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This issue contains articles that address the topic of best practices in pastoral care and counseling. I wish to extend a special thanks to Dr. Jaco Hamman who served as guest editor for this issue. Thanks also for the contributors for their hard work and insights.

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Guest Editor's Introduction

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This issue on "Best Practices" identifies the breadth and depth of members of the *American Association of Pastoral Counselors*. We asked seven authors to reflect on concerns and maladies, exploring the etiologies and theoretical frameworks that surround these, and to highlight aspects pastoral caregivers need to be aware of. In addition, we asked them to point to relevant and current literature. With creativity and wisdom, the authors knew that the theme needs deeper reflection and is not meant to be another buzzword or catchphrase. Rather, they address significant aspects of our personal and communal living. As counselors we know that each person we see is unique and requires a personal approach to caregiving. So too did our authors address a wide range of topics and interests based on personal interests, research and experience.

Bruce Rogers-Vaughn provides a foundational essay exploring the impact neoliberalism has on pastoral counseling. Indicating that "Best Practices" fits neatly into a neoliberal paradigm, he asks whether we as pastoral counselors should use such language. When care becomes routinized and methodical, central to the neoliberal agenda, where is "soul care," Rogers-Vaughn asks.

Michael Koppel's essay addresses "Best practices" through the lens of the person of the caregiver. He explores the benefits of play as an experiential process to enhance knowledge and awareness for care and counseling professionals. Play, Koppel argues

persuasively, is an undervalued transformational experience that can lead to significant self-discovery in a caregiver.

Two authors address the concerns of diagnosis within a pastoral counseling practice. Tracing the historical roots of pastoral diagnosis within a medicalized world and drawing on his empirical research, Loren Townsend, argues persuasively that we need to "retire the notion of pastoral diagnosis and replace it with a critical pastoral relationship with interdisciplinary diagnosis. " He shows how fraught a conversation on pastoral diagnosis can be, from defining "pastoral diagnosis" to engaging postmodern thought and criticisms raised by philosophers such as Michel Foucault. Pastoral diagnosis, Townsend shows, raises more questions than answers. He offers us a possible way forward.

The second author to address diagnosis is James I. Higginbotham. He argues that diagnosing a person with a personality disorder according to Axis II of the *Diagnostic and Statistical Manual of Mental Disorders* is neither a compassionate nor a useful way of understanding a person. Higginbotham offers a liberative and critical pastoral theology of personality that, with a competence-based assessment of personality that takes situational factors into consideration, can reduce stigmatizing and stereotyping.

Nancy Ramsey provides theological, clinical, and theoretical resources for pastoral and spiritual care providers who wish to be effective in providing care across embodied differences such as sexuality, gender, race, and class. By exposing and resisting the oppressive inequities of power and privilege that accompany and complicate these experiences of difference, and by encouraging care providers to be mindful of their own social location, Ramsey identifies ways to honor the *imago Dei* in the other.

Larry Kent Graham has been doing significant work with and research on veterans returning from war zones and the families and communities that welcome them back. In the context of collaborative conversations, Graham explores the dynamics of forgiveness, shame and guilt in war veterans that have experienced moral trauma and identifies ways to limit long-term negative effects in a population often overlooked.

Jeff Sandoz contributed two essays to this issue. The first focuses on the mind/spirit connection within the *Twelve Step Program* of *Alcoholics Anonymous*. Sandoz provides information to help counselors assess the severity of the abuse/dependency, examine the etiology of alcoholism, and explore alcohol addiction's spiritual dimension. Also, he details the impact of alcoholism upon the brain and how working the Twelve Steps and engaging daily sponsorship combine to evoke a spiritual experience associated with recovery.

Sandoz's second essay addresses the insights we learn from neuroscience with regard to addictions and the spiritual experience in recovery. He describes his essay as an "amalgamation of working hypotheses," acknowledging that science and technology, especially around brain imaging, will teach us much in the years ahead. Sandoz encourages us as caregivers to learn more about brain function and how both addiction, recovery, and spiritual experiences are ultimately brain based.

