distinction between the drive/structure model and the relational/structure model as the seminal beginning of the discussion of relational psychoanalysis.

Pamela Cooper-White defines the relational school of thought as a

group of psychoanalysts today that...in their clinical practice, writing and teaching, have begun with the foundations of object relations and interpersonal theory, and developed a contemporary line of psychoanalytic inquiry that emphasizes the reciprocal, co-constructed nature of the therapeutic relationship, ...(emphasizing) that the therapeutic relationship is a two-person enterprise. Both

patient and therapist are thinking, feeling, experiencing, interpreting, and mutually influencing one another. Meaning is not “discovered” and then conferred by the therapist alone...rather meaning is continually being explored, co-constructed, revisited, and revised by both partners (Cooper-White, 2011, p. 121).

A Relational Approach to Therapy with Adult Survivors of Childhood Sexual Abuse

Jody Messler Davies and Gail Frawley O’Dea (1994) provide a deep assessment of the mechanism of dissociation, which is the most common form of coping or managing trauma for survivors, and how it differs from the classical understanding of repression. In his article, “Shadow and Substance: A Relational Perspective on Clinical Process,” Philip Bromberg (1999) describes the difference between dissociation and repression in more general terms, not necessarily related to sexual trauma, but looking at dissociation more as it is expressed and enacted in the therapeutic context. Carol Adams (1990) maintains that three qualities of the pastoral counselor are essential when survivors disclose their experiences: the ability to process the information about the dehumanizing violence enacted by one person against another, the ability to provide practical assistance, and to reflect theologically. The counselor must take an active role to enable the victim to make the transition from victim to survivor.

Stinson-Wesley (1996) asserts that it is vital that the counselor believe the victim. If the victim believes she is not taken seriously, her guilt and self-blame may increase. “All disclosures of an experience of sexual assault deserve to be heard and believed” (Stinson-Wesley, 1996, p. 223). The patient’s reality is the medium through which the therapy can take place, regardless of how factually accurate the patient’s memory is of the incidents. This is congruent with a relational approach to the clinical encounter. The

counselor should emphasize the fact that she survived the rape, and has been through a severe crisis, and that she was not at fault. Enabling the victim to see she has resources that allowed her to survive the experience is powerful. It is important to allow the victim to talk about the assault when she is ready and to share what she wishes and not to ask too many questions about the incident unless she shares them willingly. In so doing, the counselor can act in the capacity as a fellow traveler in the client's narrative rather than a bossy guide.

The counselor's role is as much about restoring power to someone who was robbed of her sense of power as anything else; giving the victim as much to say as possible about what happens within the counseling relationship is a good way of sharing the power that a caregiver possesses. Therefore, the concept of power must be reconstructed. A relational, feminist approach to the therapeutic relationship incorporates a more egalitarian and accessible power for both client and therapist. Power is not something to be taken from one and given to another. In their book, *Treating the Adult Survivor of Childhood Sexual Abuse*, Messler Davies and Frawley O'Dea say:

Working with adult survivors of sexual abuse implies a cocreation of a transitional space in which therapist and patient together are free to reenact, create context and meaning, and ultimately recreate in newly configured forms the central, organizing matrices of the patient's early life. Within this treatment model, we hold no illusion regarding the therapist's 'neutrality,' and fully expect to be pulled, through transference pressures from the patient, and her own countertransference reactions to the clinical material, into constant and evershifting re-enactments. These re-enactments are not 'clinical errors,' but the essence of the material to be analyzed within the treatment (Messler Davies and Frawley O'Dea, 1994, p.174).

Messler Davies and Frawley suggest that a traditional Freudian psychoanalytic

approach to working with survivors of sexual abuse actually contributes to a collective denial of the reality of childhood abuse. Freud was concerned with the fantasies that patients brought in concerning seduction by parental figures. He initially concluded that these fantasies were a result of actual childhood sexual trauma, and then changed his mind to conclude that these fantasies were in fact fantasies, and were indicative of a developmental complex (Messler Davies and Frawley, 1994, p. 11-16).

In a somewhat different theoretical vein and building on an interpersonal approach derived from Sullivanian theory, Jean Baker Miller (1987) describes a developmental theory particular to women that is based on relationship. A sense of connection in women's lives is central to their understanding of themselves. Women learn, grow, and develop through relationships. This relates to the idea that women are biologically predisposed to be nurturing (Chodorow, 1978). They process and understand experiences through relationality and not through autonomy (Chodorow, 1978, 1989; Baker Miller, Surrey, and Stiver, 1991). When relationality is disrupted and interaction is broken, harmful, or not allowed, women become cut off from their very basic embodied experience of sharing (Baker Miller, Surrey, and Stiver, 1991). They develop symptoms and patterns of behavior that reinforce this isolation and lack of wholeness from their bodies, which represents their primary sources of knowledge and information. Many physical processes that sustain and nurture life, such as, eating, sex, nurturing, and sharing are distorted into self-destructive activities, and women turn on their own bodies, internalizing images from modern American society, culture, and media in order to try to become an illusory image derived from a male desire to control and dominate. They

silence their own voices and shut off their bodies, bending to social pressure that enforces isolation, self-reliance, independence, and consumerism.

Women become dehumanized and become part of the modern market capitalist system, a commodity to be displayed, consumed, and used as a tool to make money. This cut-offness from immediate bodily experience and reliance instead on internalized cultural images of themselves affects all areas of a woman's life: relationships, body image, sexuality, identity, and productivity (Baker Miller, 1976, 1987, 1991; Surrey, 1991; Stiver, 1991; Kaplan, 1991; Jordan, 1991).

Survivors of sexual abuse offer a particularly effective look into the power dynamics of the therapeutic relationship between therapist and client (Messler Davies, 1994; Frawley, 1994; Baker Miller, 1991). Because an abuser relies on manipulating and taking advantage of unequal power relationships, the extent of the receiver of abuse's illness and diagnosis is directly tied to intimate power dynamics in therapy. In other words, the client who has suffered sexual abuse as a child will readily and easily engage in the therapeutic relationship around issues of power (Messler Davies, 1994; Frawley, 1994) He or she will perceive the therapeutic relationship in relative terms to the abuser/abusee relationship, and the therapist will inevitably be identified with the abuser.. Therefore, if the therapist is not acutely, thoroughly, and intimately aware of her own presence, sense of power and authority in the relationship, she will be more likely to exploit the therapeutic relationship in an unhealthy manner (1994).

Consequently, even unintentional actions can be problematic and further perpetuate the cycle of trauma of childhood abuse survivors. Recent transference and

countertransference in therapy studies demonstrate the power around the role of transference and countertransference in therapy, and the growing insistence by theorists and clinicians, particularly of the relational, intersubjective, interpersonal, and psychodynamic schools for therapists to examine countertransference and the subtle and nuanced reactions, inner responses and dialogue in therapy when working with survivors of sexual trauma (Cooper-White, 2004, 2007; Mitchell and Aron, 1999;).

Sigmund Freud and Pierre Janet's Approach to Working With Hysteria and Sexual Trauma: Drawing Sociocultural Implications for Feminist Pastoral Counseling

Approaches put forward by feminist pastoral caregivers and counselors today are corroborated by Judith Herman (1992) in working with victims of trauma. The first stages of recovery involve establishing safety, reconstructing the trauma story, and restoring a reconnection between survivors and the community. These tasks become clear when the therapist and client gain an understanding of how trauma affects the body, mind, and soul of a person. Herman outlines a helpful sociocultural critique of a more traditional psychoanalytic approach to working with traumatized clients. She examines the origins of the term "hysteria" as a medical diagnosis given prominence in the 19th century in Europe and most often given to women.

For two decades in the late nineteenth century, the disorder called hysteria became a major focus of serious inquiry. The term hysteria was so commonly understood at the time that no one had actually taken the trouble to define it systematically. In the words of one historian, "for twenty-five centuries, hysteria had been considered a strange disease with incoherent and incomprehensible symptoms. Most physicians believed it to be a disease proper to women and originating in the uterus." Hence the name, hysteria. As another historian explained, hysteria was "a dramatic medical metaphor for everything that men

found mysterious or unmanageable in the opposite sex." The patriarch of the study of hysteria was the great French neurologist Jean-Martin Charcot (Judith Herman, 1997, p. 10).

If we look at the origins of studies done on the causes and effects of trauma on persons, particularly women, we can find evidence of how women who experienced sexual assault and sexual abuse were perceived, judged, and treated by medical professionals in 19th and early 20th century Europe. Two of Dr. Jean-Martin Charcot's students, Pierre Janet and Sigmund Freud, dedicated themselves to the task of uncovering the cause of hysteria. They decided it was not enough to observe and classify hysterics. (Herman, 1992) This meant that Janet and Freud suspended conventional belief and prescriptions to working with this type of client in favor of a more open-ended approach where they explored a different method in the hopes of discovering something new and useful in understanding the clients' conditions, and therefore, uncovering a more effective way to treat them.

In order to delve more deeply into the task at hand, they decided that they had to talk to the patients, and they did so with thoroughness. Talk therapy took place with a patient on a daily basis for hours at a time. This is noteworthy because it means that Janet and Freud determined that in depth, direct one on one communication in a clinical atmosphere would cultivate a more open, intimate therapeutic connection and allow the client to develop trust in the men and tell them things in a more organic and fluid manner through the medium of conversation. It seems that this approach yielded some definite results for the analysts. By the mid-1890s, both Janet in France and Freud along with his collaborator Joseph Breuer in Austria came to similar conclusions that "hysteria" was the

result of psychological trauma (Herman, 1992, 1997). Unbearable emotional responses to traumatic events produced an altered state of consciousness, which in turn induced hysterical symptoms. Janet defined this process as “dissociation,” and Freud called it “double consciousness“ (Herman, 1992, 1997). Both men recognized that somatization in hysterical patients represented disguised representations of distressing events that were repressed from immediate memory (Herman, 1992, 1997).

Janet described his patients as being controlled by “subconscious fixed ideas, the memories of traumatic events” (Herman, 1992, 1997). Breuer and Freud wrote that hysterics suffer from “reminiscences.” By engaging the patients in long and involved conversations, these men discovered that hysterical symptoms could be alleviated when the traumatic memories and the intense emotions that accompanied them were recovered and put into words and expressed by the patient. This method became the foundation of modern psychotherapy. Janet called it “psychological analysis,” (Janet, 1892) Freud called it “abreaction,” then “psychoanalysis”(Freud, 1893). Anna O., one of Breuer’s patients, who later became a student of psychoanalysis herself, called it “the talking cure” (Breuer, 1895: Herman, 1992, 1997). The collaboration between doctor and patient became a common quest: the answer to the mystery of hysteria was found in the painstaking reconstruction of the patient’s past. Janet found that after uncovering recent traumas, the doctor and patient were able to go deeper and explore earlier events.

By removing the superficial layer of the delusions, I favored the appearance of old and tenacious fixed ideas which dwelt still at the bottom of her mind. The latter disappeared in turn, thus bringing forth a great improvement.” Breuer, describing his work with Anna O, spoke of “following back the thread of memory.” It was Freud who followed the thread the furthest, and invariably this led him into an exploration of the sexual lives of women. (Herman, 1997, p.12)

Freud's commitment and passion to understanding hysteria led him to put aside his preconceptions about the cause of hysteria and simply be open and to listen empathically to his patients, who were primarily women. What he heard from them were stories of sexual assault, abuse, and incest. Following back the thread of memory, Freud and his patients uncovered major traumatic events of childhood concealed beneath more recent events that "triggered" the hysterical reaction (Herman, 1992, 1997). In 1896, in a report on 18 case studies called "The Aetiology of Hysteria," Freud made the claim:

I therefore put forward the thesis that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience, occurrences which belong to the earliest years of childhood, but which can be reproduced through the work of psycho-analysis in spite of the intervening decades. I believe that this is an important finding, the discovery of a *caput Nili* in neuropathology. (Freud, 1896; Herman, 1992)

Within a year, Freud had privately denied this assertion. In Freud's writings at the time, it is clear that he was disturbed at the implications of this conclusion, that sexual abuse was so prevalent in the upper middle class of France and Austria as to be an epidemic. Today, it is clear that the number of incidents of sexual abuse, incest and trauma are still at epidemic levels. Not much has changed in reducing the rates of sexual abuse from Vienna in the late 19th and early 20th century to the United States of the 21st century. Was this conclusion that sexual abuse was so prevalent in upper-middle class Viennese society, possibly something that Freud could not accept? Could people who were educated, powerful, wealthy, and cultured, commit such atrocious and barbaric acts against their own children or the children of friends was too much to swallow. To follow

through on this conclusion meant for Freud to challenge the structure and system of a society he belonged to and needed the support of to do his work and to be recognized (Herman, 1992, 1997). Freud's previous writings on his work with hysteric patients can be compared to his writings about "Dora," a young woman who he saw and treated who was the last hysterical patient he agreed to work with.

The work as Freud described, was no longer a cooperative effort, but more a battle between Dora and himself. Freud's account of the treatment is laced with disdain, dismissal, and disbelief about Dora's expressions, claims, and assertions. The therapeutic alliance and atmosphere was no longer open, trusting, and collaborative, but it was full of distrust and conflict (Freud, 1900, 2013). In his case study on Dora, *A Case of Hysteria*, Freud became intent on proving or disproving Dora's recollections of her family life, relationship with Herr K and Frau K, and her father as true or false, accurate or not. The accuracy of her memory and consistency of her story led him to his diagnosis of hysteria and to the conclusion that she was creating sexual fantasies of herself and Herr K and Frau K instead of recalling some actual experience that was sexually traumatic (Freud, 1900, 2013. pp28-35). His therapeutic approach to working with Dora was that of an investigator or detective, intent on uncovering lies or distortions and not one of working off the belief that Dora's sexual trauma was producing certain symptoms of PTSD.

Freud acknowledged that Dora was being used as a sexual object by her father to be passed around to his colleagues (Herman, 1992; Freud, 1900, 2013, p.25-29). However, Freud refused to acknowledge and validate Dora's feelings of outrage and humiliation. It is interesting to note that he recorded her efforts at resistance of the

advances of Herr K in his case study, yet he finds her resistance to his conclusions and to his treatment of her to be troubling. He focused instead on exploring her feelings of erotic stimulation, so as to make her feel as if she wanted to participate in these acts and they fulfilled some kind of desire for her (Freud, 1900, 2013, p. 42). This is a dramatic switch in the role of the therapist (Freud) towards his patient. Freud chose to align himself with the perpetrator of abuse, Dora's father, and not with her. This enabled him to maintain an unquestioned authority perhaps in his work and to escape the challenge of a psychiatric, medical, and psychoanalytic community. Perhaps too, he wanted to avoid any further scandal related to the sexual relationship Breuer had developed with Anna O, one of his patients, and possibly others. Perhaps he felt he could not engage in effective, empathic therapy at the depth and level needed with these patients without being drawn in himself and losing his professional 'objective' perspective. Dora herself broke off the treatment and she was scorned and ridiculed for her actions and decision to challenge Freud (Herman, 1992, 1997).

Basic tenets of modern psychoanalytic theory were developed out of the remnants of this exploration, a theory, which denies women's reality, not only in a physical, bodily sense, but in a broader systemic social sense. By the beginning of the 20th century, Freud completely reversed his previous position on hysteria and sexual trauma and without any evidence to support his new claim, he dismissed all the accounts of his previous patients of sexual abuse and trauma and stated that they were untrue (Herman, 1992, 1997). The exploration of hysteria and its connection to sexual trauma was simply too explosive on a social, political, and even economic level to continue. Herman's analysis of the

sociocultural climate at the time of Freud's, Breuer's and Janet's research is helpful to understanding how it affected his development of drive theory and how it related to women. It also provides a point of comparison between therapy with trauma clients as a collaborative, affirming, validating activity, and therapy that is non-collaborative, diagnosis-based, and operates out of a model of illness. The client who is not believed and who is continually challenged by the therapist will not heal. Further, the perpetrators of abuse continue to be supported by an unjust system and are not held accountable for their actions.

Helpfulness of Cognitive-behavior Based Therapies With Trauma and PTSD

We can engage in one more comparison of a different type of therapy utilized in treating persons living with PTSD as a result of sexual assault in order to draw helpful conclusions about the benefits of a feminist, constructivist approach to therapy with this population.

Before the symptoms of rape were conceptualized as PTSD, Veronen, Kilpatrick, and Resick (1978) developed a cognitive-behavioral treatment program, called *stress inoculation training* (SIT, Meichenbaum, 1974), for rape victims who exhibited persistent fear. Investigations have investigated the efficacy of this program in diminishing victims' rape-related fear, anxiety, and depression (Veronen & Kilpatrick, 1982). In a well-controlled study of three types of group therapy for rape victims, SIT was compared with assertion training, supportive psychotherapy, and a wait-list control group (Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988). All three treatments

were equally effective in reducing rape-related symptoms. Improvement was observed on measures of general psychopathology, general fear, and specific fear, as well as intrusion and avoidance symptoms, but not on measures of depression, self-esteem, and social fears. The wait-list control group did not evidence change. These findings would correspond with the symptomology that Billie expressed both in chronic and acute levels. During the time I worked with her, the mental health and medical professionals who worked with her, including myself, overwhelmingly agreed that Billie lived with chronic depression, and had significant social anxiety.

Exposure (systematic desensitization) and anxiety management techniques (cognitive-behavioral therapy) were compared in an uncontrolled study with rape victims (Frank et al., 1988). Both treatments were effective in reducing anxiety and depression with no differences evident between treatments. In their study, Keane et al. (1989) did not incorporate a control group for nonspecific therapeutic factors. Thus, it is not clear whether improvement was due to the specific procedures employed in the treatment or to nonspecific factors such as therapist contact. The Veronen and Kilpatrick (1982) investigation was uncontrolled and did not include measures of PTSD symptoms. Although Resick et al.'s (1988) study included the necessary experimental conditions, it did not include measures of PTSD symptoms, nor did it control the overlap of potentially important procedures among the various treatment conditions (e.g., elements of exposure were included in two treatments). Frank et al. (1988) did not assign patients randomly to treatments, had no control group, and failed to exclude patients who had been raped shortly before treatment.

One recent study compares the effectiveness of specific short-term cognitive-behavior type therapies, named Prolonged Exposure (PE), and Stress Inoculation Training (SIT) with Supportive Counseling (SC), the latter under which various types of counseling and psychotherapy might possibly fit (Foa, Rothbaum, Riggs, Murdock, 1991). After examining the content of the SIT therapy described in this study however, we can come to the conclusion that the type of collaborative counseling I am supporting in working with clients incorporates the stress reduction exercises promoted in SIT therapy. Further, the type of supportive counseling described in the study that was administered would not, in my opinion, be considered psychotherapy or pastoral counseling and I understand it to be.

In Prolonged Exposure (PE), the first two sessions were devoted to information gathering through the initial interview, explanation of treatment rationale, and treatment planning. The next seven sessions were devoted to reliving the rape scene in imagination (imaginal exposure). Patients were instructed to relive the assault by imagining it as vividly as possible and describing it aloud using the present tense. The patient repeated the rape scenario several times for a total of 60 min per session. The patient's narratives were tape-recorded, and patients were instructed to listen to the tape at least once daily as homework. Additional homework involved in vivo exposure to feared and avoided situations judged by the patient and the therapist to be safe.

The procedures included in the treatment program of Stress Inoculation Training (SIT) were adapted from Veronen and Kilpatrick (1983). The first session was devoted to information gathering through the initial interview. The session terminated with breathing

exercises to diminish anxiety that may have been elicited by the interview. During the second session, the treatment method was described to the patient, a rationale for treatment was given, and an explanation for the origin of fear and anxiety was presented.

The next seven sessions were devoted to instruction in coping skills. During the third and fourth sessions, the patients were taught deep muscle relaxation and controlled breathing. In the fifth session, they were taught thought stopping to counter ruminative or obsessive thinking (Wolpe, 1958). The sixth session was devoted to cognitive restructuring (Beck, Rush, Shaw, & Emery, 1979; Ellis, 1977), the seventh to guided self-dialogue (Meichenbaum, 1977), the eighth to covert modeling, and the ninth to role playing. No instructions for exposure were included.

Supportive Counseling (SC) followed the nine-session format, gathering information through the initial interview in the first session and presenting the rationale for treatment in the second session. During the remaining sessions, patients were taught a general problem-solving technique. Therapists played an indirect and unconditionally supportive role. Homework consisted of the patient's keeping a diary of daily problems and her attempts at problem solving. Patients were immediately redirected to focus on current daily problems if discussions of the assault occurred. No instructions for exposure or anxiety management were included.

The type of supportive counseling employed in this study does not compare in a general sense to the type of counseling that I am referring to in this dissertation and that we are taught in the ATA ThD program. Therefore, there are significant problems assessing how CBT therapies and the kind of longer term counseling that I am supporting

based on this study alone. This examination does give us some insight into the benefits of certain stress reduction exercises employed by behavioral therapists. It also gives us insight into what population of people living with PTSD might not benefit from shorter-term therapies based on the exclusion criteria.

Exclusion criteria for this particular and most recent study described were current or previous diagnosis of organic mental disorder, schizophrenia, or paranoid disorders as defined in the *DSM-III-R*; depression severe enough to require immediate psychiatric treatment, bipolar depression, or depression accompanied by delusions, hallucinations, or bizarre behavior; current alcohol or drug abuse; assault by spouse or other family member; or illiteracy in English. Eligibility for the study was determined through an interview with a master's- or PhD-level psychologist.

It is important to note that survivors of sexual abuse by a family member would be excluded from this study based on the last criteria. Therefore, my client would not qualify for this comparison in two ways. She was diagnosed with major depressive disorder in 2009 after being hospitalized for suicidality, a diagnosis she says she was given before that time as well. Additionally, conductors of this study define PTSD as an anxiety disorder. They are stating therefore, that they are treating the symptoms of PTSD that produce or exhibit anxiety. They do not attempt other symptoms of PTSD or sexual assault or childhood sexual abuse, namely depression. Their conclusions support the effectiveness of treating arousal symptoms- such as startle symptoms, hypervigilance- but no other symptoms, particularly intrusion and avoidance.

In the most recent study described, superiority of SIT and PE over the other two

conditions was evidenced only on PTSD symptoms. On other measures of psychopathology, no significant group differences emerged. Immediately after treatment, patients who received SIT showed the least pathology, followed by PE, SC, and WL, respectively. However, at follow-up, patients who received PE evidenced the most improvement, followed by those who received SIT, with patients receiving SC showing the least improvement. The conclusion that SIT was effective in reducing rape-related psychopathology is consistent with those of Veronen and Kilpatrick (1982) and of Resick et al. (1988).

Also consistent with the findings are Resick's et al.(1988) results indicating no difference between counseling and SIT on measures of general psychopathology. Two issues inherent in the study of rape victims were noted. Approximately half of the women scheduled for initial evaluations did not attend their scheduled appointments, and 19% of those offered treatment declined. This reluctance may be due to a tendency of rape victims to avoid confrontation with the rape memory, which is one of the symptoms of PTSD (Rothbaum & Foa, in press).

Unlike other anxiety-disordered individuals (e.g., obsessive-compulsives, agoraphobics), rape victims do not seem to define themselves as "patients." Consequently, they seem less likely to comply with therapeutic demands including timely appearance in the therapist's office. It should also be noted that rape is underreported, and many rape victims are reluctant to seek treatment for their symptoms. This seems to be particularly true for lower socioeconomic status individuals. Therefore, the extent to which the present results can be extended to other samples of rape victims is unknown.

In interpreting the current results, two possible limitations should be considered: First, the use of only female therapists in the study limits its generalizability. However, this issue may not pose a serious limitation because most rape victims' treatment centers employ primarily women as therapists.

This study presents certain challenges when attempting to form a helpful comparison of shorter-term therapies with feminist, narrative-based therapies for persons living with PTSD. The limitations of the study would exclude my client from being eligible. Persons who experience sexual assault more than once, or who experienced sexual abuse by a family member are excluded. Persons who experienced an adverse childhood experience that led to a chronic diagnosis are excluded. This discrete, specific investigation could be helpful in identifying which shorter term therapies reduced visible and measurable PTSD symptoms within a shorter, finite period of time, but it does not address many broader, underlying themes for a client who has been sexually abused, or who has chronic disorder from his or her assault experience.

I believe it is necessary to delve into family history, to look at a person's narrative through a critical sociocultural, psychoanalytical, and theological lens along with the client in order to empower them to get to the deeper issues they live and struggle with. Further, due to the nature of sexual abuse and the significant impact it can have on a person's development and understanding of relationships (Felitti and Anda, 1999), I firmly believe it is essential for a survivor of sexual abuse to develop a trusting, healing relationship with the therapist in order to work through the broken trust that an abusive parent, family member, or familiar person inflicts. I do think it is possible and beneficial

to incorporate certain CBT therapies within the longer –term therapeutic context that can help the client alleviate symptoms when they arise on a daily basis.

The Importance of Empathy in Pastoral Counseling

Carl Rogers (1965, 1978) placed ultimate importance on the empathic relationship as the basis for therapy. Rogers emphasized the quality of the interpersonal encounter with the patient to be the most significant element in determining effectiveness (1989, 2003). The relationship itself is the healing element in the therapy. Through my work with Billie, and through my increasing faith and confidence in a strong therapeutic alliance, I came to a crucial realization regarding understanding her symptoms and how to work with her.

I needed to gain a better understanding of how trauma affects someone and since her symptoms were so bodily related and manifested in physical ways, I began to research how trauma is innately connected to the brain and body processes as I discussed in the previous chapter. Trauma can alter deeply embedded processes in such a way as to permanently change their patterns in a life-inhibiting way. I also needed to gain a better understanding how to help her with my skills and abilities. I became fascinated with meditation and other reflective practices and their effects on the body and brain, and how they in turn are able to re-form important connections between parts of the brain and the body in healing ways. How could meditation or lovingkindness practices potentially

reverse the destructive effects of trauma on the brain? What elements of meditation allowed for this to happen? One of the reasons for this I believe is because meditation is an embodied spiritual practice. It requires the practitioner to be still and engage in a rhythmic controlled breathing pattern. Along with this, the practitioner must observe and accept whatever sensations, thoughts, emotions, ideas arise during this time without judgment, without repression, and with compassion. Incorporating a loving mantra or thought into this practice can increase the beneficial effects and increase empathy towards oneself. Pema Chodron (2000) outlines a process of “maïtri” (lovingkindness) in a series of stages. The first step she encourages practitioners to engage in is lovingkindness towards oneself. Without this ability, one cannot truly move through the next stages (Chodron, 2000-2007). The next stage involves practicing maïtri for a loved one; the next stage involves practicing maïtri towards all sentient beings. The last stage involves practicing maïtri towards someone who has harmed you.

Survivors of trauma like Billie experience a lack of compassion or empathy from others towards them and consequently they feel a lack of empathy towards themselves. For survivors of childhood sexual abuse who were abused by a caregiver or family member, this lack of compassion or empathy on the part of the caregiver is twisted into harm and deeply imprints on the soul, brain, and psyche of the child. The caregiver should teach and express towards the child compassion and empathy. This is a positive, nurturing means of expressing care. The child learns how to love themselves and feel empathy towards themselves through someone loving them. A child who has been abused does not receive love and care in a positive, nurturing, compassionate manner. In

a sense, they do not understand what compassion and empathy really are. This, I came to understand was at the center of Billie's struggles. There became and there remain three tasks for Billie and myself. 1) She needed to be willing to learn how to love herself and grow compassion for herself. 2) She needed to understand how to do this and incorporate practices in her life to be able to cultivate self-compassion and love. 3) I needed to understand how to enable her to do this without doing it for her. I had to walk the fine line between showing and demonstrating empathy and compassion for her without preventing her from learning how to do it herself.

Why do some people seem to possess and express more empathy than others? Why do some people seemingly have no empathy at all for others? This is too large a question to answer here, but it is relevant to understanding more about human nature and why people do the things they do towards others, in both harmful and beneficial ways. Are humans naturally empathetic? Do they have innate abilities to be compassionate and supportive and cooperative towards others? If yes, why? And if no, why not? How compassion and empathy help the human race and the earth as a whole? Based on recent important studies by biologists, it is clear that empathy is an important part of human experience. When it is present in someone, or expressed in relationship towards someone else, there is positivity, happiness, a bond that forms. When it is absent or lacking, there is pain, loneliness, negativity. Empathy can be destroyed, and it can be cultivated.

When examined on a collective, human, and interspecies mammalian level, scientists identified five mammalian species who practice what they call pro-social

behavior. Pro-social behaviors are behaviors that humans and other mammals exhibit towards others of their species that are targeted towards helping the others who are in need or are in danger without expecting immediate equal aid in return (De Waal, 2008-2010; Osborne, 2009). Evolutionary biologists claim that the most evolved species, including elephants, monkeys, dolphins, mice, and humans (and practice pro-social and empathic behavior (De Waal, Aug, 2011, May 2012, Jan 2013, Feb. 2014). These mammals are able to sense when one of their kin or a companion needs help react in targeted ways to provide such aid (De Waal, 2008-2014). This is believed to occur for non-human mammals as well as mammals because the body tends to react physically upon witnessing or learning upon the pain of others, a phenomenon increasingly addressed by interdisciplinary fields such as neurophilosophy (Osborne and Derbyshire, 2009). Ultimately, on a systemic and societal scale, prosocial behavior benefits all as it conveys the individual creature's desire to help others, which is not grounded just in normative behavior, but also very much so in biological and evolutionary imperatives (Osborne and Derbyshire, 2009).

Levenson and Reuf (1992), among others, argue that empathy “provides a bridge between the feelings of one person and those of another” (Levenson and Reuf, 1992, p. 234). Consequently, in a world that so often can sever the emotional connections between people, empathy is arguably one of the strongest to unite individuals in shared feeling so as help those suffering have fellow companions with whom to assist them move beyond their despair. Though empathy is particularly powerful for helping individuals to understand the pain and suffering of others, it is ultimately useful simply

because it allows individuals to understand how others feel, if people allow themselves to be vulnerable, on psychological as well as physiological bases (Levenson and Reuf, 1992). The long-established literature surmises that empathy can be defined with a three-pronged definition in which individuals who can empathize with others possess three specific qualities (Levenson and Reuf, 1992). These qualities include the following: “knowing what another person is feeling,” “feeling what another person is feeling,” and “responding compassionately to another person’s distress” (Levenson and Reuf, 1992, p. 234). Empathy, like pain, sadness, joy, fear, laughter, and anger, is contagious; Frans De Waal (2000) refers to this as emotional contagion. When individuals see someone in pain, they feel pain. The maternal instinct is based on empathy; it is a natural instinct geared towards helping the species survive. Further, it can be developed and grown to benefit the species ever more with training. Females have a more developed empathic body channel than males. Though the Levenson and Reuf (1992) understanding of empathy is robust and stems from a wealth of literature, it is important to further deconstruct that literature and provide the definitions as articulated by influential scholars whose works are part of the cannon on the subject matter. Many influential persons in the field of psychology, psychoanalysis, and psychiatry, were fascinated with empathy and its importance in their work. Heinz Kohut,(1959) an important figure in the development of psychological theory and practice stated, “Empathy is the capacity to think and feel oneself into the inner life of another person.” How is this important in the work of pastoral counseling? This is something I would like to explore. Carl Rogers said empathy is:

To perceive the internal frame of reference of another with accuracy and with the

emotional components and meanings which pertain thereto as if one were the person, but without ever losing the "as if" condition. Thus, it means to sense the hurt or the pleasure of another as he senses it and to perceive the causes thereof as he perceives them, but without ever losing the recognition that it is as if I were hurt or pleased and so forth. (Rogers, 1959)

Rogers (1978) highlights the sensed and shared nature of empathy of an expressed emotion, experience or thought. He makes the important observation that empathy is a sensed or perceived understanding of another's frame of reference without losing the understanding of the shared experience being the others experience and not one's own. Roy Schafer (1959) said empathy involves the inner experience of sharing in and comprehending the momentary psychological state of another person. Wynn Schwartz (1984) understood empathy to be the ability for us to recognize others as empathic when we feel that they have accurately acted on or somehow acknowledged in stated or unstated fashion our values or motivations, our knowledge, and our skills or competence. All of these statements involve an observation of empathy as being a "felt or perceived" process of connection between two people. They show how the person receiving an empathic response can and should acknowledge the empathic response as part of the shared experience. These definitions also emphasize the importance of empathy in the psychological and spiritual health of a person and in the work between therapist and client. What is it about empathy that is essential to healing?

Since empathy involves understanding the emotional states of other people, the way it is characterized is derivative of the way emotions themselves are characterized. If, for example, emotions are taken to be centrally characterized by bodily feelings, then grasping the bodily feelings of another will be central to empathy. If emotions are

characterized more by a combination of beliefs and desires, then grasping these beliefs and desires will be more essential to empathy. The ability to imagine oneself as another person is a sophisticated imaginative process. However the basic capacity to recognize emotions has been indicated, by the literature, to be innate, and may be achieved unconsciously (Osborne and Derbyshire, 2009). Yet it can be trained and achieved with various degrees of intensity or accuracy. The human capacity to recognize the bodily feelings of another is related to one's imitative capacities, and seems to be grounded in the innate capacity to associate the bodily movements and facial expressions one sees in another with the proprioceptive feelings of producing those corresponding movements or expressions oneself (De Waal, 2008-2014). Humans also have been found to make the same immediate connection between the tone of voice and other vocal expressions and inner feeling (De Waal, 2008-2014).

Empathy is distinct from sympathy, pity or emotional contagion (De Waal, 2008-2014). Sympathy or empathic concern is often understood to be the feeling of compassion or concern for another, the wish to see them better off or happier. Pity is the feeling that another is in trouble and in need of help as they cannot fix their problems themselves, often described as feeling sorry for someone. Emotional contagion is when a person (especially an infant or a member of a mob) imitatively *catches* the emotions that others are showing without necessarily recognizing this is happening (De Waal, 2011). Though these phenomena are interrelated, they are still distinct.

Perspective-taking

A brief discussion of dimensions of empathy can be helpful here to understand how it can best be beneficially used in therapy with persons living with PTSD. Empathy was conceptually distinguished from sympathy beginning with the early definitions of empathy in the 19th century; the term may be in the process of being distinguished further, this time from perspective taking. Due both to the conceptual confusions between the emotional and cognitive aspects of empathy and to an emerging sense of the differences in the functional aspects of the two phenomena, more-recent discussions have distinguished between empathy (as the more intuitive emotional aspect) and perspective-taking (as the more cognitive aspect). Some authors, however, see perspective taking as one of the dimensions of empathy.

Development

By the age of two, children typically begin to display the fundamental behaviors of empathy by having an emotional response that corresponds with another person (Winnicott, 1963, 1992, 2002, 2008; Klein, 1921-1945; Mahler, 1969, 1979, 2000). Even earlier, at one year of age, infants have some rudiments of empathy, in the sense that they understand that, just like their own actions, other people's actions have goals. Sometimes, toddlers will comfort others or show concern for them at as early an age as two years old. Also, during the second year, toddlers will play games of falsehood or *pretend* in an effort to fool others, and this requires that the child knows what others believe before he or she can manipulate those beliefs.

According to Jean Decety, Kalina Michalska, and Yuko Aktsuki (2008) at the

University of Chicago who used functional magnetic resonance imaging, (fMRI), children between the ages of seven and twelve appear to be naturally inclined to feel empathy for others in pain (Decety, Michalska, and Atsuki, 2008). Their findings are consistent with previous fMRI studies of pain empathy with adults. The research also found additional aspects of the brain were activated when youngsters saw another person intentionally hurt by another individual, including regions involved in moral reasoning, thus demonstrating the neurophilosophical elements of human empathy (2008). Despite being able to show some signs of empathy, such as attempting to comfort a crying baby, from as early as eighteen months to two years, most children do not show a fully fledged theory of mind until around the age of four (Winnicott, 1992, 2000; Mahler 2000). To clarify, theory of mind involves the ability to understand that other people may have beliefs that are different from one's own, and is thought to involve the cognitive component of empathy (Winnicott, 1992, 1996, 2002).

Neurological basis for Empathy

Recent research has focused on possible brain processes underlying the experience of empathy. For instance, **fMRI** has been employed to investigate the functional anatomy of empathy (Decety, Michalska, Aktsuko, 2008). These studies have shown that observing another person's emotional state activates parts of the neuronal network involved in processing that same state in oneself, whether it is disgust, touch, or pain. The study of the neural underpinnings of empathy has received increased interest

following the target paper published by Preston and Frans de Waal (2009) following the discovery of mirror neurons in monkeys that fire both when the creature watches another perform an action as well as when they perform it. Preston and de Waal (2009) argue that attended perception of the object's state automatically activates neural representations, and that this activation automatically primes or generates the associated autonomic and somatic responses, unless inhibited (Preston and de Waal, 2009). This mechanism is similar to the common coding theory between perception and action.

There are also other interesting findings from studying the effects of mindfulness meditation. For instance, monks who engage in mindfulness meditation regularly for at least two to six hours a day have larger pre-frontal cortexes, the part of the brain that regulates emotion (Emory Tibet/Conference Oct 2010). They generate more positive emotions, are able to manage and control negative or intense emotions without reacting on impulse, and they are able to act with empathy towards others in very difficult and challenging situations. The ability to gain perspective, clarity, and objectivity or distance from one's emotions is invaluable. If we are too close to our own emotions, and are like pinballs, simply reacting to stimuli instantly, people lose the ability to control their lives. People are not able to make wise, mature, loving decisions and actions that could produce more positive actions without such control.

Meditation increases the self-other distinction (deWaal, 2008, 2009, 2011, 2012, 2013). The more one is able to distinguish one's own experience and emotions from another's, the more empathetic one can be towards the other and the more oriented to the

other and truly focused on the other one can be. Therefore, a person who has a highly developed self-other distinction is able to help another person more effectively. In the brains of elephants, dolphins, apes, and humans, are spindle cells that are basically empathy cells. They are found in the pre-frontal cortex in the brain, and add connectivity between different areas of the brain and between the brain and the body. They correlate between cells in the brain and mirror self-recognition. Only very few species, such as can recognize themselves in the mirror (self-other distinction) (de Waal, 2008-2012).

Philosophers who help bridge the gap between the affective and the spiritual, such as The Dalai Lama, have long advocated scientific investigation of the effect of spiritual traditions, such as meditation, on the brain (Siegel, 2002, 2010, 2012; Kabat-Zinn, 2008, 2011; Davidson, 1991). In 1991, the exiled Tibetan leader, in particular, enlisted the help of University of Wisconsin professor Richard Davidson to study the effect meditation had on the brain. The neuroscientist's groundbreaking discovery showed activities like meditation can in fact train the mind to react to situations with positive emotions (Davidson, 1991). He argues that meditation changes circulations in the brain that are critical for the development of emotion. Characteristics like happiness and compassion are skills that can be trained. Per Davidson (1991), "We've shown that those circuits [that can be affected by meditation] are also related to parts of the body that are important for physical health." Davidson emphasizes how the human brain responds to the pain of another person. There are neural circuits that are engaged when individuals demonstrate compassion. The anterior insula of the brain contains a map of the visceral organs of the body (Davidson, 1991; Felitti and Anda, 1999). Sounds of pain, neutral

sounds, and positive sounds all activate certain parts of the brain (Davidson, 1991; Felitti and Anda, 1999). Compassion meditation modulates the BOLD signal in the amygdala and other parts of the brain in response to emotional sounds (Davidson, 1991).

Compassion meditation increases a person's ability to adopt another person's perspective (Davidson, 1991). Scientists also have been able to identify a significant connection between the head/brain and the heart (Frederickson, 2008; Porges, 2007, 2011; Beauchaine, 2007). During meditation an effect called "coupling" is visible- a joining of the heart and brain that facilitates communication between the heart and the mind (Frederickson, 2008; Porges, 2007, 2011; Beauchaine, 2007).

Lovingkindness and compassion training involve contemplating and visualizing suffering and wishing happiness for loved ones, neutrals (you have neither a positive nor negative emotion attached to them), adversaries (people you feel negatively towards), and all sentient beings (Chodron, 2000, 2002, 2007). Groups of humans who engage in regular compassion exercises exhibit more pro-social behavior and physical health benefits after a short period of time (Lazar, 2005, 2006). Studies in recent years have documented positive physical effects from meditation that include lowered blood pressure, decreased heart and respiratory rates, increased blood flow, and other measurable signs of the relaxation response. The June 13, 2006, edition of the *Washington Post* reported that heart disease patients involved in a small government-funded study who practiced transcendental meditation for four months showed slight improvements in blood pressure and insulin levels. Participating patients who learned transcendental meditation did better on blood pressure and insulin measures than those

who spent the same amount of time on lectures, discussions, and homework about the effects of stress, diet, and exercise on the heart. 103 patients in the study received regular medical care as well, including drugs to lower cholesterol and blood pressure. Meditation had "a strong enough effect that we could show a benefit over traditional health care," said co-author Noel Bairey Merz of Cedars-Sinai Medical Center.

In a report issued on May 8, 2006, by *ScienCentral News*, Massachusetts General Hospital psychologist Sara Lazar says she can see measurable physical changes in the brains of people who routinely meditate. "Meditation can have a serious impact on your brain long beyond the time when you're actually sitting and meditating, and this may have a positive impact on your day-to-day living," said Lazar, an instructor at Harvard Medical School (Lazar, 2006, p.113). Her research was funded by the National Institutes of Health and the Centers for Disease Control.

As she outlined in the Nov. 15, 2005, issue of *NeuroReport*, Lazar and her team used MRI brain scans to compare the brains of people who practiced insight (*vipassana*) meditation every day with those of non-meditators. "These are not monks," she emphasized, "these are just people who choose to meditate for about 45 minutes a day every day" (Lazar, 2005, p.23). Lazar and her research team found that certain areas of the cortex—the outer layer of the brain that contains our thinking, reasoning, and decision-making functions—were significantly thicker in the meditators. She explained, "one of them is right up in the front of your brain right above your right eye, and this is an area that's involved in decision making and in working memory [as well as] short term

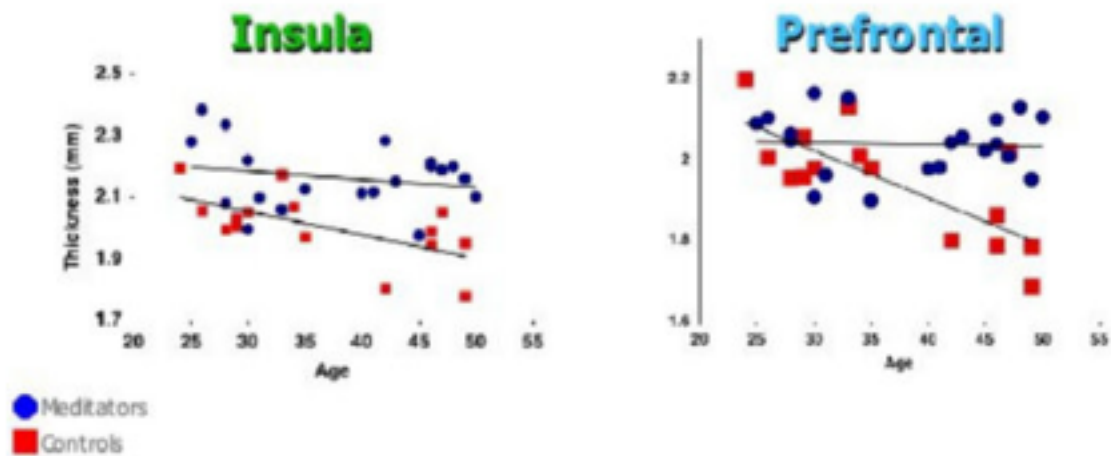
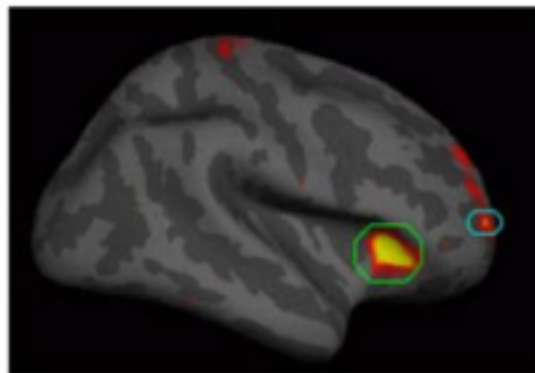
memory,"(Lazar, 2004, p.34). Lazar also saw thickening in another region of the brain, called the *insula*, that she considers "a central switchboard of the brain" (Lazar, 2004, p.21). The *insula* connects the primitive limbic cortex and the more advanced cortex, which is highly developed in primates and humans. This region is thought to be "involved in coordinating the brain and the body and the emotions and thoughts," she explained. "It helps us better make decisions" (Lazar, 2004, p. 35). Researchers think this thickening might help to counteract the natural thinning of the cortex that occurs as we get older. The brain's cortex starts getting thinner from about age 20 and continues to thin throughout life. "It's not a cure-all, but it perhaps can help prevent the loss of some functions," Lazar said (Lazar, 2004, 37). "One small part of the front of the brain does not get thinner with age... [suggesting] that this part of the brain is not affected by age. This part of the cortex is involved in short term working memory and cognitive decision-making" (Lazar, 2004, p. 38). Results also suggest that ongoing meditation would continue the thickening process. "The thickness is strongly correlated with the amount of experience. So the more they sat, the thicker it was," Lazar noted (Lazar, 2004, p. 39).

In her research, Dr. Lazar (2002, 2003) uses neuroimaging techniques to study neurological, cognitive and emotional changes associated with the practice of meditation and yoga. Her team also utilizes measures of peripheral physiology in order to understand how meditation practice influences the brain-body interaction. Magnetic resonance imaging is used to assess cortical thickness in 20 participants with extensive Insight meditation experience, which involves focused attention to internal experiences. Brain regions associated with attention, interoception, and sensory processing are thicker in

meditation participants than matched controls, including the prefrontal cortex and right anterior insula. Between-group differences in prefrontal cortical thickness were most pronounced in older participants, suggesting that meditation might offset age-related cortical thinning. Finally, the thickness of two regions correlated with meditation experience. These data provide the first structural evidence for experience-dependent cortical plasticity associated with meditation practice.

figure 1. Brain areas that are thicker in practitioners of Insight meditation than control subjects who do not meditate. Graphs show age and cortical thickness of each individual, red= control subjects, blue =

Cortical areas thicker in meditators



meditators.

Expert practitioners appear able to endure high levels of amygdala activity and to endure more suffering. On the one hand, this can be perceived as a net negative to practitioners, because they experience suffering. However, on the other hand, it can be perceived as a net positive because it allows for connections to be made at the human-to-human level. These experts are also able to express pure compassion, or compassion towards total strangers without attachment. They express the same altruistic behavior

towards different categories of people. In long-term practitioners, there is no difference between meditating for a loved one and difficult person (Kabat-Zinn,2008-2011).

Susan Smalley, Ph.D., and founder of MARC, Mindful Awareness Research Center at UCLA, describes the results of the research of Dr. Michael Irwin and his group at the Norman Cousins Center for Psychoneuroimmunology- a center dedicated to research of the mind-body connection. A recent study by Creswell (2006) used a self-report questionnaire that measures how mindful you are - as a trait in the population.. Then, brain function and its relationship to these mindfulness scores - how are people that are very highly mindful vs. not so mindful different in brain function? – were studied. An fMRI scan (functional magnetic resonance imaging) was during what is called an affect labeling task (2008). Study participants were instructed to accomplish a task where they have to label someone's emotional expression (e.g. fearful or surprised) (2008). There are certain parts of the brain that are known to be involved in doing such a task, particularly the prefrontal cortex modulating the emotional center which is the amygdala, and this study sought to further investigate this phenomenon. The researchers found that as participants' mindfulness increased, their frontal cortex activity quieted down the emotional centers. (2008) Relatedly, meditation also has been shown to improve the capacity of genes to change in their expression as a function of experience (2008).

As a geneticist, Dr. Smalley is really interested in epigenetic phenomenon, or the capacity of genes to change in their expression as a function of experience. Meditation seems to do that as well. She says, “There is one really great study where a set of about

15 genes were shown to differ (in expression) as function of a type of meditation. Those genes are ones involved in the stress response. And I'm sure there will be more studies like that. What's really cool about that, from my background in genetics, is that it illustrates that a mind state that we can self-induce can regulate gene expression - turn gene expression up or down”

One study, in particular, from the United States suggests that mind body techniques like yoga and meditation, which put the body in a state of deep rest known as the relaxation response, are capable of changing how genes behave in response to stress. Mind- body practices that produce a relaxation response have been used by people across cultures for millennia to prevent and treat disease, providing anthropological evidence of what has been discovered in epigenetic studies. The study shows how the relaxation response is marked by reduced oxygen intake, an increase in exhalation of nitric oxide, and lower psychological distress. Many experts consider the relaxation response as the counterpart to the “flight or fight stress response” that has been shown by a number of studies to have a distinct pattern of physiological and gene expression changes (Frederickson, 2008; Dusek et al, 2008). Researchers wanted to test the idea that the relaxation response produces changes in gene expression. The researchers recruited three groups of people. In the first group (called the M group), there were 19 long-term practitioners who had been practicing various ways of producing the relaxation response every day for a long time (for instance with daily yoga, repeated prayer or meditation practice). A second group was comprised of another 19 people who they called the "healthy controls" (group N1), who were not daily practitioners, and the third group was

like the healthy controls group, except these 20 people completed 8 weeks of relaxation response training (this group was N2).