Following the authors of this issue, "Best Practices," pastoral counselors must be mindful of wider systemic forces such as neoliberalism that promotes a disease model of care, places spirituality above religious and theological discourse, and suppresses prophetic resistance and social justice. "Best Practices" demands mindfulness and self-discovery in the person of the counselor. Play can assist us greatly in such a task. Also,

"Best Practices" ask that we engage the frameworks we use (such as the *Diagnostic and Statistical Manual of Mental Disorders*) and the iniquities of power and privilege we find ourselves in with prophetic compassion, honoring the *imago Dei* in all persons. Lastly, being pastoral counselors, who embody "Best Practices," implies seeing the connections between addiction, spirituality, and Twelve Step programs as well as learning from neuroscience how we can increase the effectiveness of our care.

This is a rich issue of *Sacred Spaces*. My deepest gratitude is to the authors who wrote stimulating and informative pieces. I am indebted to Ryan LaMothe, Editor of Sacred Spaces, who gave me this opportunity to be a Guest Editor.

Pastoral Counseling in the Neoliberal Age: Hello Best Practices, Goodbye Theology[1]

Bruce Rogers-Vaughn, Ph.D.[2]

Abstract This essay claims that the practice of professional pastoral counseling has undergone a radical transformation in the last three decades, as it has suffered renovation to be in compliance with the dominant neoliberal culture. It argues that neoliberalism provides a more compelling context for understanding this change than notions of postmodernity that are divorced from the economic and political power structures that support them. It suggests that this context sheds light on the meaning of current discourses such as *best practices.* Moreover, it contends that this neoliberal transformation helps explain the contemporary erosion of theological discourse in pastoral counseling. After citing evidence for this erosion, the essay identifies five specific effects of neoliberal compliance upon professional practices of pastoral counseling. Finally, the neoliberal alterations of these practices raise the question of whether pastoral counseling currently retains any continuity with the tradition of the care of souls.

Keywords: Neoliberalism, postmodernity, best practices, theology, pastoral counseling, soul

[1] Acknowledgement: Sections two and three, with minor revisions, first appeared in Rogers-Vaughn, B. (2013). "Best Practices in Pastoral Counseling: Is Theology Necessary?" *The Journal of Pastoral Theology 23,* 1, and are used here by permission of the editors.

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Introduction: The neoliberal spectrum and the transformation of pastoral counseling

My education and training in pastoral counseling began in 1983 as part of a doctoral program in "religion and personality" at Vanderbilt University. I was taught that pastoral care, including counseling, is first and foremost a *theological* practice, albeit one that is informed by a critical dialogue with psychological theories and methods. This was the assumption I took with me into the clinical practice of pastoral counseling, which by 1992 occupied me full-time and continued to do so until three years ago, when I reduced my practice by half in order to engage in more teaching, research, and writing.

What I could not have imagined during my studies in the mid-1980's was that a new paradigm was just then beginning to emerge, rooted in a radical form of capitalism that has since become known as *neoliberalism*, that would rapidly become a totalizing and global power, defining all human life in its wake according to the terms and demands of the "free market." The professions would prove particularly vulnerable to its authority, including the caregiving professions such as pastoral counseling. In our field these transformations are signaled by changes in discourse, with words like *theology*, *pastoral*, and *soul* steadily disappearing, only to be replaced by neoliberal-friendly terms like *spiritually-integrated* and *best practices.* In this essay I will attempt to articulate why and how this has occurred, and to outline the specific effects in the professional practice of pastoral counseling. The general outcome for our field is that theological reflection has become an endangered species, as the concerns that have occupied theology are no longer in focus.

Before embarking on this project, however, I should respond to a potential objection and offer a clarification. These have to do with what I am calling the neoliberal spectrum—from the macro world to the micro world. At the macro level, the possible objection is that the changes I

describe are not due to neoliberalism, but to the broad intellectual and cultural shifts often referred to as *postmodernity.* Lyotard (1984) has famously summarized postmodernity as "incredulity towards metanarratives," by which he meant "grand narratives" that attempt to express universal truths. Postmodernity thus relativizes the all-encompassing claims of religions, reducing them to the status of local truths. Furthermore, as Foucault deftly demonstrated, postmodernity celebrated an end to the controlling authority of traditional institutions, whether of political or religious origin. Finally, postmodern intellectuals challenged grand narratives regarding the absolute, bounded self. The new individual subject was envisioned as multiple, discontinuous, and fluid—a view that was soon absorbed into contemporary psychoanalytic theory (e.g., Mitchell, 1993, pp.95-150), as well as into psychoanalytically-informed pastoral theology (e.g., Cooper-White, 2007, pp.51-62). A consistent theme within postmodernity is thus the radical liberation of individual subjects. Individuals are now freed from religious and political doctrines and symbol systems, dominance by institutions, and inflexible and constricting ways of existing as selves. It is easy to see why a traditional discourse, such as theology, would not fare well in this new climate.

However, such philosophical and cultural movements do not spring spontaneously, as it were, from the head of Zeus. A growing number of philosophers and sociologists, particularly those drawing upon the insights of Marx and his early interpreters, such as Gramsci (1929-1932/1992-2007), are now examining the roots of postmodernity. Not surprisingly, therefore, they see postmodernity as resting on economically-driven agendas. These theorists include, among others, David Harvey (1990, 2005) and Fredric Jameson (1991), as well as the prolific sociologist Zygmunt Bauman (2003, 2004a, 2004b, 2005, 2007a, 2007b, 2011, 2012), who argues that postmodernity is not "post" anything, but is rather a recent development of modernity

corresponding to a global neoliberal economy, a stage he calls "liquid modernity" (2012). Jameson argues that the term *postmodern* functions as a distraction from what is actually an economic reality. In other words, it serves to hide the underlying economic agenda with an overlay of cultural logic. He observes:

> The fundamental ideological task of the new concept…must remain that of coordinating new forms of practice and social and mental habits…with the new forms of economic production and organization thrown up by the modification of capitalism—the new global division of labor—in recent years. (1991, p. xiv)

Thus the subtitle of Jameson's book on postmodernism is "*The cultural logic of late capitalism*"—late capitalism being his term for neoliberalism.

Another theorist of this persuasion who might be of interest to pastoral counselors, given his reliance on the work of the famous psychoanalyst Jacques Lacan, is the French philosopher Dany-Robert Dufour, who happens to have been an academic colleague of Foucault. Dufour also argues that postmodernity and neoliberalism are intrinsically linked. He observes: "In short, post-modernity is to culture what neoliberalism is to the economy" (2001, para. 3). The subtitle of the English translation of his book, *The Art of Shrinking Heads—On the New Servitude of the Liberated in the Age of Total Capitalism* (2008)—alludes to his conviction that neoliberalism (and postmodernity) is not as liberating as it would appear. He contends, in fact, that neoliberalism is the first truly global hegemony, and that it controls human beings through a form of domination that has not been seen before:

> The great novelty of neoliberalism, as compared with earlier systems of domination, is that the early systems worked through institutional controls, reinforcements and

> repression, whereas the new capitalism runs on deinstitutionalization. Foucault probably did not see this coming. (2008, p. 157)

The result of this new type of domination, Dufour asserts, is a historic mutation of human being. By destroying institutions and human collectives, thus achieving a sort of solitary confinement, neoliberalism produces "individuals who are supple, insecure, mobile and open to all the market's modes and variations" (2008, p. 157).