The researchers examined transcriptional profiles of the people in all three groups from blood samples. They found the expressions of a total of 2,209 genes were significantly different between groups M and N1, and a total of 1,561 genes were similarly significantly different between groups N2 and N1. More importantly, however, was the fact 433 of the genes were common to both sets of comparisons: the same ones were different between M and N1 and between M and N2, so even short term practice of the relaxation response appeared to produce changes in these 433 gene expressions (Dusek et al, 2008). Further analysis using techniques called gene ontology and gene set enrichment, showed that groups M and N1 (the long term and the short term practitioners of the relaxation response) exhibited similar physiological changes such as in "cell metabolism, oxidative phosphorylation, generation of reactive oxygen species and response to oxidative stress" (Dusek, 2008). This study provides the first compelling evidence that the RR [relaxation response] elicits specific gene expression changes in short-term and long-term practitioners. Their findings suggest consistent and constitutive changes in gene expression resulting from RR may relate to long term physiological effects. The study may stimulate new investigations into applying transcriptional profiling for accurately measuring RR and stress related responses in multiple disease settings.

Dr. Herbert Benson (1984, 2000), Director Emeritus of the Benson-Henry

Institute and co-senior author of the study said: "Now we've found how changing the activity of the mind can alter the way basic genetic instructions are implemented" (Benson, 2000). Researchers who have pursued studies revolving around this issue have demonstrated that the relaxation response changes the expression of genes involved with inflammation, programmed cell death and the handling of free radicals. Dusek (2008) asserts that, "changes in the activation of these same genes have previously been seen in conditions such as post-traumatic stress disorder; but the relaxation- response-associated changes were the opposite of stress-associated changes and were much more pronounced in the long-term practitioners" Moreover, it has been found that, historically, it has not particularly mattered which techniques have been used, e.g. meditation, yoga, breathing, or repetitive praying, because they all acted via the same underlying mechanism.

Barbara Frederickson, Director, of the Positive Emotions and Psychophysiology Laboratory and Distinguished Professor of Psychology at University of North Carolina, Chapel Hill, identified something called "The Broaden and Build Theory" (Frederickson, 2001). She has been able to conclude through research that positive emotions broaden and build over time (Frederickson, 2001, 2008). Enduring resources are able to be built. She also identifies significant moments of expansion, when larger gains and leaps can be made in an instant, or in a few moments (Frederickson, 2008, 2010). She further elaborates on the connection between the brain and heart; she identifies a nerve called the Vagus Nerve that directly connects the heart to the brain.. This nerve is responsible for regulating heart rate. Activating the calming response activates this nerve. The relaxation response opposes the "fight-or-flight" response.. She also identifies something called

Vagal Tone (Frederickson, 2008, 2010). The higher one's vagal tone is, the better, because it reduces one's heart rate. A higher vagal tone also corresponds to better glucose levels, lower incidents of diabetes, and better health.. If individuals have a higher vagal tone, they have a better ability to regulate their attention and emotions (Frederickson, 2010). Regular practice in lovingkindness meditation can improve vagal tone (2010). Rises in positive emotions forecasts rises in vagal tone. Increases in warm, loving connections with people change heart rate for the better and create upward spiral processes and increases in vagal tone (2010). All of this can translate into the creation of optimal therapeutic relationships among pastoral counselors and clients of sexual abuse and trauma.

Both basic and clinical research indicate that cultivating a more mindful way of being is associated with less emotional distress, more positive states of mind, and better quality of life (Siegel, 2003, 2007, 2010; Van Der Kolk,2006, 2011, 2013; Courtois,2011, 2013;Borysenko, 1995,2007; Kabat-Zinn, 2005, 2011, 2013). Moreover, practicing mindfulness can have profound biophysiological influences, thus also influencing activities such as, eating, sleeping, and substance use. Ultimately, emotions, especially those such as happiness, are manufactured by the brain. Humans have the power to re-train their brains to produce emotional responses such as happiness, serenity, peace, and love, but it must stem from an intimate understanding of nearly automatic thoughts so as to redirect them (Siegel, 2003, 2007, 2010). Additionally, humans can change our gene function, reverse the aging process, and improve our physical health.

As such, it is perhaps easy to understand that the therapist is a contributing factor to how each client perceives of herself and whether this translates into being able to hone positive or negative emotions and states of being. Thus, what qualities should a therapist possess in therapy and how can they contribute to the relationship in the most positive and effective manner for the benefit of the client? Following the arguments posited by various scholars, a postmodern, relational approach to the therapeutic relationship in which the therapist is equal parts traveling companion and equal parts compass is foundational to the creation of an effective therapeutic relationship and of effective therapy. Understanding the connections between spiritual practices of empathy (lovingkindness meditation, counseling, pastoral care), and physical, spiritual, and emotional health is also central to the pursuit of effective therapy (Townsend, 2013; Courtois, 2011, 2013; Van der Kolk, 2006, 2011, 2013; Baker Miller, 1991, 1997; Cozad-Cozad-Neuger, 2003). The quality of empathy, when cultivated, can be transformative and in league with the effects that meditation, mindfulness, and lovingkindness practices have been found to have on the mind and body (Emory-Tibet Partnership, His Holiness The Dalai Lama Conference, Oct. 2010).

Studies have discovered distinctive and measurable effects of these practices on the neural pathways in the brain and in body functions. The conclusion drawn from these studies is that these spiritual practices improve physical health. For instance, only eight weeks of daily mindfulness practice can effectively lower blood pressure, increase blood flow through the heart and to the brain, and lower heart rate, which can all have ameliorative effects on the individual and simultaneously lead to effective therapy (Lazar,

2007). Further, when one practices lovingkindness and compassion exercises, one can increase the production of positive hormones such as serotonin in addition to increase positive emotions. One can increase happiness and decrease stress and anxiety through meditation, a practice that can be used within the framework of pastoral counseling as well as by each client when not in session.

IV

CASE DISCUSSION

In this section, I will trace the evolution of my case conceptualization and treatment planning for Billie over the course of our work together. I will do this by looking at process notes and case conference presentations from different periods of time as Billie was engaged in therapy and comparing the goals for therapy, diagnosis, assessment, sociocultural factors, transference and countertransference, and treatment plans for each period and then by marking the differences in each period.

I will address Billie's symptoms, their origin, and treatment approach for each, and trace the progress of alleviating her symptoms and movement towards health. I will refer to Chapter II concerning the effects of trauma on the brain and body in order to discuss Billie's symptoms and illness as it manifested in her daily life. This will explain how I initially responded to Billie's needs and eventually reached the most effective diagnosis and how, together, we reached an appropriate treatment plan for Billie. I will also discuss the usefulness of medication in Billie's case and for survivors of childhood sexual abuse.

I am utilizing a constructivist, feminist approach in analyzing Billie's case and in working with Billie. This approach is appropriate because it applies a postmodern, interdisciplinary and multitheoretical model for the clinician to follow (Berman, 2010). This model illustrates how to apply trauma theory, feminist pastoral theological approaches, narrative therapy, and relational psychoanalytic theory to therapy with survivors of sexual trauma. Constructivist and narrative theory empower the client to be

the subject and agent in her own story (Berman, 2010;Cooper-White, 2007, 2011; Cozad-Cozad-Neuger, 2003). Feminist pastoral counseling validates and allows the client to give voice to the threads of her story that have been ignored, dismissed, silenced, or repressed due to oppression, discrimination, abuse, and shame (Cozad-Cozad-Neuger, 2003; Gorsuch, 2001). This method is particularly apt for survivors of sexual abuse for reasons I will continue to discuss in this chapter. Constructivist therapy according to Berman (2010) allows the client to reclaim her stories, embellishing empowering or positive ones, and to let go of oppressive, life-inhibiting, false stories impressed upon them by family, society, and even themselves. This re-editing of the life story can be transformative and life changing for the client. The therapist helps the client to bring out the threads of her story that are life-giving, forward looking, and enable growth to take place.

The client is continuously in the process of making meaning from experiences through elaborating on and exploring them. Past experiences that a trauma survivor may be trying to incorporate that are cut off, split off, and that are causing self destructive behavior are complex and sometimes contradictory (Messler Davies and Frawley, 1992; Schwartz, 1997; Van Der Kolk, 2011, 2013). Schwartz (1997), Messler Davies and Frawley (1992) outline a model that incorporates the process of working with clients who have split parts through trauma-related dissociation. Many different narratives and life stories are possible, and one is not necessarily truer than another (Berman, 2010). As Billie related her life to me, she observed certain patterns and themes that were meaningful to her in different ways. She traced her religious and spiritual history and

how her feelings about faith reflected her own feelings about herself. She traced her career path and development over thirty-five years in the health care field and where it brought her. She remembered experiences in her career that influence her self-identity today. She traced a long, complicated history of relationships between family members, lovers, and children, friends, community, and society as a larger influence. Over the five years of therapy, Billie also undertook a thorough and unflinching examination of the history of the sexual abuse she endured at the hands of her father.

Billie's Self Narratives

Berman (2010) ponders whether self-theory, as constructed by a client, is functional. In this case, with therapeutic assistance, Billie began to inquire about the significance and purpose of the various stories she carried within her (Neimeyer, 1995, 2000). Were they family myths and messages that upheld her position in the family? Were they fantasy threads that enabled her to escape the oppressive, limiting and suffocating messages that had overwhelmed her narrative? What narratives did Billie consider life-enhancing before and were they still life-enhancing for her? Do these narratives help her experience positive emotions and self-regard? Are they adaptive? Do they support other life narratives or sabotage them? Is Billie relating effectively to others?

At the time of entering therapy, Billie was forced to take adaptive action and set concrete short term goals for herself to secure her basic needs. The situation she found herself in required her to focus entirely on the present and to live for each moment. As

her situation stabilized, she began to look at how her mental and emotional instability shaped and informed her self-identity. She felt it to be incongruous much of the time, and therapy during the first two years of our work involved a fierce internal struggle between a tenacious hope and faith that she could return to her doctoral program in Canada and become ordained as a minister, and a resignation to sickness, instability, and poverty. She was stuck between realms. On the one hand, there was the promise of her capabilities and dreams. On the other hand, there was the heaviness of her past, which she had not yet left go of enough effectively set a new course for her life travels. She vacillated between experiencing as Berman (2010) put it “a disorganized, negative, overly rigid view of herself,” with negative emotions, dysfunctional relationships, and resistance to adaptive self-images and behaviors and a more expansive, hopeful, positive outlook (Berman, 2010, p. 295).

Through this chain of events, violence and abuse pass from generation to generation (Teicher, 2002). The neuro-endocrine system refers to the system of interaction between our brain/ nervous system and the hormones in our bodies. This system helps regulate our moods, our stress response, our immune system, and our digestion, amongst other things. Any disruption to the neuro-endocrine system affects a range of basic psychological and physiological functions. Research suggests that many of the long-term impacts of child abuse experienced by adult survivors result from the chronic neuro-endocrine dysregulation caused by prolonged exposure to abuse and violence (Kendall-Tackett, 2001).

What role did religion, spirituality, and faith play in the negative narrative? What

role did it play in the positive narrative? Billie's narrative for the first two years of therapy was more often "problem saturated" (White and Epston, 1990) than not. Together, we began to make the connections between the past and present regarding her narrative and its origins. Trauma is biologically encoded in the brain in a variety of ways. Changes in structures like the hippocampus, and the coordination and integration of neural network functioning have been identified. These changes are reflected in the victim's physiological, psychological and interpersonal experiences (Cozolino, 2002). Deficit in psychological and interpersonal functioning then create additional stress, which further compromises neurobiological structures. In this way, adaptation to trauma, especially early in life, becomes a "state of mind, brain, and body" around which subsequent experience organizes (Cozolino, 2002).

Over the course of the therapy, more coherent, positive, life-enhancing narratives and self-identifying behaviors began to emerge and take hold. Although, for Billie, there is still today often vacillation between hopelessness, limitation, and oppression and hopefulness, expansion, faith, and trust (Neimeyer, 2000; Cozad-Cozad-Neuger, 2003; Gorsuch, 2001). The stories that dominated much of Billie's life and development, which included oppression, invisibility, marginalization, failure, poverty, and physical and mental illness, would come to the forefront. They would be most present in her speech, thus becoming "thick narratives" (Geertz, 1973). The "thinner stories" demonstrated Billie's perseverance when faced with adversity, which included the fact that she was the first person in her immediate family to graduate from college, have a successful career, and to attend a school for her doctorate. In essence, she started from scratch with respect

to creating her own upward social, educational, and economic mobility. She was the individual in her family to break the proverbial glass ceiling. Billie's work as a social advocate for the disabled, the marginalized, and the LGBT(Lesbian, Gay, Bisexual, Transsexual) community for many years also supports her significance of her accomplishments. In therapy, we would return to Billie's narratives and more deeply assess the stories on which she focused to define her life, especially with respect to how willing she was to let go of the limiting destructive ones.

Sometimes, though, it proved more difficult than she expected to let go of certain narratives, particularly those stemming from illness and dysfunction. Billie's historical identification with illness has long provided her with certain meaning that she values. Billie began to embody the role of victim in order to get her needs met, needs that she did not get met in a healthy manner as a child. Klein (1921-1945), Fairbairn (1921), Bradshaw (2005) and Winnicott (1965) describe the process of how deficiencies in getting one's needs met as an infant and young child leads a child to adapting to get their needs met in dysfunctional ways. The child internalizes the message that he or she is not worthy of getting his or her needs met and that becomes part of the self-identity and narrative (Berman, 2010; Neimeyer, 2000).

It is important at this point to note when Billie might have begun forming the narratives that she possessed and how her childhood history affected those narratives and self identity. Teicher, Van Der Kolk, and other researchers into the effect of trauma on the brain and body show that brain development is affected by stress early in development. Extensive research has been carried about the neuro-biology of stress. The

link between a history of childhood abuse and neglect and neuro-endocrine impacts is well established. Current research tells us that the bodies of children who are being abused react and adapt to the unpredictable dangerous environments to which they are exposed. Stress can set off a ripple of hormonal changes that permanently wire a child's brain to cope with a malevolent world (Teicher, 2002). Billie's perception of the world and reality was a dangerous one where people could not be trusted, even those who she needed to trust most. Therefore, she could not trust her own instincts and desires regarding intimate relationships, because they caused her to get hurt. This can explain why she had trouble developing and maintaining intimate, healthy, and loving relationships.

Billie received care, attention, pity, and empathy from others when she was sick. So did her older sister Mary, who was diagnosed with a developmental disorder and so received special care. Billie often talks about her sister Mary with envy and even expressed once during session (June 6, 2011) that she wanted to have a disease so she could receive the special attention that Mary received. In therapy, Billie regularly described in depth Mary's kidney and renal failure that required her to be housebound for fifteen years and to continue to receive dialysis two times a week, a level of attention that Billie wished she could have secured. Billie and Mary shared a room in her childhood home, thus the proximity of the extra care with which Mary was provided was in plain view for Billie. As Billie began to uncover and explore the threads of her abuse, she wondered if Mary ever heard their father come into the room and abuse Billie. Additionally, she wondered if Mary also was abused. She was unable to satisfactorily

answer both of those questions and this continues to bother her immensely. No one in Billie's family talked about any abuse or acknowledged it. This secrecy and denial of what was happening led to Billie's split as well as her contradictory narratives and self-identity.

The practical or financial reality of Billie's diagnosis of PTSD and Major Depressive Disorder is that she is eligible to receive disability benefits, which at least in part mimics the attention given to Mary. Though, Billie can lose these benefits if she obtains a job working more than twenty-five hours a week and making more than \$15/hour. Therefore, it benefits her to remain ill. Billie has been conditioned to be complacent about her illness because it financially benefits her, in addition to which it helps to satisfy her desire to receive attention. Billie's illness allowed her to internally avoid and keep the narratives of her life incoherent. She was able to keep the myth of being Daddy's special little girl alive, and not have to question that myth in light of her memories of sexual abuse (Messler Davies and Frawley O'Dea, 1992). She was able to blame her illness for the failure of her marriage, her inconsistency in her relationships to her children, and with her lovers, and in her career. It became a crutch and an excuse for her to fall back on when she was emotionally overwhelmed, or unable or unwilling to look at different ways of coping with life or maintaining emotionally responsible behavior.

Identifying With the Perpetrator

Continually living a life revolving around her illness and benefitting from it

prevented Billie from having to identify parts of herself, especially anger and desire for power, with the perpetrator. This remained an ongoing struggle throughout her therapy that continues to this day. Survivors of sexual abuse and sexual trauma bear an internal moral struggle with accepting and acknowledging certain emotions such as anger and rage that their abusers used to violate them (Messler Davies and Frawley, 1994). They fear these feelings. Further, they worry that expressing anger will cause them to be like their abusers and then will be no better than those who violated them. This internal struggle also forces victims to recognize that their abusers are human just as they are, and demythologizes the abuser as a monster to that of a person with deep faults. However, accepting emotions of anger, sadness, and rage and bringing them to the surface and acknowledging them is part of the healing process, and thus something that, difficult as it is, cannot be avoided in order for growth to occur (Messler Davies and Frawley O’Dea, 1994; Schwartz, 2001). Traditional Christian theology often reinforces the myth of anger being bad and the myth that victims should forgive their abusers. This moral interpretation of the purpose of the life and death of Jesus can very destructive and harmful to the health and well-being of abuse survivors.

STAGES OF THERAPY

Presenting Problem

When Billie arrived for our first therapy session on January 12, 2010, she was wearing a neck brace. She came in and sat next to me in an armchair and stated fairly clearly what she wanted to get from the therapy. She immediately listed her physical

ailments of two bulging disks, migraines, IBS, fibromyalgia, and shoulder and arm pain and claimed she could not lift more than 10 lbs. of anything. She was currently homeless, having recently been discharged from a hospital after an inpatient stay due to suicidality. She described a “breakdown” that she had experienced when living in Canada and while pursuing her doctorate in theology. She explained that this breakdown was emotional, mental, and physical, and left her incapacitated and unable to function and complete her studies. She also began to experience vivid, detailed flashbacks of abuse that she had endured at the hands of her father when she was a child. She was fifty years old when she began to remember the abuse. This can be considered a turning point or even a milestone in her life, and she often describes her life before the memories with a wistfulness, comparing it to her life after the memories. This comparative exercise can also be considered part of the transformative process, and thus part of Billie’s growth journey. She presented herself as physically disabled and at the time of our first session, she was on a variety of drugs listed in the next section.

Goals of Therapy and Symptoms

Billie’s immediate goals for therapy were to 1) secure a stable place to live 2) locate sources of support and assistance, financially, emotionally, and medically 3) get “well,” which was an amorphous and fluid statement that encompassed many of her desires, dreams, wishes, and hopes. This goal evolved over time in ways that Billie admitted recently she never anticipated (Sept, 2014).

Billie had a clear understanding that she had several physical, mental, and

emotional issues with which she was struggling. Some physical issues were immediately obvious as mentioned above. The following is a list of her other stated ailments, all of which were noted on her intake form and also gleaned from her first two visits:

- 1)Migraines
- 2)Degenerative neurological illness
- 3)Fibromyalgia
- 4)Lower back and neck pain from two herniated disks
- 5)IBS
- 6)Memory loss
- 7)Cognitive processing issues
- 8)Depression
- 9)Anxiety
- 10) Insomnia

I will discuss these symptoms and approaches to treatment for each of them in further detail in the following sections. The following excerpts are taken from case presentations with peers and faculty in June 2010-Aug 2013. Again, I am including excerpts from case presentations over a period of years in order to trace themes and evolutionary processes over the period of the therapy.

Chief Complaint and History of Present Illness

Below is an excerpt from a case presentation that in narrative form, describes Billie's presenting problem, and conveys the rather perplexing nature of her condition

that I was faced with deciphering:

June 2010:

Billie has several acute crises she is facing as well as the burden of chronic illness. She is without a permanent residence since she relocated back to the United States after having lived and worked in Canada for five years. She stayed with her sister for a few months in Nov and Dec of 2009 after being released from the hospital in Huntsville, AL, and then with her daughter here in Atlanta until she found a place to live at the Gateway shelter in Jan 2010. She is also without a job. She will stay at the Gateway shelter for three months while she waits for placement into an apartment. She is not a recovering drug addict, does not have young children, or a disability, so she is difficult to place. Friends have donated money to help her get by. Since 2000, she says she has been suffering from a chronic neurological degenerative illness of some kind and fibromyalgia. Her doctors have stopped trying to identify what it is, but they have ruled out Alzheimer's and MS (Neurological and psychological report, Nov, 2009). She says her short and long-term memory is severely impaired, her reasoning and logic are impaired, and she has severe chronic muscle and back pain. I have not noticed her logic to be impaired in the four months I have been seeing her. She says she also is prone to blurting things out and has no filter for what she says, and can inadvertently say mildly offensive things. She has had strained relations with her family, and her illness and need for help has required her to seek their assistance, and made her stressed and uncomfortable.

I have included a list of Billie's daily medications from two different periods in the therapy; one reflects her medication regimen six months into the therapy, and one reflects her medication regimen eighteen months into the therapy. The last regimen is from approximately 2.5 years ago.

Family Psychiatric and Medical History:

Billie notes that her back and neck pains and resulting crises first occurred in the 1970s. She was diagnosed with fibromyalgia in 1988. She says she has been suffering continuously from a neurological disorder for nearly 7 years, seriously for 3 years. Both of her parents died in the 60s due to Alzheimer's and Cancer. An MRI of the total spine and brain on September 7, 2008, ruled out Multiple Sclerosis. (CR Neuropsychological Eval, , Sass and Wall, Jan 2012).

June 2010: Medical History:

Current medications, medical devices, and medication allergies: Daily: Neurontin (10mg), Dilaudid (10mg), Celexa, switched to Cymbalta (40mg) (antidepressant)

Substance use and abuse: none reported

July 2011:

Past and current medications, medical devices, and medication allergies: Neurontin (neurological function-January-June 2010), Dilaudid (pain reliever-January-May 2010), Celexa (antidepressant January 2010-April 2010) - Tramadone 5mg a day (May-July 2010), Seroquel 2mg a day (June 2010-July 2011), Tylenol, Prozac 10mg a day June 2010-May 2011.

Current medications: Tylenol- 100mg a day, Lexapro 15mg a day.

Substance use and abuse: none reported

Billie's psychiatrist at this period of time decreased the dosages of Neurontin until she was weaned off of it completely in June 2010. The psychiatrist did the same with Dilaudid and Tramadone for pain relief. She then switched to Seroquel and stayed on that until July 2011. After trying Celexa, then Cymbalta for a period of months, Billie switched to Prozac for antidepressant medication. She then switched to Lexapro in May 2011 after going off Prozac. Her goal was to locate a psychiatrist or prescribing doctor who could continue to provide her with the medications she felt were necessary to function. Over the five year course of therapy, she would rotate through fifteen other medications in an attempt to find a combination that she felt worked for her. This included a round of expensive steroids to treat her IBS over a period of a year. She also rotated through the approximately the same number of psychiatrists, medical doctors, internists, neurology specialists, and physical therapists.

Jan 2012

Current Medications: Celexa-daily (30mg), Aricept (5mg M/W/F and 7.5 mg Tu/Th/sa/Su), and Salsalate (500-1000 mg QD)

Billie was able to maintain a relationship with a psychiatrist fairly consistently, although she had to utilize the public welfare system in Georgia through Grady Hospital

for 2.5-3 years of the therapy (2010-2013), which created challenges to ensuring the consistency and maintenance of this relationship, particularly with the same individual. Consequently, there were times when meant that Billie did not have one particular care professional. Instead, she had to wait in line for several hours for the first available resident to see her. This led to her frustration because she would have to repeat her narrative repeatedly, demonstrating a lack of intimate, interpersonal attention given to her of the likes to which she long desired and needed. Additionally, she often expressed, anxiety and anger over having to go through this system. She experienced extreme anxiety, in particular, when she had to wait in a crowded waiting room, only to feel as though she was not heard and led to feel as though she was lying about her illness and drug seeking. Since obtaining disability, then private health insurance in May 2013, she was able to see the same psychiatrist in private practice at an affordable fee. Billie reported being very comfortable with her.

Medical and Neuropsychological Evaluation

In January 2012, Billie underwent a series of neuropsychological tests through a company contracted by the Office of Vocational Rehabilitation in Georgia. In order to present to the court when applying for disability. She gave me a copy, from which I gleaned some helpful information regarding her claims of neurological dysfunction. Comparing her claims with these tests and research around the effects of childhood sexual abuse on the brain helped me understand better her experience and her descriptions of her inability to think clearly, make decisions, retain information, and

complete tasks. Billie reported to the test administrators that she had difficulties with: concentrating for more than one to two hours at a time, remembering items after an hour delay, following directions due to missing or forgetting details, word finding, analytical thinking, and recognizing sarcasm (Jan 2012). Behavioral observations showed that Billie was cooperative during the testing. She engaged with the questions and “put forth adequate effort on tests involving thinking, but appeared to be less effortful on tests involving speed.” (NE report 2012, p. 3) She showed comprehension of testing instructions and did not need repetition of the instructions.

The types of tests administered were the Animal Naming, Beck Anxiety Inventory (BAI), Beck Depression Inventory-2nd ed (BDI-II), Boston Naming Test-2nd Ed. (BNT), California Verbal Learning Test- 2nd Ed. (CVL-II), Controlled Oral Word Association Test (COWAT), Grooved Pegboard, Minnesota Multiphasic Personality Inventory -2nd Ed. (MMPI-II), Multidimensional Pain Inventory, Pain Symptom Questionnaire, Rey 15 Item Test and Recognition, Rey Complex Figure Test (RCFT), Trail Making Test, Visual Search and Attention Test (VSAT), Weschler Adult Intelligence Scale-4th Ed. (WAIS-IV), Wide Range Achievement Test – 4th Ed)WRAT-4), Wisconsin Card Sorting Test - 64 card version (WCST-64) (NE report, Jan 2012, p.4).

The validity of Billie’s effort was assessed to be normal, based on the results of the Rey 15 Item Recognition Test score: 22/30, and embedded measures of effort (CVLT-II Forced Choice: 16/16 and Reliable Digit Span 9/9) (NE report, 2012, p.4).

Intellectual Functioning. Billie’s intellectual function was deemed to be in the average to high average range (WAIS-IV Full Scale IQ= 101, 53 percentile). Verbal

Comprehension was higher than average, and Perceptual Reasoning was low average to average (WAIS-IV: VCL=114 or 82 percentile, PRI=96 or 39 percentile). Working Memory and Processing Speed were in the lower average range (WMI=95 or 37 percentile and PSI= 94 or 34 percentile). These results were compared to a 2009 neuropsychological evaluation, and the results of the comparison showed Billie's scores improved on 2 subtests, vocabulary and coding, declined on 3 subtests, similarities, information and block design, and stayed the same on 2 subtests.

Academic Achievements administered through the Wide Range Achievement test-4ed showed Billie to possess average to superior achievement in Word Reading, Sentence Comprehension, Reading Composite, Spelling, and Math Computation. Her scores ranged from a 61% percentile rank in sentence comprehension to a 91% rank in Math.

The tests of attention revealed variability in performance, ranging from impaired to average. Performance on a timed cancellation measure (VSAT) was in the impaired range. Two shorter WAIS-IV subtests of auditory simple and sustained attention revealed average results. One two measures of rapid visual scanning (Trail Making Test), Billie's results were in the impaired range, and in the low average range on divided attention, switching cognitive set, and visuomotor speed while scanning (Trails B). These scores were all lower than her 2009 score on the Trail Making Test. This would correspond with findings discussed in this Dissertation, which show that certain areas of the brain are affected by trauma, particularly childhood trauma.

Language: Billie reported no problems with expressing or receiving language skills during the interview but she expressed difficulty in finding words. Language skills

indicated great variability from impaired to superior. Superior results for Billie were in the vocabulary and high average results were for reading and spelling. Low average results were around confrontation naming (BNT). In measures of word generation, Billie performed in the impaired range in response to a phoneme (COWAT), but improved to low average in Animal Naming. These results were lower than her 2009 test. (NE reports, 2009 and 2012). This would correspond with studies of the brains of adults who experienced childhood trauma or abuse. Traumatized children (and adult survivors) become increasingly responsive to relatively minor stimuli as a result of decreased frontal lobe functioning (learning and problem solving) and increased limbic system (amygdala) sensitivity (impulsiveness) (Streeck-Fischer & van der Kolk, 2000). When children are under threat, the fast tracts of the limbic system are likely to be activated before the slower prefrontal cortex has a chance to evaluate the stimulus (Streeck-Fischer & van der Kolk, 2000). Only a state of non hyper-arousal allows activation of the prefrontal cortex needed for learning and problem solving.

Measuring verbal memory (CVLT-II) was average with large fluctuations in learning and memory. Initial recall was in the low average range. Performance on an interference task was average, but her ability to remember following the interference task was “borderline.” Recall following a longer delay was improved to average, with cuing providing minimal benefit. Recognition and forced choice recognition was average. Visual memory and visuoconstructive ability was low average to average, as was planning, organization, and attention to detail (RCFT). Immediate recall on the execution of a figure was low average. Recognition for figure details was low average. In executive

functioning, measuring problem solving and mental flexibility (WCST-64), Billie showed average capability. She performed in average range for approach to novel information, an concept formation, and low average range for perseveration.

Motor skills: Results of the grooved pegboard test showed impaired performance with her dominant right hand and average range with her left hand.

Emotional and Personality Functioning: The administrators of the test concluded that Billie may have difficulty in reporting her symptoms or they may vary within short time periods. I found this to be accurate as well. How does one explain this? On self-report measures, she reported a minimal amount of subjective depression (BDI-II= 13) and a moderate level of subjective anxiety (BAI=21). She expressed moderate feelings of indecisiveness, difficulties concentrating, inability to relax, nervousness, fear, sweating, and trembling hands. Another self-report personality test, the MMPI-II, yielded moderate feelings of distress, including dysphoria, anhedonia, and agitation. She indicated frequent worry about her health and cognitive functioning, and reported experiencing cognitive difficulties with attention, concentration, and memory, as well as physical symptoms such as fatigue, sleep disturbance, pain, and neurological complaints. She feels mistrustful of others and relaxes best at home alone, which leads to isolation and alienation from others. The test evaluators concluded that the emotional distress and resulting isolation would exacerbate the physical pain and perception of cognitive problems. “Her results suggest a long-standing pattern of emotional and interpersonal difficulties.” (NE 2012, p.7)

The administrators of the test in 2012 suggested that Billie’s impaired functioning

in parts of the testing including attention and memory recall could have been due to slowed processing speed or depression. (p.7) Language abilities varied from impaired to superior, as did overall memory function. Across verbal and visual memory testing, Billie performed better in the delayed recall rather than the immediate, which suggests an ability to encode and retrieve information stored in memory.

Why would her immediate memory recall be impaired? This could be a result of Billie's immediate reactivity and overactive limbic system, which is evident in survivors of trauma and people living with PTSD. The limbic system is sometimes called 'the emotional brain'. It controls many of the most fundamental emotions and drives for survival (McLean Hospital, 2000). The limbic system initiates the fight, flight or freeze responses to threat. The amygdala and the hippocampus are part of the limbic system. A study by Teicher et al. (1993) found a 38% increased rate of limbic abnormalities ('emotional brain') following physical abuse, 49% after sexual abuse, and 113% following abuse of more than one type combined (Streeck-Fischer & van der Kolk, 2000). The amygdala processes emotions before the cortex gets the message that something has happened. For example, the sound of a loved one's voice is communicated to the amygdala, and the amygdala generates an emotional response to that information (for example, pleasure) by releasing hormones. When someone is threatened, the amygdala perceives danger and sets in motion a series of hormone releases that lead to the defensive responses of fight, flight or freeze. Because the amygdala is immune to the effects of stress hormones it may continue to sound an alarm inappropriately, as is the core of PTSD (Rothschild, 2004). It takes longer for her to process information through

the cortex than someone who does not have PTSD, but once she does, she shows an ability to retain it.

Why would Billie have problems evaluating her own symptoms and assessing her own emotional and mental health and state? Why would her symptoms vary in type and intensity from day to day and week to week? Measures of physical pain from the NE test in 2012 showed that Billie indicated a below average level of pain when compared to other chronic pain patients, but reported that it greatly impacted her life and reduced her activities (2012, p.7). Her perception of pain, according to the psychologists assessing her, could be due to the moderate anxiety and depression she experiences. She reported experiencing moderate to severe pain “but did not exhibit behavioral indicators of pain or require extra breaks during a full day of testing” (p.7). This observation was consistent with my own observation and confusion around the discrepancy between Billie’s self reporting and self assessment of her pain and symptoms and observable behavior from my viewpoint.

Billie was creating a cycle of illness and isolation based partly on her inability to trust herself and trust others. Her anxiety and fear so overwhelmed her that faced with the choice of going outside and interacting with strangers or even friends and acquaintances, she chose to stay home alone with her dog. The hippocampus helps to process information and lends time and spatial context to memories and events. The hippocampus assists the transfer of initial information to the cortex, which works to make sense of the information. However the hippocampus is vulnerable to stress hormones, in particular the hormones released by the amygdala's alarm. When those hormones reach a

high level, they suppress the activity of the hippocampus and it loses its ability to function. Information that would make it possible to differentiate between a real and imagined threat never reaches the cortex and a rational evaluation of the information isn't possible (Rothschild, 2004). If a particular stimulus is misinterpreted as a threat, this leads to immediate fight/flight/freeze responses (to non-threatening stimuli). This causes this system to respond to minor irritations in a totalistic manner (Streeck-Fischer & van der Kolk, 2000). Research shows that environments of extreme stress lead to increased cortisol levels (Murray-Close, Han, Cicchetti, Crick, & Rogosch, 2008), which can lead to decreased hippocampal volume. Decreased hippocampal volume has been associated with poorer declarative memory, which places adults at greater risk of developing PTSD-like symptoms, and is closely correlated with experiences of depression and physical inflammations (Danese, Pariante, Caspi, Taylor & Poulton, 2006).

This question for us in therapy became: how would Billie find and sustain a support network and a social network if she could not make the effort to meet people and make friends? This was a challenge that she and I acknowledged early on in the therapy. Part of healing and changing the self-narrative involved gaining new experiences, being open to new things, and changing attitudes, perceptions, and views about herself, others, the world, and life. Isolating herself could not help her make these changes.

Overall, Billie's NE test results from 2009 and 2012 showed no progressive cognitive disorder that, in my opinion, could be defined as a degenerative neurological disease. This, however, could not necessarily rule out effects of acute stress on brain function.

The test administrators gave Billie the following diagnoses: DSM IV-STR

Axis I 308.89 Pain Disorder Associated with Psychological Factors and a General Medical Condition

296.35 Major Depressive Disorder, Recurrent Episode, in Partial Remission

300.00 Anxiety Disorder , NOS (By History)

309.24 Adjustment Disorder, with Anxiety (By History)

309.81 Post Traumatic Stress Disorder with Dissociation (By History)

Axis II- Diagnosis Deferred

Recommendations were to receive psychotherapy, relaxation skills training, sleep hygiene and emotional distress training. Stressful situations such as a new job or new living situation should be given extra attention to ensure emotional stability. They also recommended self-hypnosis, and learning other behavioral pain management skills, Physical therapy was recommended, and regular re-evaluation of her medication regimen was encouraged. She was also encouraged to have a regular physical activity routine and to increase social interactions.

The results and assessments from these Neurological Evaluations corresponded with my initial and ongoing impressions of Billie. However, to me, these diagnoses still did not explain her isolating and self-limiting behavior in a satisfying manner. As a person of faith, I believe that people genuinely want to be happy and do not want to suffer. Billie regularly expressed a wish to have satisfying and intimate relationships in her life. She expressed a wish to be healthy, successful, and loved. How could she go about achieving this and what was stopping her? Was her depression severe enough to

cause such impairment and dysfunction? Or were there elements of something else in her history that was preventing her from achieving happiness and self-fulfillment.

Part of the answer ended up coming from Billie herself, as she began to read more about toxic shame through the writings of John Bradshaw, and to read in Eastern philosophy, which led her to do more self-reflection, and also encouraged her to believe in her own capabilities to heal herself and liberate her mind from destructive and limiting attitudes and perceptions. Billie's intellectual curiosity and capability would be a path out of the darkness and pain for her. Instead of seeing overwhelming challenges and difficulties, she began to find new ways of looking at her life, her behaviors, and problems. She began to see how she contributed to the challenges and problems, and how she would "spin out" into different reactivity cycles of fear, guilt, pain, and despair, which preoccupied her energy and prevented her from seeing possibilities and from focusing on immediate tasks and opportunities.

Billie informed me in our first meeting that she could only pay me \$5 per session. At the homeless shelter where she was staying, she was given an allowance of \$10 per day for food. Billie had gone through all of her savings and had no assets. She had returned to Atlanta from Canada primarily because her daughter, with whom she had a strained relationship, lived here.

Billie's immediate mental and physical needs were obvious. I quickly became occupied with the immediate crisis she was in and was invested in helping her secure a stable and safe place to live. Since Billie was my second client at CCCG during my training, I was eager to help her while also a bit overwhelmed with her needs and my

ability to effectively assist her in the ways in which she required and deserved. The next few months were a quick and steep learning curve as to how to connect with Billie, how to engage with her in therapy, what kind of boundaries to establish, and understanding how best to help her.

Past Experience With Therapy

Billie has an extensive history with the health care system, both with respect to physical and mental care and as a client and a professional. She received training and certification as a nurse by the age of eighteen and began working in that field thereafter. She worked as a nurse, a nursing supervisor, and as a hospital clinician on and off for the next twenty-five years. She left a well-paying supervisory job to enroll in Queens University in Canada in 2005 to pursue a doctorate in theology and be ordained a minister in the United Church of Canada, a field she described as her first love. So, given her diverse and complicated background, how, initially, was I to assist Billie?

Since there were some immediate physical needs that needed to be addressed, I was able to focus on assisting her with finding shelter, food, and some financial assistance. The ultimate goal of these practical or residential-oriented endeavors was secure permanent housing for Billie. Billie proved to be extremely resourceful at identifying and obtaining assistance through the public welfare system in Atlanta. Her resourcefulness eventually led her to secure permanent housing and disability benefits, which enabled her to leave the shelter and the dangerous transitional community. The question remained with me, however; how did an educated, formerly successful woman

such as Billie get into the situation she was in, and become completely destitute and homeless, without any support network to rely on?

The task remained to accurately and effectively diagnose Billie in order to get her longer-term help and healing. How was I to help her with this? I began to delve into her family history and listen to her story in order to better understand her. One question that stuck with me throughout our work together, was, why was Billie here? What was she really looking for in the therapy, what was she receiving from it and how was she benefitting from it? What kept her coming back to see me week after week, year after year? I had to suspend considerations of immediate judgments or Billie's diagnoses in order to delve into the therapy and get to the heart of the issues with her. I did sense early on that this was part of Billie's strategy, and that she presented with certain obvious ailments in order to get what she needed from the therapy, but that there was more going on beneath the façade.

If I were to simply diagnose her with the presenting ailments that she expressed and were evident, but remain skeptical of it, it would be easy to go along with her "story" and not delve deeper into the reality of her emotional, mental, and physical world. It would have been easy to be skeptical of her story and write her off as drug or attention-seeking. When I presented her in case conferences, much of the discussion focused on the believability of her story. I struggled with my own disbelief of some of her story and how to include it in a diagnosis or treatment. The dilemma for me became not the proper diagnosis and set course of treatment out of that diagnosis, but more how to get to the "real" story, to the heart of the matter or reality that Billie was living in and struggling

with. That she was struggling with something was clear. That she was creating or expressing a set of stories and symptoms for some benefit was also clear. But, it simply did not make sense to me that I should continue operating the therapy out of a therapeutic stance of disbelief and dismissal. How would this help either of us? Both of us would receive the most benefit from me committing to the therapy and work as well as Billie. This meant committing to believing her story, and the emotions, reactions, and thoughts that went with it. This meant validating parts of her story that were even contradictory, or unprovable (Messler Davies, 1992; Herman, 2002; Berman, 2010 ; Geertz, 1978; Neimeyer, 2000).

Billie herself admitted she struggled with believing what happened to her actually happened. She would have doubts about memories of her childhood that appeared, but then she would verify those memories with her siblings, or events that she knew happened as a result of those memories. If Billie herself thought she might be fabricating these memories, or be crazy and that her mind was playing tricks on her, how would we be able to acknowledge that and have it be a positive or constructive piece of the therapy. The research on effects of trauma on the brain shows that it affects memory and ability not only to recall traumatic events accurately and in detail, but prolonged trauma, the type Billie experienced, affects memory on a basic, continuing, daily level. This loss of ability to recall traumatic events corresponds to the dissociative reaction of trauma survivors and its ability to “split” a person’s experience into different, disparate parts that do not acknowledge or interact. (Streeck-Fischer and Van Der Kolk, 2000; Teicher et al, 1993) Billie’s consistent worry and anxiety throughout therapy was that her mind would

completely stop functioning and she would be incapacitated. After doing research into the effects of trauma on the brain and the personality, I began to more completely understand Billie, her fears, and her struggles.

I eventually decided not to diagnose Billie with factitious disorder or somatization disorder or something that defined her as a liar, or borderline, or making stories up for some hidden or obvious benefit. Trauma survivors can be understood as somatizing their pain, but this in itself is not the disorder (Felitti and Anda, 1999).

I had to take Billie at her word and believe her story and commit to the therapy. To question her and be suspicious of her story would hinder the work. And, I was intrigued by the puzzle. Week after week, I chose to engage, to listen, to validate, to acknowledge, and to support Billie and the narratives she presented. As time went on, and there was more trust in the therapeutic relationship, I began to ask challenging questions, point out inconsistencies, and challenge the thread of Billie's story that were life-inhibiting, limiting, and negative.

Billie was usually the first to admit the inconsistencies in her story. She readily admitted an inability to accurately remember recent interactions, conversations, and events. This was a consistent problem she faced on a daily basis. She would vividly recount how she would forget entire pieces of conversations with people, what she was planning to do that day, where she was going, and details of her work when she became employed. The consistency of her recounting these problems and her anxiety around job performance and her lack of decent short term memory led me to believe she did indeed have short term memory issues. She walked away from, quit, or was fired from three

jobs in two years. Two of those jobs were found for her by the office for disability in Georgia.

Billie's long term memory was remarkably good. She remained an avid reader her whole life and also journaled regularly, which she continued to do during our work together. Her recounting of experiences during childhood and events during young adulthood was remarkably detailed. Her memories of interactions with her parents as a child were so vivid that she could recall the smells, feel of fabrics, the type of seasons she lived through in Michigan, scenery, details about objects in the house, and she would recount long conversations between herself and her family or her parents with each other. Her ability to recount family history in detail, along with her educational background in health care and theology, analytical ability, and intelligence, allowed me to find a way to connect with her and understand her. The only area of her long term memory that she struggled to put together and integrate into her childhood narrative was around the abuse. Our conversations initially integrated broader theoretical, religious, spiritual, social, and psychological themes into her personal history and her current experience.

Family History

The following are excerpts from case presentations dated June 2010 and May 2011. They reveal important pieces of Billie's history that I have examined in depth in certain portions of this dissertation. I feel it is important, however, to get a snapshot of her history in narrative form as presented by her to me in session.

June 2010:

Social History: Billie was raised in a strict lower-class family environment in Flint, Michigan, and she says she carries around a “hypercritical parent” voice inside her due to her family upbringing. Her parents were always bickering, and generally unhappy. Her father was physically abused as a child; he never expressed affection for her or her siblings. He told Billie about how his father treated him and raised him, and Billie heard stories from her father’s siblings and parents when they were alive about her father’s childhood experience. Her mother gave up a promising academic career to become a housewife. I hear a theme of loss, giving up of dreams, and sacrifice that runs through Billie’s family and through her own life.

Billie has lived independently for most of her life, and says she had strained relations with her parents until they died and also her sisters and brother. She left home right after high school graduation in 1971 to get a nursing certificate at Bronson Methodist School of Nursing in Kalamazoo MI in 1974. She was married in 1976 and divorced her husband in 1984, then remarried him in 1986 and divorced him for the final time in 1987. She had her son, Mark, in 1979, and her daughter, Elizabeth, in 1983. After her divorce, she came out as a lesbian, and her husband sued her for custody of the kids and won. The kids stayed with their father, and she left North Carolina where the family had been living and moved around to different states and areas, including Michigan, Washington, D.C., and then to Vermont with different partners. She notes that this was when “the craziness” began. She says she carries a lot of pain and anger from this period of loss and alienation and has trouble forgiving herself for moving away from her kids.

She has an M.Div received in 2007 from Queens Theological College in Canada.. She was in her second year of her doctoral program in Canada when this illness began to seriously inhibit her performance. She moved to Canada in 2005 to pursue her terminal degree and to work, and she says she loved it there and would have stayed if she could have kept her visa and her job. She had a trusted community of friends and colleagues there, and she feels a great loss at having had to relocate to the United States. She did not save money and so she has been left with no finances to help her through this time. She had a \$60,000 a year job as a nurse and left it to pursue her doctorate. She says her parents died in their 70s due to Alzheimer’s and Cancer. Her last girlfriend abandoned her (for the last time) when Billie told her about her financial problems last summer.

Billie does not appear to me to have a severe cognitive or neurological problem. She says the Neurontin has improved her logical processing and memory. She says she used to have a harder time talking and maintaining normal conversations with people. The Dilaudid helped with her pain and she is able to move around better. She said that until recently, the pain was so bad she could not move or work for any period of time. She still cannot carry anything, sit at a desk for a long time, or engage in repetitive motion because it aggravates her neck and arms. She was recently switched to Tramadone after she began visiting the Grady Clinic. She is now getting her medications from that clinic and is very frustrated at the dismissive manner in which the doctors treat her and others. Lack of choice and loss of dignity has been her biggest stressor.

She decided to relocate to Decatur because she does not want to live in Huntsville, AL where she believes she will not be comfortable due to her sexuality and lifestyle. I

have continually encouraged Billie to get connected to the seminary and religious community in Atlanta and Decatur since this was her profession and her passion. She worked briefly fundraising by phone for the Atlanta Opera which she was excited about for about a week. Then, she said the job became too stressful- the noise from the phones gave her headaches, she could not remember instructions, and she perceived that her boss became upset with her.⁶ She quit after two weeks

She is currently applying for disability and hopes her case can be expedited. This is really her only hope for income, according to her. She feels she cannot maintain a full-time job and very few part-time jobs will work for her and satisfy her conditions and requirements physically and mentally. She has recently begun exhibiting more severe signs of depression, and has told me she has thought about dying more, although she assures me she will not kill herself because of her children. She is wondering if the change in medication her psychiatrist prescribed for her has also made her depression worse. My concern is more elevated, and I did tell her I will admit her as an inpatient if I feel she is in serious danger. She has taken to that idea more readily than I hoped. If she is admitted as a 1013 (involuntary commitment), it would expedite her disability case due to Major Depressive Episode and that might be very appealing for her and give her a different place to stay for awhile other than the shelter.

As the therapy progressed, I was able to glean more information about the family dynamics in Billie's household growing up, and how Billie might have understood love, sex and sexuality, religion, and relationships to be from her family of origin. I also focused more on the discrepancies between Billie's education, articulability, vocabulary, intellectual analytical ability, and her professed inability to remember and recall daily events, interactions with people, and her extreme persistent anxiety and physical symptoms. I was unable to reconcile much of what I heard and observed with her professed symptomology.

⁶ Billie regularly and continually expressed fear and anxiety around how people perceived her and how she appeared to them. This anxiety was intensified in a work environment to the point where Billie would become convinced that her supervisor or boss was ready to fire her due to their disapproval of her work performance. We would trace back this fear that Billie held about her supervisor's opinion of her to a conversation, a phrase, even comments to others that Billie would interpret to be about her and always in a deprecating manner. 3 out of the four jobs she obtained over the five year period of our work she quit before she believed she would be fired.