The implication of these developing theories is that postmodernity is essentially the culture as it is shaped by neoliberal economies. And they suggest, quite shockingly, that postmodern critical theory, which announces the end of metanarratives, is itself a metanarrative—one which now serves the interests of the new neoliberal status quo. What "incredulity towards metanarratives," *really* means, therefore, is the following: *There are no longer any grand narratives, except the narrative of the market, which governs every place and applies to all people regardless of gender, race, nationality, religion, sexual orientation, etc*. Derrida, Lyotard and Foucault have, in effect, been turned on their heads (or, at the very least, require reinterpretation in light of this novel type of hegemony). What we now have, rather than an end to metanarratives, is one metanarrative (that of neoliberalism) driving out competing metanarratives. In fact, many scholars— in the fields of both economics and theology—are asserting that neoliberalism is a faith system and is acting exactly as a new religion (e.g., Broad & Cavanagh, 2000; Cox, 1999; George, 2000; Rieger, 2009; Sung, 2007, 2011; Thistlethwaite, 2010). Thus we may reasonably understand the current situation as one in which a new religion is appropriating and marginalizing existing religions (Carrette & King, 2005). In my judgment, therefore, neoliberalism—not postmodernity—provides the context for the marginalization of theology generally, and the erosion of theology in pastoral counseling in particular.

The clarification I must now offer requires us to turn from the macro level to the micro level of neoliberal governance. This has to do with identifying the role of *best practices* in the everyday functioning of this form of control. This is an important explication, it seems to me, in an issue of *Sacred Spaces* that focuses on best practices in pastoral counseling. The term *best practices,* which has become a business buzzword and cultural meme, should be understood as a signifier for the neoliberal definition of professionalism and efficiency. After hours of effort I have not been able to identify who first used the term. However, it has clearly emerged from the corporate business sector, where it is associated with standardization, benchmarking, lean production, and lean service. The roots of this idea no doubt go as far back as early twentieth century manufacturing in what was known as Taylorism (named for Frederick Taylor, the man who invented the method) and Fordism (for Henry Ford, who was best known for its implementation). Taylor's followers were known as "efficiency experts" that looked for the "one best way" to accomplish specific tasks. The method diligently eradicated "all false movements, slow movements, and useless movements," utilizing repetitive, mechanized motions of laborers on assembly lines to speed up production and minimize waste of time and materials. These methods were then codified in training manuals, used by managers to teach new employees. The goal was control and predictability (Ritzer, 2013, pp. 34-37). A modernized form was perfected by Taiichi Ohno for Toyota, and became known as the Toyota Production System (TPS). In the 1970's and into the 1980's these manufacturing ideas were increasingly adapted by human services corporations, the result usually designated as *lean service*, most notable in the success of McDonald's. During the 1990's and the first decade of the twenty-first century the approach spread throughout the service sector (Seddon & O'Donovan, 2009), first in retail and education,

and finally into the healthcare industry, and somewhere along the way became known by the current phrase *best practices*.

Once into healthcare *best practices* eventually dominated the mental health field, including psychotherapy. Here it is most associated with the now-familiar notions of *empirically-supported treatments* (ESTs) and *managed care.* The goal is the same as before: standardization for the sake of *efficiency*. The focus is on the *behaviors* of "successful therapists," which can then be repeated, manualized and taught to psychotherapy students. Caregiving becomes subject to, even defined by, cost-benefit analysis. What all this finally accomplishes is increased outcome at less cost in order to improve profits for practitioners and, more importantly, the owners of health-related corporations. These are the hallmark signs, of course, of neoliberalism. *In fact, we should think of the emphasis on best practices as the neoliberalization of counseling and psychotherapy*.