May 2011

Billie's mother was a strict Baptist who was continually reassuring herself that her children were saved and warning them of the dangers of Hell. Her father was emotionally and sexually abusive to Billie between the ages of four and sixteen. Billie has lived an independent life for most of her life since she left home at age nineteen, and she says she had strained relations with her parents until they died. She says she has always felt that she was not worthy of being loved, that she was an outsider in the family, and she was never good enough. She was the family scapegoat and her mother blamed her for the incest she endured. She wonders now if her brother and sister knew about the incest as well. Sexuality was taboo in her house. Because of that and the fact her mother did not teach her basic female hygiene, from bathing and cleaning herself, to learning about puberty- she never felt comfortable in her body. It always felt dirty, strange. She says she did feel somewhat male-identified from an early age, and behaved like a tomboy. She did have a few male friends in high school, but she developed a much closer relationship with a female friend two years older than she, who basically took Billie under her wing and cared for her. When this friend moved away after high school and married, Billie was devastated. She had her first suicidal thoughts at that time. Soon after, she entered nursing school and several of the nursing staff who were lesbian began to express interest. She explored a relationship with one female nurse, then got scared at the realization she could be bisexual or a lesbian, and moved to California for a job and met her husband George.

Billie says she carries a lot of pain and anger from the period of loss and alienation that stemmed from the final dissolution of her marriage and the loss of child custody. She continues to have trouble forgiving herself for moving away from her kids. Her recounting of the three main relationships she was involved in during the next twenty years sounds like a roller coaster ride of drama, mental illness for both partners, with some periods of real happiness intermixed. She describes her first female partner as a sex addict and narcissist, her second partner as suicidal and bi-polar, and her third partner as a narcissist. Her first and second partners also suffered severe childhood sexual trauma, the third suffered physical abuse from an alcoholic father and Billie dealt with the effects of that and related fallout in her relationship with these partners.

Billie is very intelligent, insightful, and creative. She has a very high vocabulary. However, I find over time that her description of memory lapses, dissociative episodes, and mental efforts at staying calm when her fight-flight instinct is triggered, make more and more sense. I believe her when she talks about feeling crazy and not remembering what she did for days at a time. She repeatedly tells me that she cannot remember the entire period of March until early May, what was said in our sessions, and a lot of what she did. After I repeated back to her some of the notes I had taken from each session, she seemed to change and get back into the rhythm of discussing her life and her past.

Since we have begun exploring the memories and issues around the trauma, she has not reported as many physical symptoms to me; her discussions concerning back pain, migraines, and fibromyalgia are less about convincing me she is sick and more about a reporting of symptoms. She has opened up to me about the several personalities or people

that inhabit her consciousness and unconscious.(Messler Davies, 1994; Schwartz, 2003 ; Mitchell and Aron,1999;Cooper-White, 2011) She has a young girl named Jeannie who is four or five years old and talks to her. This personality remembers the abuse. She lets Jeannie write in her own words about what happened. When Billie shows me what Jeannie wrote, the handwriting is distinctly different from Billie's, and she writes left handed. The handwriting is loose, and the language simple. There is another girl she calls Elizabeth, who is slightly older than Jeannie. Elizabeth's handwriting is neat, careful, and uses more sophisticated language In addition to a female personality, Billie also has a male personality, Jo, who is a tough, rebellious, cynical protector. Jo is motivated by anger and acts on it. Billie says her impulsivity and reactivity comes from Jo. She can blurt things out to people or get into arguments when she feels her anger and outrage being triggered. She credits Jo with getting her out of her house when she was nineteen. Jo's handwriting is closest to Billie's, and the excerpts she showed me while writing in Jo's emotion-state, are direct, clear, short sentences. They usually express anger or blame at a person or event. She also has a female personality – Medusa, who can kill with her looks. She has a caregiving personality who wants to take care of everyone else named Nancy Nurse. And finally, she has the crazy priest who tells her what is right and wrong and judges her for her behavior and thoughts, usually condemning her.

Billie won disability in court in March 2012 and feels huge relief that she has a steady income. She also feels vindicated that her claims of being sick/ill are validated by the court, her doctors, and lawyers. She says her sisters were in shock that she got it so quickly because they never believed she was sick. She has not told them about the sexual abuse their father inflicted on her for years because she feels they would not believe her and it would shatter the family myth of him and her mother being devout and honest Christians. She has received back pay from several years of tax returns, and has been able to find a one-bedroom apartment on her own. Therefore, she will soon move out of the public housing complex she is in.

Looking at case write-ups that I completed for Billie over the course of our five years-long therapeutic relationship, it becomes clear that my diagnosis and assessment of her illness and ways to help her had to evolve. In the first few months, I was overwhelmingly concerned with identifying her immediate needs and with concretizing and categorizing her behaviors. I felt that by doing so, and by giving her the “right” diagnosis, I could then effectively treat her. I went through several diagnoses, outlined further in this chapter, and also included some rule/out diagnoses that I eventually withdrew because they neither accurately, or effectively, identified the main issues

affecting Billie nor did they help outline ways to help her. I became increasingly dissatisfied with the diagnoses that were available in the DSM IV to describe the symptoms and phenomena with which Billie was suffering. The following is a list of rule out diagnoses I gave Billie: r/o Borderline Personality Disorder; r/o Dependent Personality Disorder; R/o Somatization Disorder; R/o Bipolar Disorder; R/o Factitious Disorder; R/o Dissociative Disorder.

I felt Billie had exhibited, at one time or another, characteristics of all of these diagnoses, but not enough to warrant an official diagnosis of any. And, if she exhibited elements of all of these behaviors and symptoms, was there a different diagnosis that could encompass all of these behaviors and symptoms? If Billie was somatizing or “making up” symptoms and behaviors in order to receive a diagnosis and treatment, why would she pick the symptoms she did or the behaviors she had? Her behaviors were not convenient or did not serve someone who was merely seeking to take something from the therapy or to get by. Her behaviors were so self-detrimental and self-sabotaging that they exceeded any goal or desire to merely receive a paycheck from the government, but they could arguably be understood in the context of her long-held need to receive attention from others, something over which she was envious of her sister Mary as a child. (Bradshaw, 2006; Winnicott, 1936, 1992) This especially applies to her social inhibitions and anxiety.

She expressed and continually showed such social anxiety that her fear of interacting with people determined every move she made, from where she sat on the bus, to how one brief, two word conversation with her boss or coworker affected her for days.

I continually encouraged her to engage in social activities, and she would promise to find activities and groups to join but most of the time she would recoil and isolate herself and avoid anyone and not attend the event she planned to go to. Billie continually struggled with choosing how to introduce and identify herself. She tended to share with people that she just met that she had a disability and this was the filter through how others saw her. The problem with people identifying her as disabled was that they tended to pity her, want to take care of her, or shy away from her, the last result of which would not have satisfied her desire for attention (Berman, 2010 ; Neimeyer, 2000 ; Bradshaw, 2006).

I would encourage her to identify herself in different ways, but this was difficult. She eventually would locate a dog that she brought into her home and trained as a service dog that would accompany her everywhere. This helped her anxiety about going out in public greatly. However, it also clearly identified her as disabled to strangers and friends alike, thus demonstrating her continuation between realms of self-sufficiency and hope, on the one hand, and fragility and past suppression, on the other.

Evolution of Diagnosis

DSM IV-TR Diagnosis:⁷

June 2010

Axis I: 296.32 Major Depressive Disorder, recurrent; r/o 293.84 Anxiety Disorder due to neurological and chronic illness; r/o 296.52 Bipolar I Disorder Most Recent Episode Depressed.

Axis II: r/o 301.83 Borderline Personality Disorder; r/o 301.6 Dependent Personality Disorder

Axis III: Degenerative neurological disease, fibromyalgia, memory loss

Axis IV: lack of permanent residence, lack of employment and income, no family

⁷ I am referring to the DSM IV because that is the manual I was utilizing at the time for diagnosing clients.

assistance, family problems, isolation

Axis V: 50-55

May 2011

Axis I: 309.81 PTSD; 296.3 Major Depressive Episode, recurrent in partial remission; 300.15 Dissociative Disorder; r/o 300.19 Factitious Disorder with combined psychological and physical signs and symptoms; r/o 300.81 Somatization Disorder

Axis II: 301.83 Borderline Personality Disorder; r/o 301.82 Avoidant Personality Disorder; r/o 301.6 Dependent Personality Disorder

Axis III: Degenerative disk arthritis, fibromyalgia, migraines, memory loss

Axis IV: lack of employment and income, no family assistance, family problems, isolation

Axis V: 55-60

Sept 2013

DSM IV-TR Diagnosis:

Axis I: 309.81 PTSD; 296.3 Major Depressive Episode, recurrent in partial remission; 300.15 Dissociative Disorder; r/o 300.19 Factitious Disorder with combined psychological and physical signs and symptoms; r/o 300.81 Somatization Disorder

Axis II: r/o 301.82 Avoidant Personality Disorder; r/o 301.6 Dependent Personality Disorder

Axis III: Degenerative disk arthritis, fibromyalgia, migraines, memory loss

Axis IV: lack of employment and income, no family assistance, family problems, isolation

Axis V: 55-60

As the months of therapy turned into years, my diagnosis of Billie became clearer for me. I diagnosed her with Major Depressive Disorder and chronic PTSD. This diagnosis enabled me to continue to focus on what was important in Billie's journey to health and wholeness and to include and not exclude any behaviors or symptoms that she expressed or exhibited. It was also consistent with her family history and her current coping behaviors and patterns. I did ask Billie to bring her daughter into therapy once early in the therapy in order to get a sense of what was going on with Billie as well as to better understand her needs (Feb 2010). After discussing this Billie, she agreed to invite

her daughter to a session. Her daughter was reluctant to come in, but she did, and her reactions and contribution to the therapy confirmed what Billie had shared about her current circumstances, her recent history, and her needs moving forward. Consequently, the inclusion of her daughter was an affirmation of Billie's narrative, and a way of demonstrating to both Billie and me that while I was there to assist her in her journey, she was the leader, the guide.

Evolution of Assessment

The following are excerpts from case presentations given over a period of years:

June 2010

Assessment: I do believe Billie has some debilitating mental illness, but I will not be 100% convinced of how much it impairs her function until I have seen her several more times. She is facing an acute crisis of lack of permanent home/financial problems. I continue to encourage her efforts and to minimize any stress or stigma she may feel from her illness, current condition, and isolation. I do feel I am her only source of personal support. For longer term treatment, I plan to continue to help her rebuild her esteem, her identity here in the States, and her goals in order to move forward. I also plan to monitor her medical care and treatment so she can stay as capable as possible. Her frustration, fatigue, and physical and emotional pain are evident, and I hope to help diffuse that and assist her with gaining a new perspective on her life.

By May 2011, I was really struggling with accepting Billie's physical and mental illnesses as she presents them and I am trying to identify with confidence any "true" or real illness that is going on. What did start to make more sense to me was the increasing evidence of the effect of trauma on the body and how somatization can be real. Billie described chronic physical pain in many parts of her body. Some of this pain was verifiable via MRI, and ultrasound, including a bulging disk in her neck, sensitivity to

certain foods and an irritable bowel. Her claim of memory loss was somewhat validated through a comprehensive mental health examination in (Jan, 9 and 10, 2012), which determined that she had lower than average short term memory retention. The MRIs on her brain, however, showed no obvious or visible damage or abnormality.

As Billie outlined a continuous litany of physical illnesses, I began to wonder why she was so fixated on maintaining such a list of illnesses to identify herself. While again there was some evidence to substantiate her claims, the list of illnesses was so long and involved it would be impossible to cure her of them or to become completely well. This led me to wonder why she wanted to remain ill and why she was so insistent on claiming these illnesses. When I began looking at the effects of severe childhood sexual abuse and trauma, her insistence on being seen and heard as sick made sense. Further, to me, Billie's insistence on being perceived as sick was evidence of her desire to draw attention to the abuse, abuse which was never acknowledged by her family, and which is not culturally acknowledged in a way that supported her story, and is not medically or therapeutically validated or acknowledged. If she could not tell her story truthfully and directly and be believed, she would receive validation in another way. In other words, her self-identity as sick validated the abuse in a way that admitting the truth never could. However, it does not allow for real healing to occur either. My belief through this work, with Billie and other clients, is that the truth does set them free. The opportunity for survivors to tell the truth of their story without fear of judgment or dismissal is healing and liberating. Once Billie began trust me that I would not dismiss or judge her or challenge her story, and that she could say whatever she felt she needed to or wanted to

no matter how “crazy” or unbelievable it sounded, she continued to tell her story in further detail to me. As we progressed into her history, into her emotional states and her inner world, together, something remarkable happened. Billie’s somatization decreased. She began exercising regularly. Her anxiety and paranoia decreased. She began sleeping through the night. She found and maintained a job for 2 years, the longest she had been able to do so in the time we worked together. She began to make plans for the future and hope for a better one. Her relationship with her daughter stabilized and improved. Her dissociative episodes decreased. She spent less time in session repeating the litany of illnesses she had and more time talking about her productivity that week, and her goals for the next week. She moved into a more positive self-narrative and identity without either of us explicitly encouraging her or demanding her to do so.

Excerpt from June 2011:

I am not sure if I believe Billie has a chronic physical illness. It is probably somatization or dissociation related to the abuse and her Axis II diagnoses. Her relationship patterns, and her fusion with, and dependence on, someone in her life to carry her initially led me to diagnose her additionally with dependent personality disorder and borderline. Much of my reflection about Billie has changed since she has begun disclosing the sexual trauma history. I feel we are making real progress. I want to take time so I can see how the trauma still affects Billie in so many ways in her daily life today. She suffers from regular dissociative episodes that disrupt her daily life and from PTSD from the years of sexual and emotional abuse. She has shared journal entries in our session that are very insightful, reflective, and analytical about her situation. However, as soon as I feel confident she is aware of what is going on in her life, how she got to this point, and how she can move forward, she does something to wipe that out or erase that perception. I am not sure if that is a pattern of self-sabotage she regularly engages in to remain dependent and in the therapeutic relationship with me. The pressing crisis of homelessness is gone and her depression and suicidal thoughts have decreased dramatically in the past few months.

July 2013

I believe at this point Billie has a debilitating mental illness, but I'm not that it is as extensive or multiple and varied as she claimed. She tends to somaticize when she feels criticized, dismissed, or unheard. She suffered from regular dissociative episodes that disrupted her daily life and from PTSD from the years of sexual and emotional abuse, which have decreased in intensity and frequency over the past three years. She has shared journal entries in our session that are very insightful, reflective, and analytical about her situation. However, as soon as I feel confident she is aware of what is going on in her life, how she got to this point, and how she can move forward, she does something to wipe that out or erase that perception. I am not sure if that is a pattern of self-sabotage she regularly engages in to remain dependent and in the therapeutic relationship with me. The pressing crisis of homelessness is gone and her depression and suicidal thoughts have decreased in the past few months. She still reports high levels of anxiety.

The challenges that occurred during the five years of our therapy and in diagnosing Billie, assessing her, and then prescribing a course of treatment compelled me to look at my own role in this work, and to remain open as to how to best form a therapeutic relationship and maintain it. I had to suspend my own judgments, suspicions, doubts, and instead focus on the interaction. I had to exercise qualities of empathy, active listening, and presence.

Evolution of Transference

Excerpts from certain periods of the therapy regarding transference shows an anxiety around Billie's overwhelming litany of needs and also a growing trust in the therapeutic relationship from my side and from her side despite my misgivings and lack of clear insight on how to proceed in therapy with her.

June 2010

Billie has expressed relief during our sessions at my presence and ability listen to her story. She says that just the fact that I tell her, "I hear you," and "I know," is a great help

to her. She has become more expressive during our sessions as she senses my empathy, sometimes tearing up, laughing, and exclaiming. Several times she has expressed a wish to succumb to this degenerative neurological illness she believes she has, and live in “the back ward.” We have delved extensively into her personal family and relationship history, and she has gone into great detail about her life. She becomes animated when talking about her life, and I sense it is a bit of escape for her. She displays remarkable insight and reflective abilities when discussing her life.

May 2011

Billie has a history of forming strong dependent attachments to a female that may not necessarily be sexual but for her represents a primary relationship. When these end, she goes into a deep depression. I feel that I have become an example of that attachment and primary relationship for her over these thirteen months and this has put pressure on me. I feel that I am her only source of support. She will send me four to five emails per week, as well as call and leave one to three messages per week on my office extension. She used to call my cell phone number when she was initially placed in the shelter, and I asked her to stop. I feel she sees me as her best friend and someone to lean on, and when I try to push her to rely on herself, she panics and resists. She used to interpret and process my comments in sessions as criticism, judgment, and that she is a failure. When we revisit my comments and her reactions in the following session, she is able to trace the triggers that cause her to feel such shame, guilt, and anger. She now engages in a regular pattern of reflection after each session and shares some thoughts with me that we both find helpful. She has begun to trust me enough to be able to express her deep anger and rage at the injustice she endured at the hands of her father who “ruined my life” and “made me crazy.”(2010-2015) She has lately expressed more feelings of anger, and we are working on where her anger comes from and the difference between healthy and unhealthy anger.

July 2013

Over the course of our therapeutic relationship, a pattern of attachment became clear to me. Billie at all times maintained a health care network of three to five professionals who worked with her in various areas to “treat” her. This is in my opinion, indicative of her method to get her emotional needs met in a dysfunctional way. She paid for physical therapy weekly from June 2012-July 2013. She constantly saw a psychiatrist, which I supported, who prescribed various medications over the course of the work. She paid for rehabilitative yoga for six months before declaring she was unable to pay for it. Rehabilitative yoga is typically geared for someone recovering from an injury, or who possesses a long term chronic physical condition.

Service Dog

Billie found and trained three different dogs over a period from Feb 2012-present to be service dogs for her, which allowed her to take them on public transportation since she does not have a car and does not drive. Her severe anxiety about being on the bus or MARTA (Metropolitan Atlanta Rapid Transportation Authority) in a crowd of people was significantly reduced with the presence of her service dogs. She currently has a terrier after working with a black Labrador who was much bigger in size. She says the terrier still provides her some sense of security and comfort and is easier to manage when walking and maneuvering in public spaces. The recent incorporation of service dogs to be trained to work with people living with PTSD, primarily military vets, has shown to be effective.

When recalling early family life, Billie often described herself as being left alone to occupy herself. She was the youngest of four children by eight years. Her older sister Mary possessed some developmental disabilities and Billie never felt close to her or spent a lot of time with her although they shared a room when she was young. She has memories of playing in her closet to avoid interaction with her strict, critical mother, or her strict, temperamental father. She was allowed few toys and was expected to complete all of her studies and activities on her own and do them well. Her dog was her best friend, and probably her only one, until she was forced to give the dog away by her father at age ten. Because her family lived very modestly on her father's manual labor job in

the auto factory until he was hurt and went on disability, Billie rarely had new clothes throughout her childhood. She wore hand me downs from her older sisters. This atmosphere of scarcity and deprivation, coupled with her mother's despair at the understanding that they would never advance or move out of their situation, left a permanent mark on Billie. Another permanent mark was the influence of the baptist church to which Billie's parents belonged. The fear of judgment, or going to hell, and the constant striving to be good enough to receive the blessings of God, without ever really getting there, left Billie with an internalized sense of guilt and shame that remains and will probably always be present to some degree (Bradshaw, 2005).

Evolution of Countertransference

The following are excerpts from Case Presentations given to colleagues and faculty at the Care and Counseling Center of Georgia. There is a relationship and interconnectedness to the excerpts written about transference and also an evolution on my side on how to understand Billie, to help her, and to engage in the therapy.

June 2010

I feel myself concerned for Billie's well-being and safety. My frustration at her situation has grown over the past months. I had the hope earlier that she could maintain a part-time job and an apartment on her own, but that hope has faded. At this point, I feel like I am struggling to help her find more options, and she has stopped looking. She is really hanging on to the goal of getting disability for income, which may take awhile. In the meantime, she is stuck where she is indefinitely. I feel a bit baffled sitting there with her sometimes, because she is so intelligent. I wonder and she does too, how she got into this predicament. This, coupled with the fact she has a very small circle of friends, makes me feel like I am her only source of support. I do feel a more collegial and equal dynamic with her than I have with my other clients due to her profession, her age, maturity and intelligence. However, I do feel burdened by her neediness at times. She calls my cell phone two or three times a week to complain or vent her frustration at the truly frustrating

environment in which she lives. She sends me at least one or two emails a day. I can see how debilitating and frustrating her life is right now. At the same time, I do not want to feel like I am being pulled into it. I have called her back twice, but I am very reluctant to do so again despite her worsening depression.

May 2011

I feel myself alternating between concern for Billie's well-being and safety and feeling encouraged by her intelligence, determination, and focus, and her securing a good place for herself to live. I hope that she can continue to function better than she has so she can return to doing what she wants to and move towards her goals again. I do not know how realistic that is at this point. When we focus on the family history, dynamics, and destructive emotional patterns that she was raised with, she responds very strongly and comes alive. Instead of focusing on improving the physical problems, I have directed the conversation to her emotional and spiritual life. I have become much more patient with her, interested, and invested in the therapy because I feel like we have gotten to the heart of the issue and her symptoms and behaviors make sense to me and to her. She and I expressed relief and sadness at this realization. She feels relief that she is not crazy and sadness that the abuse was real and her family was not as she imagined.

Theological Dimension

There are many elements to Billie's theological history and experience, some of which I have addressed in previous chapters. Billie eventually chose a career in theology and ministry based out of a need to be educated, and to re-address the religious education she received in her family of origin. She longed to be ordained and to be an authority in the Church admittedly on her part to refute her Baptist mother's strident doctrine that she found so repressive. She also found a community and home where she felt accepted for who she was at Queens College in Canada. She regularly expresses a longing to find that kind of community again and a sadness at having lost it. She blames herself for having to return to the US before graduating with her doctorate in theology. Billie is so well-read in theology and also psychological and developmental theory, that when we engaged in

discussion around certain authors, I felt as if I were talking to a colleague. This space allowed us to relate on an equal level, as colleagues, and not as patient and therapist. However, that impression would quickly disappear as Billie would then react to something said in session or reveal that she could not remember our discussion from the day before because she was dissociating.

June 2010

Billie's faith, her scholarship, and her passion for theology have enriched our discussions greatly. I enjoy our time because of this, and it adds a depth and dimension to our time. I feel I am talking to a colleague in that sense, someone with creativity, spirituality, intelligence, and who has a sense of identity deeply rooted in her faith. She identifies with the story of Job and this helps me situate myself in Job's story also, as his friends who sit with him on the ash heap in grief as well, and as Job's wife, who combines the curse and the blessing, the lament and praise of God in Job's story.

May 2011

This is one bright if sometimes complicated light in Billie's life. Billie's faith, her scholarship, and her passion for theology have enriched our discussion greatly. I enjoy our time because of this, and it adds a depth and dimension to our time. I feel I am talking to a colleague in that sense, someone with creativity, spirituality, intelligence, and who has a sense of identity deeply rooted in her faith. She perceives of my appreciation of her intelligence, perspective, and what she has accomplished. She has a deeply intellectual and spiritual quality that enriches our time together and enables her to get some perspective on her own situation. This is a place where she can go when emotions become overwhelming, and it balances out the therapy. She attends an Episcopal church regularly and participates in some of the programs there. She has written several articles for their newsletter, the latest being on women and homelessness.

Powers and Principalities:

Billie believes that her father and mother essentially robbed her of having a fair shot at life. I would re-articulate this to say that her parents lived out of a lower-middle

class traditional 1950s ethic of patriarchal family values. On the surface, Billie's family was a church-going, law-abiding, happy family of five. Billie's mother was so careful to preserve an image of good Christian Baptist family values that she was unable to relate to her intelligent daughter in a loving, encouraging, and positive manner. She saw her daughter through a judgmental lens of a punishing, insatiable God who demanded absolute loyalty. This attitude transferred over to the marriage relationship and Billie's mother quit a potential career in business administration in order to be a housewife at her husband's demand. Billie's father held absolute authority- no one questioned him. Therefore, any suggestion that he would have abused Billie would have been met with disbelief, shame, and retribution.

Billie struggles with the reality that her mother must have known about the sustained abuse and turned a blind eye of denial. Her mother chose the limiting, strict social system and her unhealthy marriage over protecting her daughter- she sacrificed her daughter to preserve a false image. If Billie were a male child, she would have been encouraged to utilize her considerable intelligence and talents to succeed. Because she was a girl, she was discouraged from doing so. Furthermore, because she was a girl, she was subject to abuse at the hands of her father- she describes how much she remembers wishing she were born a boy.

Billie's physical, emotional, and psychic pain from enduring years of body violation led her to hate her body and to suffer chronic pain. She does not trust her body, and feels more comfortable with pain than she does with pleasure. Pleasure for Billie is associated with guilt, specifically guilt that she does not deserve to be happy and

experience something good due to Christian values of denial of self and her parents' insistence, and guilt that she felt pleasure when she was young from such an act of injustice. Her journey to identifying herself as a homosexual is full of struggle and pain. Already a mother, she was denied rights to see her children once she came out. She was deemed to be an "unfit mother" because she did not fit the typical stereotypical role of a woman and a mother – someone who is heterosexual. Once again, she was labeled an outsider, someone who was "crazy," and who did not matter, and someone who was victimized by the justice system and laws of the jurisdiction in which she lived. Instead, her children were forced to live with their stepmother, who abused them due to mental illness. Billie continues to live with this guilt and is attempting to repair the relationship with her children in order to make up for those lost years. As Billie faced homelessness, she recognized that most of the people caught in the vicious cycle of poverty and homelessness are women and children. As a white woman, she was viewed as an outsider among the homeless community. As an educated, homosexual white woman, she was truly exceptional and attracted some unwanted attention. Billie has been very fortunate to be among the very few to move out of the homeless system and is working to become independent and self-sufficient.

Evolution of Treatment: Role of the Clinician When Working With Clients Living

With PTSD

Identifying Triggers

Initial treatment with Billie revolved around gathering extensive family history

notes and building a perception of Billie through her stories. She had plenty of things to talk about and was prepared to engage in conversations about her situation on an intellectual, emotional, and spiritual level. I connected to her on an intellectual and spiritual level for several months. Once we established a base of trust and respect, I began to focus more on Billie's emotional life, which I realized was fractured. I wanted to delve into her emotional life in depth and enable her to access and inhabit emotional states that were denied and cut off. I soon realized Billie was not capable of doing this in a planned, organized manner. She automatically and unconsciously, or without her own choice, switched from one emotional state to another due to triggers that were not immediately known to her (Messler Davies and Frawley, 1994; Teicher, 2000). She was so afraid of being emotionally vulnerable in any way that she could not be authentically emotionally present with me or anyone. Again, the research supports this realization. The corpus callosum is a major information pathway connecting the two hemispheres of the brain (McLean Hospital, 2000). A number of studies have found that the corpus callosum is smaller in abused children than in healthy children (De Bellis et al., 1999; McLean Hospital, 2000; Teicher, Ito, Glod, & Andersen, 1997). Furthermore, McLean Hospital (2000) found that abused patients shifted the degree of activity between the two hemispheres to a much greater extent than normal. They theorized that a smaller corpus callosum leads to less integration of the hemispheres. This can lead to dramatic shifts in mood or personality.

Billie could not initially handle any strong affect of emotion from me or even herself. After a year, she was able to cry in session after expressing anger,

disappointment, and grief at the losses and painful experiences in her life. She also began to share with me, through emails, that she could not remember parts of previous sessions. She would go home after a session, and then react to what was discussed and process it over a period of a few days to a week and more. Sometimes she would pick out a comment that I had made and explain that she heard it in such a way as for it to be judgmental and she would express shame, regret, fear, and sadness around it. In other words, she would go into a shame spiral. When she would come back into session, we would talk about these delayed reactions to our conversations and where they came from. She felt only able to feel and react to what we talked about when she was in the safety of her own home. And more often than not, what would come up was toxic shame and guilt (Bradshaw, 2006).

Billie consistently reported to me that anxiety was her prevailing emotional state and on a scale of 1-10, she continually operated at a 5 or 6 and once or twice a day her anxiety would rocket up to 8 or 9, enough to cause dissociative episodes and panic attacks, which she says started as a dull roaring sound that filled her head so she could not hear anyone talking to her or communicate, and she often felt paralyzed. Anyone in her vicinity looked menacing and threatening. And, she had an overwhelming urge to escape. The nervous systems of children who are abused run on a constant high because they are constantly anticipating further danger. Their bodies are flooded with fight-or-flight hormones (Cozolino, 2002). A study by Linares et al. (2008) shows alterations in cortisol production in children with histories of abuse and neglect. This state of chronic 'hyper-arousal' persists for many survivors throughout their adult years as well. Even

when the abuse and violence has ceased and the environment is 'safe', many adult trauma survivors still perceive the threat to be present; their fear is maintained and becomes pathological (Giarratano, 2004b). A study by Joyce et al. (2007) found that experiences of childhood abuse were associated with high cortisol levels in depressed adult survivors.

We began to trace backwards from the occurrence of the panic attack to identify triggers that possibly precipitated the dissociative episode. We began to note that, most often, the panic was caused by the proximity of a large or powerful looking man who might or might not resemble her father. Also, elevated voice patterns, or deep male voices were triggers for her. So, Billie had auditory and visual triggers. This is consistent with her memories of her father coming up the stairs into her bedroom early in the mornings and her hearing his approach and entering into her dark room and turning her to face away from him and raping her. She also experienced extreme anxiety around speaking in public. During these dissociative states, she would lose track of time completely. This led to a sense of helplessness and extreme vulnerability.

Treatment Plan

The following are excerpts from the treatment plan portion of case presentations given over a period of four years to peers and faculty. I have discussed my approach to Billie's treatment plan in depth throughout this work. As time passed, I became more able to focus on helping Billie identify triggers that arose from her PTSD and how to help her alleviate the reactions.

June 2010

I have been overwhelmed by Billie's immediate needs and have been focused more on helping her think of ways to find a place to live. The acuity of this need rises and falls. I hope to delve more into her past and get more information about her childhood, development, etc. I also hope to continue helping her re-imagine her future and encourage her to continue towards the goals she had prior to the severe onset of this disease. I hope to continue to be the support for her that she needs in this lonely and challenging time, without feeling overwhelmed. I noted to her that I believe she has trouble feeling and expressing anger so I want to help her properly grieve and feel the anger of all she has lost and been through. I am struggling with a diagnosis, and once I am able to pin that down, I can proceed more effectively with her.

May 2011

We are focusing on identifying the triggers that will send her into a dissociative state and following her line of thought so that she can reduce the duration of the dissociation, remain in the present moment, and differentiate the past memories from her current experience. She has also been able to make changes at her home in order to feel more secure, to leave a situation that makes her anxious, and to nurture her inner children. She has decided to pursue inquiry into the Episcopal Church and to become a member at All Saints. She has joined the GALA group there for Gays and Lesbians- they have a weekly book club that she will attend because we decided she needed to have more social interaction, but not to date just yet. Her denominational affiliation over the years has bounced around to almost every Protestant denomination and even a brief membership at a Catholic Church in the 1970s. She has been able to win disability in a very short time, which has eased the stress a bit. She has taken a few editing jobs helping students write their papers. She has also joined a women's support group and is developing positive relationships. I have encouraged her to continue to nurture the named personalities she describes inside her, to do things so she feels safe in her apartment, and to create a loving, secure space for herself in order to counteract the PTSD. The hope I have is that she will be able to use her intellectual, academic, and writing skills to edit, tutor, teach, or write. This creative and reflective outlet has been very productive for her. I continue to encourage her efforts and to minimize any stress or stigma she may feel from her illness, current condition, and isolation. For longer term treatment, I plan to continue to help her rebuild her esteem, her identity here in the States, and her goals in order to move forward. She currently lives at Winn Way, a group of public assistance housing in South Fulton. She wants to move into her own apartment as soon as possible to gain some security as she does not sleep well where she is and does not like sharing her place with a roommate. She also wants to get a service dog who is trained to work with people living with PTSD. She loves dogs and had one growing up who was her best friend. She currently has two stuffed animals she carries around sometimes for comfort.

July 2013

.Billie has been able to make changes at her home in order to feel more secure, to leave any situation that makes her anxious, and to nurture her parts. I have encouraged her to get connected to the seminary and religious community in Atlanta and Decatur since this was her profession and her passion. She joined a women's support group for two years and recently terminated that due to work schedule.

Evidence of Dissociation, Multiplicity, and Trauma

Another way we approached exploring Billie's inner life was to begin to give characteristics to different emotional states and she went as far as to name them. Schwartz (1997) goes into depth about how therapy with his clients became more effective when he saw their internal life as a family system of its own. Messler Davies and Frawley (1994) encourage therapists to act as conduits to allow abuse survivors to enact different dissociated parts in order for their therapists to become familiar with each as clients transitioned between them. The goal of this work is integration of split off parts into a more mature and identifiable whole. Integration is painful because it involves the client accessing emotional and visual and auditory memories of abuse and re-living them in order to release the emotional charge associated with them, and to release the old feelings, reactions, thoughts, and messages and to re-claim them. The task of the therapist is to allow the client to enact these states, generally labeled as the victim, the perpetrator, and the rescuer, without connecting with one state over the other and by allowing the client to attach an identification of a part to the therapist. According to Messler Davies and Frawley (1994), the client will enact the cycle of abuse over and over through these emotional states and will attempt to bring the therapist into the cycle. However, if the client succeeds in doing this with the therapist, the therapy can be

derailed as the therapist usually becomes the fantasy rescuer or the abuser all over again. Integration involves the client accepting the abuse, grieving the loss of innocence and loss of childhood, and letting go of the fantasy that they will be rescued. Only then can the power of the abuser be dispelled. The client has to become her own rescuer.

Becoming her own rescuer or savior proved to be very challenging with Billie. She enacted the cycle of continually looking for a “rescuer” to “fix” her. As I, over time, began to get a sense of how Billie viewed me and what she wanted from me, I became more aware of my role in the therapy and how to hold different states that Billie presented in tension simultaneously without getting hooked or going too far in one direction or another. This became clearer to me after Billie would tell me she had no memory of previous sessions, or she would come in with a very different affect, and have almost an opposite approach to a subject that we had discussed the week before. Sometimes it was as whatever we had agreed for her to do one week was forgotten. I tried to understand how she might have forgotten or been able to dismiss so completely our previous discussions. When, and at what point, would she remember “me” consistently and on a daily basis? Did we have to reach a certain depth or emotional level that she was unable to do at this point? It did seem that she remembered more about our interactions and our therapeutic relationship than anyone else in her life besides her children, and her family – the family she remembered from childhood.

One of our most emotionally charged and explosive sessions came in April 2013 when I verbalized to her once more that I could not do the work she needed to do for herself. She had to do it. She told me she wanted me to “fix” her and would not accept

my refusal to do so. This challenge by her and my response surfaced from time to time over the period of three years. Into our fourth year, Billie slowly began to talk about taking care of herself, listening what her needs were, and paying attention to her own emotional states and reactions in order to alleviate her suffering.

This helped her to find perspective on an experience of herself that was often overwhelming, terrifying, and painful. She identified four main states that she felt she inhabited and moved between. Jeannie was the youngest one, and Billie gave her an age of four, which was approximately the age she began to be abused by her father. Jeannie was the most emotionally connected, positive, exuberant, childlike, and innocent. For me, this was very telling, because it reflected Billie's emotionally stunted nature. Billie would talk about wanting to do simple, childlike things for fun. This would include watching Disney movies, reading young adult books, coloring in coloring books, and eating ice cream and candy. So we agreed she could explore and indulge her childlike desires and observe where they took her. I encouraged her to act as a friend or mother to her younger self.

The other two parts Billie talked about were older. Elizabeth was around eleven or twelve years old. She was very quiet, and she was always afraid. She was the container for Billie's fear. Elizabeth loved the arts and music. This was one activity in which she found joy. But, most of the time, Elizabeth was helpless, mute, and hopeless. This would be consistent with a young, pre-teen Billie who had experienced six or seven years of abuse and despaired at anything changing for her. Jo was around fourteen or fifteen years old and was, according to Billie, male in character. His primary emotional state

was anger. Jo was rebellious, reactive, and cynical. Billie saw him as the protector of Jeannie and Elizabeth. He would speak out, react, and act out when challenged or perceiving danger. As Billie became more comfortable identifying and expressing the emotion states of these parts, her dissociation in therapy and outside decreased. Her affect became more responsive, less extreme, and she was more present in sessions. The liminal space (Winnicott 1923-1978) of a relational and intersubjective environment (Cooper-White, 2011; Mitchell and Aron, 1999) in the therapy enabled her to access and observe how she moved between these emotion states and what purposes they served for her. I was only able to help her access these states by keeping an open, receptive mind, and holding any judgment, set plan of procedure or technique or agenda aside and by being receptive enough to observe the fluctuations of these states.

By allowing Billie to enact the states with my presence, and not attempting to control or stop them, she was able to remain more present with them and therefore observe, process, and integrate some of the intense emotion contained in these states. (Messler Davies and Frawley, 1994). Her insomnia also decreased, and she was able to stay asleep longer instead of waking up at 2AM and 5AM as she reported doing for the first two years of therapy.

Bradshaw (2006) outlines the emotional/inner life of people living with toxic shame due to trauma and abuse. Because the core of toxic shame involves the client identifying with being bad and that their needs are bad, any need or desire that comes up involving intimacy produces a strong shame and guilt reaction in such a client. Billie was so sensitive to any criticism or judgment that it caused a reaction that triggered a shame

spiral and sent her into the defensive that any challenge to her claims, assertions, and expressions caused her to close down emotionally. This was also true with my other clients who are also survivors of sexual abuse. Because they operate out of shame and guilt, it is impossible for them to ask for their needs to be met, let alone for them to identify their needs. It was essential for me to have “narrative empathy” (Berman, 2010) for Billie and my other clients in order to establish trust and to enable them to release and move past the shame/guilt pattern they exhibited around emotional intimacy. I attuned myself to their thoughts and feelings in such a way as to validate, affirm, and support their expressions, feelings, and self-identity in a positive way. Consequently, the goal is not only to assist Billie with processing her experiences and to support meaning construction, but to also assist her with articulating her story, elaborating any aspects that are confusing or limiting or problematic. However, for this to occur, I must first assist clients with abandoning shame-based emotionality, and to feel affirmed, safe, and cared for enough to begin practicing expression of needs, and to be vulnerable enough to acknowledge their needs, wants, and desires.

The collaborative nature of therapy empowers survivors of abuse to make decisions about their own care, and to choose and develop meaning in their own story. Billie was highly resistant to being limited to one treatment technique. She resisted any categorization, authority, or control in all areas of her life. Collaborative therapy allowed her to choose a mode of therapy and to see it through without feeling obligated to follow it. It also took the blame off of the therapist if the treatment was not effective. Billie believed that her own opinions, decisions and feelings about her life were

important. She knew and knows herself best as the expert of her internal world. This goes against the more traditional medical model approach in which a client relies on his or her provider for help, and feels labeled and judged with a diagnosis, or that something is wrong with them, and then they are told what to do to get better without being able to contribute to the therapy. They feel their opinions and feelings are not valued, respected, and unproductively and unjustly, they are dismissed and rejected. This process only reinforces the shame/guilt cycle with which survivors of abuse and trauma live. Therefore, it is counterproductive to health and healing. I have heard this experience from clients over and over again.

Sociocultural Factors

Billie says she has always felt different. This has meant several things, including her feeling as if she exists on the periphery of life and alone throughout her life. She was the youngest of four children, and she felt unwanted by her working class parents who struggled to make ends meet. She was very studious and curious and performed very well in school. Her curiosity led to her question her family system beliefs and to explore larger questions of faith, spirituality, social systems. Her older siblings married and began families. With the exception of her brother, her siblings did not pursue higher education. They did not question the family system and resented Billie's challenging it. As a sexual abuse survivor, Billie's behavior is ruled by one main motivation: to perceive threats that are very real to her and survive them. In this way, daily activities can be a challenge. Because of the anxiety that each day produces, Billie tends to isolate, which

increases her sense of being lonely and misunderstood by others. When she began to recognize and explore her attraction to women, which was a decade-long process, she first had a secret affair with a woman while she was married and had two young children. Her second female relationship led her to “come out” and seek a divorce from her husband at the same time.

In 1988, the state of North Carolina was not a welcoming place for gays and lesbians and the law discriminated against them in many ways. Billie’s soon to be ex-husband took her to court in order to declare her an unfit mother. The court agreed and gave her husband full custody of her two children. Billie was not allowed to see them except for monthly supervised visits. She was also required to pay, according to her, significant child support and alimony. After two years of legal battles, interactions full of conflict with her children’s’ father, Billie left North Carolina and moved to Vermont with her girlfriend. She wrote her children regularly only to find out years later that the letters were never given to the children. Her deep sense of loss, guilt, and shame over these events haunt her. Moreover, they influence her relationships with her children today. When Billie left Canada and came back to Atlanta, she was homeless. For three months, she lived in a homeless shelter until she was able to secure an apartment in public housing. She was the only Caucasian female over fifty years old who had a master’s degree the entire time she was at the shelter. This led her to make some very profound observations about the welfare system. This also allowed her to see how it can perpetuate a cycle of poverty.

Fellitti and Anda (1999, 2009), in the largest study of its kind on Adverse

Childhood Experiences, which includes child sexual abuse, found that, within their study group, sexual abuse comprised 22% of adverse childhood experiences. In the categories listed to be adverse childhood experiences, Billie's criteria fit four categories out of eight. These adverse childhood experiences included the following: psychological abuse (parents), physical abuse (parents), sexual abuse (anyone), and mental illness in the family. Burt (2001) asserts that virtually every study shows that ACEs are strong predictors of homelessness. This makes sense to me in my understanding of Billie's geographical history. If we trace the pattern of locations where Billie lived and how long she lived there, we can see that from 1982 onward, the longest period of time where she lived in one location was 6 years, and that was when her children were born, and again during a period of time in her second relationship when she lived in Vermont. She continually expressed to me dissatisfaction with living in Atlanta, and a longing to return to Canada or Vermont. She came into session at least 4 or 5 times declaring she was moving. She eventually acknowledged her defensive mechanism or desire to run or escape when her anxiety, hopelessness and sense of failure overwhelmed her. Her desire to run and "start over" often overruled or overrode any attachments she had made and relationships she had established. This is a powerful and sad observation. She says her children never forgave her for "abandoning" them and moving to Vermont, then even farther away to Canada, where they were unable to visit her and had minimal contact. When she told her daughter recently that she was planning on moving to Vermont, her daughter said she did not want her to move so far away. (Aug 2014) Billie constantly expresses a fear of becoming homeless again, and much of her motivation and actions

center around this deep fear. Part of her believes she will end up homeless. This could happen if her disability is terminated.

Based on the findings of the Felitti and Anda (1998, 2008) study, the ACE score, of which Billie has a 4, increases one's chances of developing chronic depression by 65%. In contrast, a score of 3 corresponds to a 40% increase in the risk of developing chronic depression among women. An ACE score of 4+ increased Billie's chances of a suicide attempt by nearly 20% in contrast to an ACE score of 3 in which her risk would be increased by 10%. Billie's history of suicidality is prevalent. She claims she never attempted suicide, but that was suicidal several times in her life. She hospitalized herself in December 2009 due to suicidality. With the odds stacked against someone so early in life, it is easier to understand how one can struggle to routinely cope with the difficulties of interacting with others, and to get through the day.

Trust vs Threat

A constructivist approach to therapy with survivors of childhood sexual abuse is very useful when looking at the quality of the therapeutic relationship. Because "relational constructivism" focuses on the exchange and communication between therapist and client, and because it also facilitates the client's meaning-making process through listening to clients' stories and allowing them to tell their stories and re-create them, it is a powerful method to form a strong bond of trust and attachment between a client whose trust has been deeply abused and broken and someone who acknowledges and validates that client's experiences. A survivor of childhood abuse is challenged with

connecting to a deeper, coherent whole that can process and integrate immediate experience (Messler Davies, 1994; Schwartz, 1997, 2001). This is backed up by recent neuropsychological research as discussed in this dissertation.

They often move between emotional states as a reaction to immediate stimuli without any ability to control this process, and they may not even be aware of the shifts of emotional states. This is a similar process that Berman refers to in constructivist case conceptualization where the client's immediate sense of self is a process under construction within every interpersonal exchange. The client has a storied sense of themselves that is whole or coherent based on the stories the client tells and the meaning they make out of these stories. They are always open to revision (Berman, 2010, p. 292). Survivors of abuse often cannot remember events of abuse perfectly or exactly as they happened (Van Der Kolk, 2000; Danese, Parianti, Caspi, Taylor, and Poulton, 2006). Science now proves that traumatic experiences affect the brain and body in such ways so as to enable the victim to survive by repressing the traumatic memories, thus also causing the person to dissociate, or have an out of body experience, and also to shut down sensation in certain parts of the body that were traumatized (McLean Hospital, 2000; De Bellis et al, 1999; Teicher, Ito, Glod, and Anderson, 1997). Therefore, the claim or push to verify the accuracy of traumatic events is not helpful to clients' recovery.

Unfortunately, the client's inability to accurately describe the trauma can seem to invalidate their experience and allows the perpetrator to capitalize on a human bodily automatic response to stress and trauma and to deny or dismiss the event. A research study, led by Michael Meaney from Douglas Mental Health University Institute in

Montreal examined samples from the hippocampus region of the brain, which is associated with memory function, and is known to develop differently in abused children (Meaney, 2009). They found a gene - NR3C1, which influences the brain's susceptibility to stress hormones - was less likely to be activated in people who have been abused. This study is one of the first to demonstrate that a genetic process appears to underlie such changes. Those who have been abused had lower levels of expression of the gene for the glucocorticoid (cortisol) receptor, which is critical for the stress response pathway. Children who are abused early are flooded with stress hormones like adrenaline and cortisol, impacting on how the brain develops and the stress regulation method. This in turn impacts on the hippocampus, the area which controls feelings, meaning that adult survivors will be more likely to be highly stressed, have difficulties with anger and emotions, and be prone to self-harm, anxiety, suicide and depression.

Prognosis

My prognosis or belief that Billie could “get well” in her words vacillated throughout the years of therapy. I was very hopeful and optimistic at the outset of therapy despite the overwhelming challenges Billie faced when she came into therapy. Her intellectual capacity was sophisticated enough and her commitment to the therapy was evident to lead me to believe she understood what was happening and how to get out of her current homeless situation. Once we began to trace back to recent history and even further, it became clear to me that getting Billie to better physical, emotional, and spiritual place would take a long time and a lot of work on both of our parts. In order to

be helpful to Billie and continue to co-journey with her, I had to let go of my own hopes and expectations for her and not be set on any particular long-term goal.

After doing research on the effect of childhood sexual abuse such as the kind Billie endured, I am not sure that “healing” or wellness on par with others who have never been abused is possible. Maybe there is a “new normal” for Billie. She and I struggled with this realization from time to time and to her credit, she reached an acceptance of her reality in 2014. She recognized she would never be able to do things she once did relating to work, physical activity, and interpersonal relationships. She has had to let go of returning to Queens Theological College to complete her doctorate. However, with this acceptance has come stability. She has remained in one place with a safe, clean place to live for over 5 years, she has obtained a small but steady income, and her relationship with her daughter, arguably the closest person to her, has improved. She will bring up the idea of moving from time to time, but not as frequently and with as much urgency as she did from 2010-2013. She maintains a healthy diet, and exercises every day. She recently left a job she had maintained for 2 years. This I measure as progress.

I do believe the consistency of our therapeutic relationship was key to her improvement. She credits me with “saving her life,” which may or may not be true, but that phrase conveys the meaning of our work together for her. The turning point for me came when Billie accepted responsibility for helping herself and taking care of her own needs. It also came with her incorporating self-reflective exercises and practices into her daily life, which enabled her to step back from the spiraling cycle and prison of her own mind and reactivity, and to reach some objective perspective outside of this reactivity that

for so long ruled her thoughts and actions. She found a place, a center, where she could integrate her thoughts, emotions, and physical responses in such a way as to process them more healthily and not just be a ball of reactivity like a pinball, bouncing from one threat to another. Part of this was achieved through listening to her body in ways she had never done before or knew how. She would describe listening to her intuition, her gut, and also to the voices or messages in her head that would play at times when she felt anxious. She learned how to respond to these impulses and remove herself from a perceived threatening situation or respond to the messages in her head with new messages of calm, hope, and positivity.

V

SUMMARY AND CONCLUSIONS

Since this was a case study analyzing five years of therapy with Billie, the goal was for a grounded theory approach to yield certain conclusions and observations that would be useful for continued work with this client in addition to other female clients living with PTSD and who are survivors of sexual abuse. At a minimum, the aim has been to utilize the qualitative data extracted from my therapeutic relationship with Billie to raise questions about the effectiveness of current modes of therapy for female survivors of sexual trauma and about social, psychological, and theological frameworks that have informed discussions about PTSD in women and subsequently, how to treat it.

Through the use of rigorous qualitative case study research, the purpose of the study has been to uncover the processes and features of effective pastoral counseling with female adult survivors of childhood sexual abuse who have PTSD. It has endeavored to create further understanding on the side of the researcher/therapist regarding the relationship between abuse-related PTSD, female development and identity, meaning-making, and healing. The procedure and operational details of the study are presented and justified in this chapter. Additionally, guidelines for maintaining quality research and analysis are provided. Ultimately, Stake's (1995) assertion that "The function of research is not necessarily to map and conquer the world but to sophisticate the beholding of it" (p. 43) is the goal of this dissertation; to illuminate and understand the therapist's

successes, hesitations, and struggles with a postmodern, feminist, pastoral and relationalist pedagogy and with traditional clinical diagnostic models and therapeutic techniques.