Before moving on I should highlight an important feature of the application of *best practices* to human service forms of labor, including and especially psychotherapy. In this sort of labor one's very self becomes the tool of production. The worker must therefore allow her own subjectivity to be manipulated by the goal of efficiency. She must behave such that the customer is convinced that she is *really sincere* in her carefully performed demeanor. This has been extensively researched by Bunting (2004), who interviewed hundreds of human services workers to describe the unique psychological exploitation that usually occurs in this sort of labor. Bunting calls this "emotional labor." Where muscle strength is uppermost for laborers in manual forms of work, "its modern-day equivalent is emotional empathy and the ability to strike up a rapport with another human being *quickly*" (p. 61, emphasis in original). Corporations, she observes, have learned that "empathy has become big business" and that "empathy makes money," because

customers are far more likely to return to stores and service providers, and even pay a premium, for receiving "a certain kind of interaction" (pp. 61, 66-67). Bunting cites one consultant firm who was hired to conduct "empathy audits" for any company that "wants its employees to sound warmer or more natural" (pp. 66-67). A human resources manager for a retail giant boasts that his employees are exhorted and trained to provide "miles of smiles" and adds: "It's got to be a *real* smile" (p. 103, emphasis in original). This practice not only oppresses workers, who are denied the spontaneous response of self-expression because they must follow a corporate script, but it commodifies human relationships. Bunting concludes:

> There is a world of difference between the waitress who chooses to smile, quip with her customers and be good-natured, and the one whose behavior has been minutely prescribed by a training manual. The former has some autonomy over her own feelings; the latter has been forced to open up more aspects of herself to commodification. (p. 71)

The end result for laborers can be disastrous: "Employees are left to manage the dilemmas of authenticity, integrity and their sense of their own natural, spontaneous personality, which all spill into their private lives" (p. 72). More and more our thoughts, interpersonal desires and even our feelings belong to the work—"the practice"—and less to our selves. Incidentally, Bunting's findings are similar to those described by Boltanski and Chiapello (2005) in their heavily-documented survey, *The New Spirit of Capitalism*.

This holds tremendous poignancy, I believe, for how we train to become psychotherapists and pastoral counselors. The current emphasis on *best practices* encourages, if not assures, the routinization and mechanization of the therapeutic relationship. We are implored to become experts on how to empathize. Whereas Heinz Kohut (1984, pp. 172-191) emphasized empathy as a genuine human bond and a form of authentic appreciation of the other, *best practices*

transforms empathy into a *methodology of connection*. Whereas empathy as a genuine human bond may be formed or nurtured, empathy as a therapeutic performance can be *taught*. And it must be done with excellence. We must not simply appear empathic; we must demonstrate *real* empathy and warmth. To use Ritzer's metaphor (2013), this amounts to the "McDonaldization" of psychotherapy: Do you want fries with that? <insert authentic smile>. The line between genuine empathy and virtual empathy becomes blurred. It comes as no surprise, then, that Olson (2013) now contends that neoliberalism is threatening the very existence of empathy.

This spectrum of neoliberal governance, from the macro world to the micro world, has, in my judgment, everything to do with the erosion of theology in pastoral counseling. Specifically, it places the matters that *concern* theology (e.g., *soul, faith, love, mercy, forgiveness, justice, righteousness, obligation, etc.*) off the radar, because these matters are, in the language of economists, *external to the market*. In the following section I will summarize the evidence that pastoral counselors are losing interest in theology. In the third section I will delineate five effects of neoliberalism for pastoral counseling, and how each one reduces the importance of theological reflection for our work. Finally, in the conclusion I will suggest that the neoliberalization of professional pastoral counseling could mean this enterprise might no longer remain within the tradition of the care of souls.

The decline of theological reflection in pastoral counseling

Evidence for the diminishment of theology within pastoral counseling appears in four major areas: education and training, business models, everyday clinical practice, and changes to the mission statement of the American Association of Pastoral Counselors (AAPC). Let us consider each of these in turn.