What are some ways to measure the effectiveness of therapy? The first would be to assess whether the goals of therapy have been reached. As I continue to emphasize, the goals of therapy evolved and changed over the five years to take on new definitions and new expectations.

- 1) Negative to Positive Narrative: Billie realized that there was important evidence of her positive transformation that had developed over the course of the therapy. Evidence included her increased empowerment over decisions in her life, increased self esteem, and acceptance of the events that occurred and acceptance and contentment with herself. Her self-narrative and self identity progressed from those of illness, sickness, poverty, and limitation, towards a narrative of empowerment, expansion, hopefulness and trust. Billie still vacillates between drawing out positive as opposed to negative narratives, but it is not as often as previously, and she is able to move out of the negative shame-based thinking cycle much quicker and with more ease than before. With research on the effects of childhood sexual abuse on the brain showing that neural patterns are set early in life and are a challenge to change, what is the likelihood of Billie being able to make a consistent, permanent change in her own thinking and perception?

The process of working with Billie necessitated that we formulate an understanding of new ways to assess her progress. I will describe these below:

- 2) **Acceptance:** Billie's goals evolved throughout the course of therapy, which we both agreed was healthy. Her fantasy of returning to a "normal" life, moving back to Canada and picking up her studies where she left off was abandoned. She began to accept that she could not return or erase what happened. Instead of denying the work and progress we made regarding caring for herself, building healthy daily habits, staying present and paying attention to potentially threatening and anxiety-producing stimuli and responding to it, and creating support networks, she embraced it. Acceptance of her situation and taking responsibility for getting her needs met was a big step from identifying as ill and helpless, and continually looking for someone else to take care of her and get her needs met. She became her own agent of positive change. The cycle of the rescuer, abuser, and victim was broken, although Billie still expresses an occasional longing to find someone who could care for her through the end of our work together.
- 3) **Detachment or perspective:** Perspective as referenced herein concerns Billie's exploration of new spiritual practices, primarily through Eastern meditation and readings on Buddhist philosophy. She connected strongly with the writings and talks of Pema Chodron, an American Buddhist nun who explains her spiritual perspective in a clear, simple and understandable manner. An avid reader, Billie, absorbed these talks and writings and interpreted them in a way that positively applied to her life and affected her thought process. Because Buddhism is a deeply personal and individual practice, as it is so often promoted in the United

States, Billie was free from the pressure of institutional doctrine and the conflict she felt with some Christian doctrine around gender stereotypes, a sacrificial Christology, the doctrine of Original Sin, and the oppression she felt growing up in a Baptist household.

As she read, Billie expressed an application of the Buddhist philosophy of *tonglen*, *vispanassa*, and *maitri*, that, involved mindfulness exercises and a reflective meditation practice along with reading and journaling, and yoga. These exercises allowed her to gain better clarity of her thought process by observing her thoughts and emotions. She reached a new perspective concerning her swings between negative and positive narratives, and she expressed this ability clearly.

These practices emphasize validating reality and experience from the senses, from perception, and reception by the body and mind of external and internal stimuli. Consistent practice enabled Billie to begin to trust her senses, her mind, her emotions, and to inhabit them without judgment. This is a crucial and important step for survivors of abuse and trauma to accomplish. Trauma causes a disruption in the sensory processing of external stimuli and a person with PTSD will feel like their body and brain is out of control, and misfiring on many levels to signal danger to the person, when in fact there is no external threat. Billie continually described living in a body that was like an enemy, a body that caused her pain, fear, anxiety, and that she could not trust. As shown in this Dissertation, she possessed a deep distrust of her own brain function, of everyday ability to process information, of ability to communicate and relate to people in a healthy manner, and a distrust of her recent and distant memories. She reported daily chronic

pain in various forms of neck and back pain, fibromyalgia, IBS, and migraines. To Billie, her body was a scary place to live in. Reflective practices provided an avenue for her to accept her perceptions, thoughts, impressions, stimuli, and emotional responses as they appeared, and to do so without judgment. She was able to start a new relationship with her body that was more accepting, loving, and positive. She began paying closer attention to what she was eating and how it affected her, and created a more selective diet for herself that did not irritate or inflame her system as much.

As discussed earlier in this Dissertation, research into the effects of meditation and reflective practices on the brain and body shows a positive correlation. Meditators who sat in reflective practice for as little as 10 minutes a day for 8 weeks showed increased prefrontal cortex size and activity, and improved communication between parts of the brain, and the brain and Vagus nerve (Lazar, 2006).

The Emory-Tibet Partnership at Emory University has deeply investigated the effects of meditation, and mindfulness and lovingkindness practices on the brain and body. They have discovered distinctive and measurable effects of these practices on the neural pathways in the brain and in body functions. The unanimous conclusions from these studies done by the top experts in the biological and social sciences is that these spiritual practices improve physical health. Only 8 weeks of daily mindfulness practice can effectively lower blood pressure, increase blood flow through the heart and to the brain, and lower heart rate. Further, when one practices lovingkindness and compassion exercises, one can actually increase the production of positive hormones such as serotonin and increase positive emotions.

Trauma disrupts the connections between the amygdala and limbic system and the prefrontal cortex, and meditation can restore those connections and increase activity in the reasoning and logical processing part of the brain. The ability for someone living with PTSD to resist reactivity and the impulsivity coming from the overactive limbic system being triggered is crucial to their healing. Research also shows that new neural pathways formed through intentional practice and attention can become permanent. In other words, Billie and others like her can in fact change their brain patterns through meditative and reflective practices among other things.

Is this evidence that survivors of trauma can heal themselves? My experience with Billie taught me that the meaning of healing and wellness is relative to each person. My hope and her hope that her pain and symptoms would disappear for good gave way to an acceptance of the daily reality and of the necessity for her and myself to address them on a daily basis. The small steps towards healing, liberation, positivity, and hope were celebrated and the backsliding into negativity, fear and anxiety was accepted and met without judgment.

Billie's journey and the journey of those who have experienced trauma and live with physical symptoms relating to trauma show us that yes we can take our own steps towards healing by forming and creating experience from the inside out as well as outside in. The courage of trauma survivors to go to the most horrible places of their memories, and to re-live those experiences in the quest to get better is remarkable. Therapists who work with trauma survivors generally agree that it is not healthy or safe to allow a survivor to re-member and re-live traumatic memories for too long because it is too

disruptive and re-traumatizing. The power of the mind, and the body, to reproduce such an experience for someone with such emotional effect still shows us the power and capability we have within ourselves that we can use towards healing.

Their persistence and commitment to healing and to sharing that with us enables us to better understand how humans experience and live with the effects of trauma and how we can take steps to heal from it and stop the cycle of pain. Billie gave me an unflinchingly honest look into her every day experience of inhabiting her body and the conflicts she had within herself. She felt imprisoned and betrayed by her body, but agreed to keep finding ways to inhabit it and listen to it and search for new ways to connect with it. Together we have searched for and found ways out of the prison from the inside out.

Reduction of Symptomology

Another way to measure effectiveness of therapy is to measure reduction of symptoms. Billie's symptoms were listed in the previous chapter as:

- 11) Migraines
- 12) Degenerative neurological illness
- 13) Fibromyalgia
- 14) Lower back and neck pain from two herniated disks
- 15) IBS
- 16) Memory loss
- 17) Cognitive processing issues

18) Depression

19) Anxiety

20) Insomnia

There were several underlying symptoms related to dissociation and PTSD that we explored further into the therapy. Again, we would not be able to address these issues if we utilized a more solution based or cognitive based therapy regimen. These symptoms included the following:

a) Dissociation and splitting

b) Extreme anxiety

c) Toxic shame

d) Inability to create and sustain intimacy in relationships

a) Billie and I were in agreement that her symptomology was more of a universal nature in that she more often had an overwhelming sense of anxiety, pain, and fear that manifested in different parts of her body and emotion states at different points in time. This experience of symptoms corresponds with someone living with chronic and complex PTSD. Therefore, the reduction of symptoms was first most evident by less frequent “splitting” and dissociative episodes, Billie’s increased ability to stay calm and be comfortable in a public setting, especially for an extended period of time, her increased ability to identify triggers and process internal reactions and, ultimately, her ability take appropriate action to reduce and anxiety and prevent panic. Billie began to operate out of, and inhabit, an increasingly visible core self that was more integrated emotionally with her other parts. She exhibited improved consistency with memory on a day to day

basis, and in her experiences and ability to reflect on them over time.

b) There has been an increased ability for Billie to voice her feelings and reactions more in the moment, to express her needs, and to disagree with persons in a respectful manner without fear of punishment or repercussion. She is more present, her emotional life is more accessible, and she is able to identify her emotions more readily as they come up. She has been able to express anger, establish boundaries, and handle conflict much better with co-workers, friends, and family.

c) Billie spent much of her time over the past few years exploring different religious communities, which included everything from church communities to more general and less structured spiritual communities. She also explored different spiritual practices. She has connected deeply with Buddhism on a practical level and has been reading Buddhist philosophy by several well-known and traditional contemporary Buddhist practitioners and writers. Her approach to Buddhist spirituality has led to a new perspective on her thoughts, reactions, and perceptions and given her a freedom that she has not experienced before. She has tied this learning into her efforts to be more connected to her body and to inhabit it and love it. Her body has been her enemy for a long time and her efforts to connect to it were often frustrating. She has been able to connect to her intuition, feelings of sadness, anger, hurt, pain, and joy in a more immediate sense than before.

Billie has undertaken extensive research into her diet and also regarding nutrition in an effort to improve the IBS she experiences and to balance her moods. She has had moderate success towards this end.

Therapeutic Relationship

The therapeutic relationship between Billie and myself has undergone adaption and growth over the last five years. The therapeutic relationship, which, if effective, grows and strengthens over time, enables trust to grow between client and therapist. This facilitates the client's healing process. Trauma survivors' ability to heal and overcome their symptoms depends on the strength of the relationship between their own allowed and disavowed parts and emotions, between themselves and their parents, loved ones, communities, and between themselves and their environment or their place in the world. The trauma survivor must make meaning out of lived experience (Berman, 2010). The sense of responsibility, shame, blame and pain for the events experienced can blurred between victim and abuser (Messler Davies and Frawley 1994). Recognizing and accepting what happened creates a level of vulnerability for the victim to the frightening possibility of identifying with the perpetrator around certain emotions such as anger, fear, power, impulsive behavior.

Because of the nature of the illness of PTSD related to traumatic experience, I have come to the belief that short-term therapy with this population is not as effective as longer term, collaborative work. The relationship between client and therapist is key to a trauma survivor's progress towards healing. Billie has stated this clearly to me and I see it evidenced in my work with other survivors of sexual abuse.

I ultimately became more comfortable with Billie during therapy sessions. I also remained open to going where the therapy led as far as what approaches to take when working with her. I continually asked her how we could go forward so that she could

decide how the work would proceed most productively. Billie provided input concerning what to talk about, and what resources would be used, e.g. written, visual, and oral, within therapy and outside of therapy. Routinely, as Billie became more of a positive agent in her life, but nevertheless occasionally became unsure of her power, I reminded her that she did, in fact, possess the agency and power to make decisions about her life, to set boundaries, and to act as her own emotional container. As a result, she grew into the confidence and ability to accomplish these things.

The power dynamic between therapist and client must be collaborative, shared, receptive and giving in reciprocity in order for healing to take place (Cozad-Cozad-Neuger, 2003; Cooper-White, 2004; Doehring, 2006 Ramsay, 2004). Understanding the influence of sociocultural roles and how power affects them is necessary for the therapist to inform, empathize, and sympathize with the client so as to help the client to voice abuse and injustice. This requires awareness and knowledge on the part of the therapist of her own sociocultural location, gender identity, and how these factors can influence relationships and communication.

Effectiveness of Medications

Over the course of the therapy, Billie was prescribed over twenty types of medications, and she experimented with several of them with the support of her psychiatrist in order to address her physical illnesses. She still expresses unresolved physical symptoms concerning IBS, memory loss, back and neck pain, but not to the

degree she did upon entering therapy, and her discomfort on the pain scale rests around a 3-4 versus a 7-8.

Nature of Human Beings

I hope this discussion highlights and affirms a deep belief that I hold as a pastoral counselor and person of faith and that I am trying to convey is essential to healing therapy. Humans are innately compassionate, caring beings. Our survival depends on the caring of others towards us and our health and happiness does also. We are relational beings; it is hardwired in us. With that understanding, when a caregiver inflicts pain on us, or we experience pain or trauma in some way, our system does not know how to process it. We literally cannot accept or understand pain and suffering and continue to be healthy, loving people, particularly deliberate pain. The brain disconnects the traumatic experience from the rest of the body, and literally shuts down sensation to the parts of the body that were inflicted in an effort to protect the organism. (Felitti and Anda, 1998, 2009) This self-defensive mechanism however, eventually becomes life-inhibiting, and a trauma survivor remains stuck in a cycle of reactivity and fear. How are they able to make their way out of a traumatic experience and back to a more open, trusting, and calm place? This is the challenge. The practice of reflective activity, along with processing the trauma with a therapist, enables the trauma survivor to form a new relationship with himself or herself. Acknowledgement of the event, accepting the emotions associated with the event, grieving the perceived loss of self-identity through such an experience, and beginning a new relationship with a self after the event is part of the healing process.

In addition to positive relationship-building between a client and themselves, a client and therapist, healing can be improved through forming new adaptive relationships with others in the community and world. This was a challenge for Billie and remains so.

In 1947 Kardiner revised his classic text in collaboration with Herbert Spiegel, a psychiatrist who had just returned from treating men at the front. Kardiner and Spiegel argued that the strongest protection against overwhelming terror was the degree of relatedness between the soldier, his immediate fighting unit, and their leader. Similar findings were reported by the psychiatrists Roy Grinker and John Spiegel, who noted that the situation of constant danger led soldiers to develop extreme emotional dependency upon their peer group and leaders. They observed that the strongest protection against psychological breakdown was the morale and leadership of the small fighting unit. The treatment strategies that evolved during the Second World War were designed to minimize the separation between the afflicted soldier and his comrades. (Judith Herman, 2002, p. 25).

Finally, building a new transformative relationship between a trauma survivor and a higher force, or God, as I will name Him/Her, is also very powerful.

A pastoral theological model that best fits this process for me is a relational theological model put forward by Pamela Cooper-White (2007). If we are relational beings and make meaning out of our experience based on relationships with ourselves, and with others, then it is only understandable that we can best form meaning of our existence through a relational understanding of God. According to Cooper-White, this involves the following:

This God responds and is affected by us as we are by God. This God has a particular and individual relationship with each and every one of us. This God cares

about us and wants us to be our fullest, happiest, most joyful selves, and does not want us to suffer. This God understands our experience at a most intimate level, our joy, sadness, pain, anger, and frustration and hears it and accepts it. This God is a God that is evolving over the course of history. If we are made in the image of God, then this God continually responds to stimuli, communication, experience, and events and validates our own. This is a God that can facilitate healing for trauma survivors.

People who witness trauma are often left with the question of: why did God allow this to happen to me? Or to my loved ones? Or to a whole group of people? How can a loving, benevolent God allow that to happen to God's creation? Billie possessed anger and sadness over her childhood relationship with a God who was distant, judgmental, cruel, and allowed her to endure horrible pain at the hands of someone she loved the most in this world. And, he did so in God's name. Her mother reinforced this image of God and also abused Billie emotionally by threatening her with God's judgment if she did not do what her mother wanted. Furthermore, Billie was instilled with the belief that she was born sinful or bad and had to earn her way into heaven constantly.

Billie struggled with obtaining approval and validation from this God and her parents, who modeled a parental relationship after this type of God. Her grief and anger at seeking and needing love and validation from her parents and this God and never receiving it unconditionally was expressed in many sessions. She began to let go of her longing to be validated by this God and to validate herself. She began to let go of understandings of a God or higher being that possessed such negative qualities. She

spent much time over the 5 years, searching for a faith community where she felt accepted unconditionally and welcomed and supported. She continues to struggle to find a place where she feels this. Her sexuality is an issue for some faith communities. Doctrinal beliefs is another issue. Billie's relationship with God and her perception of who God is in her life has changed and evolved over her lifetime and over the past five years of our work together. She has been a member of several different denominations, but she has not stayed with one congregation or denomination for longer than 5 years. She will continue to explore faith communities in Atlanta to find a "home" where she feels validated and accepted and where she can practice her faith as she lives it now.

Conclusion

We counselors sit with clients for hours on end, giving them respect, our listening presence, a containing space within which to express their deepest feelings, and compassion. We note how healing this is for them. Why don't we provide the same service for ourselves? Committing to sitting with ourselves, and practicing *maitri*, an ancient Buddhist principle, which is chiefly practicing compassion for oneself, can produce the same healing results. We know ourselves best. Why not leverage that inside knowledge to be our own best friends? Why not agree to be gentle, friendly, and humorous with ourselves by sitting and observing our innermost thoughts and feelings, and by refraining from judgment or shutting down? By practicing meditation, we sit and merely observe our thoughts, letting them come in and out of our consciousness, merely

noting they are present. We do not attach a judgment to them. We consciously refrain from attaching judgment to them. This is where our compassion for ourselves comes in—*maitri*. We act as our own best friends and simply observe and listen without judgment. This act of opening up, of courageous receiving and accepting whatever we are feeling at the moment, through the action of breathing, is revolutionary, miraculous, and healing. We breathe in, and take in, and accept the emotion that comes up in the stillness. We open our hearts, our arms to the fear and the pain that had long been hidden inside because we recoil from facing it. In such moments, we free ourselves. Then, we breathe out and release that pain into the universe.

Goldvin (2005), a Stanford University research scientist, emphasizes the importance of compassion, something that is directly relevant for pastoral caregivers and counselors. His “care” video task examines the following question: How much do you feel a sense of care for the person being cared for? He found that if the caregiver participated in compassion meditation practices, then his or her willingness to sit and talk with another person increases, and emotional contagion decreases. The ability to change the meaning of an emotion being perceived by the caregiver through cognitive empathy and reappraisal increases over time. Anxiety that is absorbed or generated by the care receiver is less likely to be exhibited or experienced by the caregiver with increased compassion and lovingkindness training. The tendency for a caregiver to suppress emotion decreases with meditation training. For Goldvin, high suppression of emotion means that the caregiver is less able to recognize emotions in self and others and possesses less of a sense of caring for others and willingness to help others. By corollary,

less suppression of emotion means the caregiver is better able to recognize emotions in themselves and others and has a stronger sense of caring for others. Practitioners of compassion cultivation training tend to be more emotionally expressive, and they tend to recognize, show, and experience a broad spectrum of emotions. They also tend to express less of a need to hide things or parts of themselves from others.

Anxiety and perceived danger decrease in the brains of practitioners who are more easily able to engage in emotional exchange and risk with others. They are also able to expose themselves in a vulnerable way. Practitioners are more able to care about others' difficulties and empathize with them than their non-practitioner counterparts (Lazar, 2006). Additionally, they are able to harness their altruistic desire to help and turn it into action. Pema Chodron (2004) discusses how meditation involves the act of opening oneself up to the world. By doing this, by opening oneself up to unconditional love, compassion, and lovingkindness, one is able to free oneself from the chains of fear, reaction, and self-centeredness, and one is also able to form new pathways in the brain that produce positive emotions, love, empathy, and happiness, and increase the desire to help others as well as improving one's physical health. Cultivating compassion and empathic concern not only increases therapeutic effectiveness and healing, it also produces good emotions, good health, and good deeds, which benefits all.

My work with Billie taught me more about the human soul, the power of relationships to our psychosocial development, growth, and happiness, and about our need to give meaning to our lives and existence than I ever imagined. Despite the horror

and pain that humans inflict on one another, especially to the ones closest to them, they still look for hope, and they can indeed find and cultivate resiliency.

We liberate ourselves from our past experiences and exercise choice and power that was taken from us. We are not slaves to our history, but we can learn from it and move forward. The freedom and healing that comes from telling the truth, telling our stories, and learning to trust again is invaluable. I have learned about the power of the human body to heal itself and seek equilibrium in all things through the use of meditation, prayer, and other spiritual practices, and also through creative activity (Winnicott, 1954).

Over these five years of therapy as well as my research endeavors into trauma, abuse, PTSD, and how humans experience violence, a few things have become clear. Humans are not built to cause violence or to experience it. Our bodies, minds, and souls simply cannot handle it. There is a breakdown of brain function, mind-body interaction, emotional regulation, and of meaning-making when we experience it. There is no way to clearly or easily explain violence to someone who has experienced it. This is the pain and tragedy of attempting to heal. There is no clear answer or step-by-step guide to healing. It is individual for each survivor, and the journey can be long and tedious. Symptoms can be alleviated through medication, therapy, and healing practices. The bigger questions “why did this happen to me, or to them,” are more complex, ambiguous, and difficult to answer. The client must find an answer that she is satisfied enough with to continue living, healing, and growing and finding the positivity in her narrative.

I undertook an investigation into the effects of PTSD on female survivors of childhood sexual abuse in order to better understand my client. I conducted research in depth into trauma therapy, which greatly helped me in my work as a pastoral counselor with clients of this population. I had to do this more or less on my own and I had to form my own integrations with pastoral counseling approaches and trauma therapy, because there is a lack of awareness and understanding in the pastoral counseling field of the causes, effects, and treatments for trauma. I hope that my research and integration of trauma theory and therapy and pastoral theologies and themes can raise awareness about how pastoral counselors can truly and effectively work with survivors of sexual abuse and with survivors of trauma. As I stated, I believe pastoral counselors have particular strengths and gifts for working with this population and I outline why this is so. I hope to continue to explore the interconnections between pastoral theology and counseling and trauma work in order to provide the best care for my clients and others who come to counseling for help. I also hope that the work I have done and that others are doing in this area can inform our field as pastoral theologians in new and exciting ways. The lived experience and living community can inform our theology in ways that help us move forward as a local, regional, and global community so that justice, equality, dignity, and care can be present and recognized for everyone.

REFERENCES

- Adler, P.A. & Adler, P. (1994) "Observational Techniques" In N.K. Denzin and Y.S. Lincoln, (Eds.) *Handbook of Qualitative Research* (pp. 377-392). Thousand Oaks: Sage Publications.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders*, (4th ed.). Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders*, (5th ed.). Washington, DC: American Psychiatric Association.
- Anderson, H. & Foley, H. (1998). *Mighty Stories, Dangerous Rituals: Working Together the human and the divine*. San Francisco: Jossey-Bass.
- Anderson, J., Martin, J., Mullen, P., Romans, S., and Herbison, P. (1993) Prevalence of Childhood Sexual Abuse in a Community of Women. *Journal of The American Academy of Child and Adolescent Psychiatry*. 32 (5), 911–919.
- Aron, L. & Mitchell, S. (1999). *Relational Psychoanalysis: The Emergence of a Tradition*. Hillsdale: Analytic Press.
- Baker Miller, J. (1986). *Toward a New Psychology of Women*. Boston: Beacon Press.
- Baker Miller, J. (1998) *The Healing Connection: How Women Form Relationships in Therapy and in Life*. Boston: Beacon Press.
- Ballou, M., Hill, M. & West, C. (2008). *Feminist Therapy: Theory and Practice*. New York: Springer Publishing Co.
- Benjamin, J. (1998). *Shadow of the Other: Intersubjectivity and Gender in Psychoanalysis*. New York & London: Routledge.
- Benjamin, J. (1998). *The Bonds of Love: Psychoanalysis, Feminism, and the Problem of domination*. New York: Pantheon.
- Berliner, L., & Saunders, B. E. (1996). "Treating fear and anxiety in sexually abused children: Results of a controlled two-year follow-up study." *Child Maltreatment*, 1(4), 294-309.
- Berman, P. (2010). *Case Conceptualization and Treatment Planning: Integrating Theory With Clinical Practice*. Los Angeles: Sage Publications.

- Bidwell, D.R. and Marshall, L.I. (2006). *Formation of Pastoral Counselors: Challenges and Opportunities*. Binghamton: Haworth Press.
- Booth, W., Colomb G., and Williams J. (2008). *The Craft of Research, Third Edition*. Chicago: University of Chicago Press.
- Bowman, B. "Bill Cosby raped me. Why did it take 30 years for people to believe my story?" *Washington Post*, Nov 13, 2014.
- Bowen, M. (1993). *Family Therapy in Clinical Practice*. New York: Jason Aronson Publishers.
- Bradshaw, J. (2005). *Healing the Shame That Binds You*. Deerfield, FL: Health Communications.
- Briere, J. (2014). *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation, and Treatment*. Los Angeles: Sage Publications.
- Bremner, J.D., Southwick, S., Johnson, D., Yehuda, R., & Charney, D. (1993). Childhood physical abuse and combat-related posttraumatic stress disorder in Vietnam veterans. *American Journal of Psychiatry*. 150(2):235-9.
- Bremner, J.D. et al. (2003). MRI and PET study of deficits in hippocampal structure and function in women with childhood sexual abuse and posttraumatic stress disorder. *American Journal of Psychiatry*, 160(5): 924-932.
- Chodron, P. (2001). *Start Where You Are: A Guide to Compassionate Living*. New York: Shambhala Classics.
- Chodron, P. (2000). *When Things Fall Apart: Heart Advice for Difficult Times*. New York: Shambhala Classics.
- Chodron, P. (2001). *The Places That Scare You: A Guide to Fearlessness in Difficult Times*. New York: Shambhala Classics.
- Chodorow, N. (1978). *The reproduction of mothering: Psychoanalysis and the Sociology of Gender*. Los Angeles: Univ. of CA Press.
- Chopp, R. (1995). *Saving Work*. Louisville: Westminster John Knox Press.
- Chopp, R., & Davaney, S.G. (eds). (1997). *Horizons in Feminist Theology: Identity, Tradition and Norms*. Minneapolis: Fortress Press.
- Clebsch, W. & Jaekle, C.A. (1964). *Pastoral Care in Historical Perspective*. Englewood: Prentice-Hall.

- Cooper-White, P. (2004). *Shared Wisdom: Use of the Self in Pastoral Care and Counseling*. Minneapolis: Augsburg Fortress Press.
- Cooper-White, P. (2007). *Many Voices: Pastoral Psychotherapy in Relational and Theological Perspective*. Minneapolis: Fortress Press.
- Cooper-White, P. (2011). *Braided Selves: Collected Essays on Multiplicity, God, and Persons*. Eugene: Cascade Books.
- Cooper-White, P. (1995). *The Cry of Tamar: Violence Against Women and the Church's Response*. Minneapolis: Fortress Press.
- Cooper-White, P. (2008). Feminisms, gender, and power: Reflections from a feminist pastoral theologian, *Journal of Pastoral Theology*. Spring 2008:18-32.
- Courtois, C. and Ford, J. (2012). *Treatment of Complex Trauma: A Sequenced, Relationship-Based Approach*. Boston: Guilford Press.
- Courtois, C. and Ford, J. (2009). *Treating Complex Traumatic Stress Disorders*. Boston: Guilford Press.
- Cozolino, L. (2010). *The Neuroscience of Psychotherapy: Healing the Social Brain* (Second Edition) (Norton Series on Interpersonal Neurobiology). New York: Norton.
- Creswell, J.W. (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Thousand Oaks: Sage Publications.
- Creswell, J.W. (2009). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Los Angeles: Sage Publications.
- Crotty, M. (2003). *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London: Sage Publications.
- Cushman, P. (1995). *Constructing the Self, Constructing America: A Cultural History of Psychotherapy*. New York: Da Capo Press.
- Davidson, J, Foa, E.B., Blank, A.S., Brett, E.A., Fairbank, J., Green, B.L., Herman, J.L., Keane, T.M., Kilpatrick, D.G., March, J.S., McNally, R.J., Pitman, R.K., Resnick, H.S. & Rothbaum, B.O. (1996). Posttraumatic Stress Disorder. In T.Widiger, A. Frances, H. Pincus, R. Ross, M. First, & W. Davis (Eds.), *DSM-IV Sourcebook*, 2: 577-605. Washington DC: American Psychiatric Press.
- Davidson, R., Kabat-Zinn, J., Schumacher J., Rosenkranz M., Muller, D., Saki, F., Santorelli, S., Urbanowski, F., Harrington A., Bonus K., and Sheridan J (2003). Alterations in Brain

and Immune Function Produced by Mindfulness Meditation. *Psychosomatic Medicine*, (65) 564–570. DOI: 10.1097/01.PSY.0000077505.67574.E3

- Davies, J. M. and Frawley, M. G. (1994). *Treating the Adult Survivor of Childhood Sexual Abuse: A Psychoanalytic Perspective*. NY: HarperCollins Publishers, Inc.
- de Waal, F. B. M. (2009). *The Age of Empathy: Nature's Lessons for a Kinder Society*. New York: Harmony Books.
- de Waal, F. B. M., & Ferrari, P. F. (2012). *The Primate Mind: Built to Connect With Other Minds*. Cambridge, MA; Harvard University Press.
- de Waal, Frans (2013). *The Bonobo and the Aethiopian: In Search of Humanism among the Primates*. New York: Norton.
- de Waal, F. B. M. (2012). The antiquity of empathy. *Science* 336: 874-876.
- de Waal, F. B. M., & Ferrari, P. F. (2010). Towards a bottom-up perspective on animal and human cognition. *Trends in Cognitive Sciences* 14: 201-207.
- de Waal, F. B. M., Leimgruber, K., & Greenberg, A. R. (2008). Giving is self-rewarding for monkeys. *Proceedings of the National Academy of Sciences, USA* 105: 13685-13689.
- de Waal, F. B. M. (2008). Putting the altruism back into altruism: The evolution of empathy. *Annual Review of Psychology* 59: 279-300.
- de Waal, F. B. M. (2009). Darwin's last laugh. *Nature* 460: 175.
- de Waal, F. B. M. (2010). For Goodness' Sake. Review of "The Price of Altruism," *New York Times Book Review* (July 11).
- de Waal, F. B. M. (2011). What is an animal emotion? *The Year in Cognitive Neuroscience, Ann. N.Y. Acad. Sci.* 1224: 191–206.
- Decety, J. and Michalska, K. (2009). Neurodevelopmental changes in the circuits underlying empathy and sympathy from childhood to adulthood. *Developmental Science*. 13 (6): 886–899.
- Decety, J., Michalska, K., and Akitsuki, Y. (2008). Who caused the pain? An fMRI investigation of empathy and intentionality in children. *Neuropsychologia* 46 (11): 2607-2614.

- Denzin, N.K. and Lincoln, Y.S. (2005). *The Handbook of Qualitative Research*. Thousand Oaks: Sage Publications.
- Derbyshire, S., Osborn, J., & Brown, S. (2013.) Feeling the pain of others is associated with self-other confusion and prior pain experience. *Front Hum Neuroscience*. Aug 14. 7: 470.doi: 10.3389/fnhum.2013.00470.
- Doehring, C. (1995). *Taking Care: Monitoring Power Dynamics and Relational Boundaries in Pastoral Care and Counseling*. Nashville: Abingdon Press.
- Doehring, C. (2006). *The Practice of Pastoral Care: A Postmodern Approach*. Louisville: Westminster John Knox Press.
- Dube SR, Anda RF, Felitti VJ, Chapman D, Williamson DF, Giles WH. (2001) Childhood abuse, household dysfunction and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association*. 286:3089-3096.
- Dube SR, Anda RF, Felitti VJ, Edwards VJ, Williamson DF. (2002) Exposure to abuse, neglect and household dysfunction among adults who witnessed intimate partner violence as children. *Violence and Victims*. 17:3-17.
- Dusek, J. Otu, H., Wohlhueter, A., Bhasin M., Luiz F., Zerbini, M., Herbert Benson, H., Libermann, T. (2008). "Genomic Counter-Stress Changes Induced by the Relaxation Response." *PLoS ONE* 3(7): e2576, Published online 2 July 2008 DOI: 10.1371/journal.pone.0002576
- Epstein, J.N., Saunders, B.E., & Kilpatrick, D.G. (1997). Predicting PTSD in women with a history of childhood rape. *Journal of Traumatic Stress*, 10(4), pp573-588.
- Erikson, E. (1950). *Childhood and Society*. New York: Norton and Co.
- Evans, M., Kincade, E.A., and Seem, S.R. (2011). *Introduction to Feminist Therapy: Strategies for Social and Individual Change*. Los Angeles: Sage Publications.
- Felitti VJ. (2002). The relationship between adverse childhood experiences and adult health: Turning gold into lead. *The Permanente Journal*. 6:44-47.
- Felitti, V. & Anda, R. et al (1999-present) The Adverse Childhood Experiences Study. CDC and Kaiser Permanent. Atlanta and San Diego. www.acestudy.org.
- Felitti, V. & Anda R. et al. (1998). The relationship of adult health status to childhood abuse and household dysfunction. *American Journal of Preventive Medicine*. 1998; 14:245-258.

- Foa, E., Rothbaum B., Riggs, D., Murdock T., (1991). "Treatment of Post Traumatic Stress Disorder in Rape Victims: A Comparison Between Cognitive Behavioral Procedures and Counseling." *Journal of Consulting and Clinical Psychology*. APA.
- Fontana, A. and Frey, J.H. (1994). "Interviewing: The Art of Science" in N. K. Denzin and Y.S. Lincoln (Eds). *Handbook of Qualitative Research* (pp. 361-376). Thousand Oaks, CA: Sage Publications.
- Foy, D. W., Resnick, H. S., Carroll, E. M., & Osato, S. O. (1990). Behavior therapy with PTSD. In A. S. Bellack & M. Hersen (Eds.), *Handbook of Comparative Treatments* (pp. 302-315). New York: Wiley.
- Fredrickson, B. (2008). Open hearts build lives: Positive emotions, induced through loving-kindness meditation build consequential personal resources. *Journal of Personality and Social Psychology*. 95, 1045-1062.
- Freud, Sigmund. (2013). *A Case of Hysteria (Dora)*. Anthea Bell, (Transl). Oxford: University Press.
- Garland, E. et al. (2010). Upward spirals of positive emotions counter downward spirals of negativity: Insights from the Broaden and Build Theory and affective neuroscience on the treatment of emotion dysfunction and deficits psychopathology. *Clinical Psychology Review*, 30, 849-864.
- Garman, N. (1994). *Qualitative Inquiry: Meaning and Menace for Educational researchers, Mini-conference on Qualitative Research*. Adelaide: Flinders Institute for the Study of Teaching, The Flinders University of South Australia.
- Geertz, C. (1977). *The Interpretation of Cultures*. New York: Basic Books.
- Gill-Austern, B. & McLemore, B. (1999). *Feminist and Womanist Pastoral Theology*. Minneapolis: Abingdon Press.
- Glaz, M. (1991). Reconstructing the pastoral care of women. *Second Opinion: Health, Faith, and Ethics*, Oct. 1991, pp. 94-107.
- Glaz, M. and Stevenson-Moessner, J. (Eds.). (2001). *Women in Travail and Transition: A New Pastoral Care*. Minneapolis: Fortress Press.
- Gorsuch, N. (2001). *Feminist Pastoral Care and Counseling*. Cleveland: Pilgrim Press.
- Graham, E. (1996). *Making the Difference: Gender, Personhood and Theology*. Minneapolis: Fortress Press.

- Graham, E. (1996). *Transforming Practice: Pastoral Theology in an Age of Uncertainty*. Eugene: Wipf and Stock.
- Greenberg, J.R. and Mitchell, S.A. (1983). *Object relations in Psychoanalytic Theory*. Cambridge: Harvard University Press.
- Greider, K. (1996). "Too militant? aggression, gender, and the construction of justice" in *Through the Eyes of Women: Insights for Pastoral Care*. Minneapolis: Fortress Press.
- Hanson, R.F. (1998). Book review, Transforming trauma: A guide to understanding and treating adult survivors of child sexual abuse, by Anna C. Salter, 1995. *Child Maltreatment*, 3, 80-82.
- Harrison, B.W. (1979). "The power of anger in the work of love: Christian ethics for women and other strangers," in *Making the Connections: Essays in Feminist Social Ethics*. Louisville: Westminster John Knox Press.
- Heim, C. et al. (2000). Pituitary-Adrenal and autonomic responses to stress in women after sexual and physical abuse in childhood, *JAMA*, 284(5), pp. 592-597.
- Herman, Judith. *Trauma and Recovery: The Aftermath of Abuse, from Domestic Abuse to Political Terror*. New York: Basic Books, 1997.
- Hiltner, S. (1969). *Pastoral Counseling*. Nashville: Abingdon Press.
- Holbrook, T. L., Hoyt, D.B., Stein, M.B., & Sieber, W.J. (2002). Gender differences in long-term posttraumatic stress disorder outcomes after major trauma: Women are at higher risk of adverse outcomes than men. *Journal of Trauma*, 53, 882-888.
- Holifield, E.B. (1983). *A History of Pastoral Care in America: From Salvation to Self-realization*. Nashville: Abingdon Press.
- Holzel, B. et al. (2011). Mindfulness practice leads to increases in regional brain gray matter density. *Psychiatry Research: Neuroimaging*, 191(1), pp. 36-43.
- Hooks, b. (2000). *Feminist Theory: from Margin to Center*. Cambridge, MA: South End Press.
- Horner, V., Carter, D. J., Suchak, M., & de Waal, F. B. M. (2011). Spontaneous prosocial choice by chimpanzees. *Proceedings of the Academy of Sciences, USA* 108: 13847–13851.
- Huberman, A.M. and Miles, M.B. (1983). Drawing valid meaning from qualitative data: Some techniques of data reduction and display, *Quality and Quantity*, 17 (17), pp.281-339.

- Hunter, R. (Ed.). (1990). *The Dictionary of Pastoral Care and Counseling*. Nashville: Abingdon Press.
- Jordan, J., Walker, M., Hartling, L. Eds. (2004). *The Complexity of Connection: Writings from the Stone Center's Jean Baker Miller Institute*. New York: Guilford Press.
- Kabat-Zinn, J. (2013). *Full Catastrophe Living (Revised Edition): Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness*. New York: Bantam Books.
- Kabat-Zinn, J. (2006). *Coming to Our Senses: Healing Ourselves and the World Through Mindfulness*. Hatchett Books.
- Kaplan, A., Miller, J.B., Jordan, J.V., Surrey, J., Stiver, I.P. (1991). *Women's Growth in Connection: Writings from the Stone Center*. New York: Guilford Press.
- Karr-Morse, Robin. (2012). *Scared Sick: The Role of Childhood Trauma in Adult Disease*. New York: Basic Books.
- Kazdin, A. (Ed.) (2000). *Encyclopedia of Psychology*. London: Oxford Univ. Press.
- Kilpatrick, D.G. (1986). Addressing the needs of traumatized victims. *The Practical Prosecutor*, 1986, 15-18. Published by National College of District Attorneys, University of Houston Law Center, Houston, TX.
- Kilpatrick, D.G. (1988). Rape Aftermath Symptom Test. In M. Hersen & A.S. Bellack (Eds.), *Dictionary of behavioral assessment techniques*. New York: Pergamon Press, 366-367.
- Kilpatrick, D.G., & Amick, A.E. (1985). Rape trauma. In M. Hersen & C.G. Last (Eds.), *Behavior therapy casebook*. New York: Springer, 86-103.
- Kilpatrick, D.G., & Calhoun, K.S.. (1988). Early behavioral treatment for rape trauma: Efficacy or artifact? *Behavior Therapy*, 19, 421-427.
- Klein, M. (1975). *Envy and Gratitude and Other Works: 1946-63*. New York: Delacorte.
- Krathwohl, D.R. and Smith, N.L. (2005). *How to Prepare a Dissertation Proposal: Suggestions for Students in Education and the Social and Behavioral Sciences*. New York: Syracuse University Press.
- Lartey, E. (2006). *Pastoral Theology in an Intercultural World*. Cleveland: The Pilgrim Press.
- Lartey, E. (2003). *In Living Color: An Intercultural Approach to Pastoral Care and Counseling*. London: Jessica Kingsley Publishers.

- Lazar, S. et al. (2005). Meditation experience is associated with increased cortical thickness. *Neuroreport*. Nov 28; 16(17): 1893-1897.
- Levinas, E. (1967, 1994). *Totality and Infinity: An Essay of Exteriority*. Pittsburgh: Duquesne Univ. Press.
- Levenkron, S., with Levenkron, A. (2007). *Stolen Tomorrows: Understanding and Treating Women's Childhood Sexual Abuse*. New York: Norton and Co.
- Levenson, R.W. & Ruef, A.M. (1992) Empathy: A Physiological Substrate. *J Pers Soc Psychol*. Aug;63(2):234-46.
- Lutz A., Brefczynski-Lewis J., Johnstone T., Davidson R. (2008). Regulation of the Neural Circuitry of Emotion by Compassion Meditation: Effects of Meditative Expertise. *PLOS*. DOI: 10.1371/journal.pone.0001897
- McCauley J. Kern, D. Koloder, K. (1997). Clinical characteristics of women with a history of childhood abuse: unhealed wounds. *JAMA*. May 7;277(17):1362-8.
- McClintock Fulkerson, M. (1994). *Changing the Subject: Women's Discourses and Feminist Theology*. Minneapolis: Fortress Press.
- McLemore, B. (2012) *Christian Theology in Practice: Discovering a Discipline*. New York: Eerdmans Pub.
- Means, Jeffrey. (2000). *Trauma and Evil: Healing the Wounded Soul*. Minneapolis: Fortress Press.
- Merriam, S.B. (1998). *Qualitative Research and Case Study Applications in Education*. San Francisco: Jossey-Bass.
- Mertens, D.M. (1998). *Research Methods in Education and Psychology*. Thousand Oaks: Sage Publications.
- Messler Davies, J. and Frawley, M.G. (1994). *Treating the Adult Survivor of Childhood Sexual Abuse: A Psychoanalytic Perspective*. New York: Basic Books.
- Miles, M.B. and Huberman, A.M. (1984). *Qualitative Data Analysis: A Sourcebook of New Methods*. Thousand Oaks: Sage Publications.
- Miller-McLemore, B.J. and Gill-Austern, B. (Eds.). (1999). *Feminist and Womanist Pastoral Theology*. Nashville: Abingdon Press.
- Miller, J.B. (1986). *Toward a New Psychology of Women*. Boston: Beacon Press.

- Minuchin, S. (2011). *Families and Family Therapy*. 2nd ed. Boston: New York: Routledge.
- Minuchin, S. (1998). *Family healing: Strategies for Hope and Understanding*. Boston: Free Press.
- Mitchell, S.A. and Black, M.J. (1995). *Freud and Beyond: A History of Modern Psychoanalytic Thought*. New York: Basic Books.
- Mitchell, S.A. and Greenberg, Jay (1983). *Object relations in Psychoanalytic Theory*. Boston: Harvard University Press.
- Mitchell, S.A. and Lewis, A. (1999). *Relational Psychoanalysis: The Emergence of a Tradition*. New York: Routledge.
- Mitchell, Stephen A. (2003). *Relationality: From Attachment to Intersubjectivity*. New York: Routledge.
- Moore, Z.B. (2002). *Introducing Feminist Perspectives on Pastoral Theology*. Cleveland: Pilgrim Press.
- Molnar, B., Buka S., Kessler, R. (2001). Child sexual abuse and subsequent psychopathology: results from the National Comorbidity Survey. *American Journal of Public Health*. May; 91(5): 753–760.
- Mullen,P., Martin, J.,Andersen, J., Romans, S. Herbison, G. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: a community study. *Child Abuse and Neglect*. Jan;20(1):7-21.
- Myers-Shirk, S.E. (2009). *Helping the Good Shepherd: Pastoral Counselors in a Psychotherapeutic Culture, 1925-1975*. Baltimore: Johns Hopkins Univ. Press.
- Neimeyer, R.(2009). *Constructivist Psychotherapy: Distinctive Resources*. New York: Routledge.
- Nichols, M.P. and Schwartz, R. (2008). *Family Therapy, Concepts and Methods*. 8th Ed. New York: Pearson.
- Cozad-Cozad-Neuger, C.C. (2001). *Counseling Women: A Narrative Pastoral Approach*. Minneapolis: Fortress Press.
- Cozad-Cozad-Neuger, C.C. (2000). “Women’s Depression: Lives at Risk” in *Women in Travail and Transition*. Minneapolis: Fortress Press.

- Nichols, M.P. and Schwartz, R. (Eds.). (2008). *Family Therapy- Concepts and Methods*. 8th Ed. Boston: Pearson Press.
- Oates, W. (1981). *Pastoral Counseling*. Boston: Westminster John Knox Press.
- Owens, M.J., & Nemeroff, C.B. (1991). The physiology and pharmacology of corticotropin releasing factors. *Pharmacol. Rev.* 43: 425-473.
- Poling, James Newton. (1991). *The Abuse of Power: A Theological Problem*. Nashville: Abingdon Press.
- Porges, S.W. (2012). *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-regulation*. New York: Norton and Co.
- Radford Reuther, R. (1985). *Womanguides: Readings Toward a Feminist Theology*. Boston: Beacon Press.
- Ramsay, N, ed. (2004). *Pastoral Care and Counseling: Redefining the Paradigms*. Nashville: Abingdon Press.
- Resick, P.A., Jordan C.G., Girelli, S.A., Hunter, C.K., and Monheofer-Dvorak S. (1988). A Comparative outcome Study of behavioral group therapy for sexual assault victims. *Behavior Therapy*, 19, 385-401.
- Rothbaum, B., Foa, E., Riggs, D., Murdock T., & Walsh W. (1992) A Prospective Examination of post-traumatic stress disorder in rape victims. *Journal of Traumatic Stress*. Article first published online: 19 FEB 2006. DOI: 10.1002/jts.2490050309
- Sass, J. & Wall, A. (2012). *Neuropsychological Evaluation for BA*. Georgia Program of Rehabilitation Services. Decatur: CRC.
- Saussy, C. and Clarke, B.J. (1996). "The Healing Power of Anger" in *Through the Eyes of Women: Insights for Pastoral Care*. Minneapolis: Fortress Press.
- Schafer, R. (1994). *Retelling a Life: Narration and Dialogue in Psychoanalysis*. New York: Basic Books.
- Schwartz, R.C. (1995). *Internal Family Systems Therapy*. CT: Guilford Press.
- Schwartz, R.C. and Goulding, R.A. Goulding. (2002). *The Mosaic Mind*. Trailheads Publications.
- Shapiro, Robin. (2010). *The Trauma Treatment Handbook: Protocols Across the Spectrum*. New York: Norton.

- Siegel, D. (2012) *Pocket Guide to Interpersonal Neurobiology: An Integrative Handbook of the Mind*. Norton Series on Interpersonal Neurobiology. New York: Norton.
- Stake, R.E. (1994). "Case Studies" in N.K. Denzin and Y.S. Lincoln (Eds.). *Handbook of Qualitative Research*. (pp.236-247). Thousand Oaks: Sage Publications.
- Stake, R.E. (1995). *The Art of the Case Study*. Thousand Oaks: Sage Publications.
- Stevenson-Moessner, J. (Ed.). (2000). *In Her Own Time: Women and Developmental Issues in Pastoral Care*. Minneapolis: Fortress Press.
- Stevenson-Moessner, J. (1996). *Through the Eyes of Women: Insights for Pastoral Care*. Minneapolis: Fortress Press.
- Stevenson-Moessner, J. and Snorton, T (Eds.). (2009). *Women out of Order: Risking Change and Creating Care in a Multicultural World*. Minneapolis: Fortress Press.
- The Visit of His Holiness XIV The Dalai Lama. The Visit 2010.
www.dalailama.emory.edu/previous/2010.html.
- Tracy, D. (1996). *Blessed Rage for Order: The New Pluralism in Theology*. San Francisco: Harper Collins.
- Van der Kolk, B. (1996). *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. Boston: Guilford Press.
- Van der Kolk, B. (2014). *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma*. Boston: Guilford Press.
- Walker E. et al. (1992). Medical and psychiatric symptoms in women with childhood sexual abuse, *Psychosomatic Medicine*, 54(6), pp. 658-664.
- Walker, Pete. (2013). *Complex PTSD: From Surviving to Thriving*. Azure-Coyote Publishers.
- Wimberly, E. (2006). *African American Pastoral Care and Counseling: The Politics of Oppression and Empowerment*. Cleveland: Pilgrim Press.
- Winnicott, D.W. (1992) *Babies and Their Mothers*. Reprint. New York: De Capo Press.
- Winnicott, D.W. (1982). *Playing and Reality*. 2nd ed. New York: Routledge.
- Winnicott, D.W. (1996). *Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*. London: Karnac Books.

Woodward and Pattison. *The Blackwell Reader*. London: Blackwell Publishing Ltd, 2000.

Yin, R.K. (2003). *Case Study Research Design and Methods*. Thousand Oaks: Sage Publications.

Ziegler, D. (2011). *Traumatic Experience and the Brain*. Jasper: Acacia Publishing.