Much attention has been given recently to the closure of AAPC accredited training centers and the similar reduction or termination of graduate programs. Less consideration has been paid to the shifts occurring within the programs that have survived, and especially within those that are thriving. These programs typically emphasize psychological theory and core clinical competencies. Theology becomes optional, essentially reduced to the status of an elective. Furthermore, faced with the demands of young students who wish to enter professional practice as soon as possible, theology courses are either dropped or reduced to the minimum that might be perceived as necessary in order to retain the designation "pastoral." For example, the Graduate Program in Pastoral Counseling & Spiritual Care at Loyola University in Maryland, one of the strongest of such programs in the U.S. in terms of enrollment, offers a Master of Science degree in pastoral counseling. This degree requires students to successfully complete twenty-two courses and clinical units. Only two of these are in the area designated as "Theology/Spirituality." (Two additional courses are required for those seeking clinical membership in the AAPC.) These may be waived for students who have had previous coursework in theology/spirituality.[3] It is therefore possible, presumably, for students to complete the program only having taken survey courses in, for instance, world religions or comparative spirituality. At most graduates will have had a mere introduction to theological studies. Such a curriculum, of course, determines the character of the program. Townsend (2009) observes: "Unlike traditional and seminary-based programs, Loyola's makes no specific claim that pastoral counseling is an extension of the church's ministry or that pastoral counseling is tied to students' faith traditions or religious commitments….Expected outcomes are psychological rather than religious or spiritual—helping clients flourish 'in their emotional and

[3] Loyola program requirements are available at http://www.loyola.edu/pastoralcounseling/files/advising/LUM_MS_66.pdf (accessed June 16, 2012).

psychological domains'" (p. 65). Furthermore, Townsend notes that "this approach to pastoral counseling has been embraced by a number of religious and state universities and is shaping the future of the field. More pastoral counselors are currently trained in these programs…than in traditional and seminary specialty programs combined" (p.65). Such programs, judging by their apparent successes, would have to be considered *best practices* in pastoral counseling. Nevertheless, theological studies have been reduced to a minor role at best.

Current business practices in pastoral counseling also point to a decline in the significance of theology. Here again there has been considerable anxiety with regard to a reduction in the number of pastoral counseling centers, with somewhat less attention to modifications in the centers that survive or are flourishing. The history and current status of the Samaritan Institute provides an apt example. First established in 1972 as a resource network for pastoral counseling centers, it now consists of 481 offices in 389 cities in the U.S. and in Tokyo, Japan.[4] Under the pressure of market forces, however, the Samaritan Institute has steadily distanced itself from its roots. Townsend (2009) concludes that "the same changes driving diversity in the field also challenged Samaritan Centers. In response, the Samaritan Institute shifted its defining language away from any unified vision of pastoral counseling and toward a diverse institutional collaborative providing care" (p. 67). Not surprisingly, a reduction in the role of theologically trained counselors within the organization, relative to members of other psychotherapy disciplines, has accompanied this shift. This represents another instance in which a "best practice" in pastoral counseling has, for all intents and purposes, removed theological reflection from its core agenda.

[4] As documented on the Samaritan Institute website, located at http://www.samaritaninstitute.org/about-samaritan-institute/ (accessed June 16, 2012).

Changes within the educational programs and business practices appear to be mirrored in the day to day clinical practices of pastoral counselors. This observation has recently been documented by McClure (2010). Summarizing interviews and surveys she conducted with over thirty faculty and supervisors in leading pastoral counseling centers and programs, all members of the AAPC, she notes that their theological identities tended to be confined to their inner, personal sense of call. Their theological reflections typically occurred within their own minds (rather than in dialogue), in the way they interpreted their work or the dynamics of a particular case. They were "theologically shy," one practitioner admitting that theological reflection was "not typically an explicit part of his work with a client" (p. 65). Even when they do reflect theologically, McClure observes, they tend to confine theological meaning to internal, personal experience. Thus theology becomes an individualistic enterprise—a way for the individual to interpret her own private life.

Similarly, Townsend (2009) has articulated the results of a study titled "What's Pastoral about Pastoral Counseling? A Grounded Theory Study." The study, funded by Eli Lilly and the AAPC, was based on interviews or written statements from eighty-five pastoral counselors. Many of the quotes cited by Townsend are similar to those of McClure. He notes that the typical response to the inquiry as to what made their counseling pastoral was "Pastoral is who I am, not what I do." As a consequence, "All therapist behaviors, thoughts, intents, and interactions were pastoral since these *originated in the person of the therapist*" (pp. 60-61, emphasis in original). The confinement of theological reflection to individual experience, as I will observe later, effectively removes it from a context which accords it substantive meaning. Thus the essential character of theological reflection is eroded even when an attempt is made to maintain its practice.

Finally, these trends are epitomized in the recent revision to the mission statement of the AAPC.[5] By replacing the term "pastoral" with "spiritually grounded," the AAPC has denoted nothing less than a paradigm shift in its self-understanding. McClure has observed that the displacement of theology is reflected in "the language of 'spirituality' the AAPC has begun to adopt rather than an explicitly articulated theological position" (2010, p. 46). Likewise, Anderson (2001a) has maintained: "Changing the adjective modifying care from pastoral to spiritual signals a fundamental shift in the pastoral care movement as it has been developing over the last decades" (p. 233). Anderson also claimed that this change is an accommodation to the surrounding society, which brings us directly to a consideration of the reason theology has lost its place in the contemporary practice of pastoral counseling.

Neoliberalism: Ground zero for the erosion of theology in pastoral counseling

Psychotherapists, including pastoral counselors, rarely pause to ponder their place and designated function in the larger society in which they practice. Unless we do this, however, we are condemned to become chaplains to the status quo, and particularly on behalf of any hegemony that happens to be in power. A consensus is emerging among some political theorists, economists, sociologists, geographers and theologians that the moral ideology and economic practices designated by the term neoliberalism represents the current reigning hegemony. It is the first hegemony in human history that can legitimately claim to be global in its reach. Known to the general public as simply "the free market," the threefold economic agenda of neoliberalism is free trade in goods and services, free circulation of capital, and freedom of investment (George,

[5] "The mission of the American Association of Pastoral Counselors is to bring healing, hope, and wholeness to individuals, families, and communities by expanding and equipping spiritually grounded and psychologically informed care, counseling, and psychotherapy." Available at http://www.aapc.org/home/mission-statement.aspx (Last accessed on June 20, 2012).

2000). It accomplishes this agenda through a trinity of instruments: deregulation, globalization, and technological revolution (Bello, Malhotra, Bullard & Mezzera, 2000). Socioeconomic consequences include the privatization of public wealth, suppression of fair wages, record poverty, and a global increase in economic inequality. Centeno and Cohen (2012) argue that neoliberalism may be viewed from three vantage points: economic, political, and cultural. With regard to the first two, neoliberalism collapses politics into economics, such that governments exist primarily to serve the economic interests of large corporations and wealthy individuals. The third vantage point, culture, reveals neoliberalism as a way of being that permeates society from the level of organizational management, the use of technology, the academy, the sciences, and the media all the way down to the level of "private" relationships and even the experience of self. Social consequences include unrestrained consumerism and radical individualism, both of which are required by "free markets" for the sake of efficiency and economic growth. Psychologically, neoliberalism yields what amounts to a new type of human being, distinguished by the fragmentation, discontinuity, and fluidity of the self (Dufour, 2001, 2008; Harvey, 1990; Rogers-Vaughn, 2012). This is associated with a global increase in the full range of what has come to be called mental illness: self-disorders, narcissism, depression, anxiety, addictions, etc., as well as the disruption of human attachment and relationships at every level (Alexander, 2008; Bauman, 2003; Dufour, 2001; Wilkinson & Pickett, 2009). In other words, the issues, which bring individuals, couples, and families into the counseling office, are both intensified and transformed by the impacts of neoliberalism.

Neoliberalism was actively promoted by the Chicago School of Economics under the leadership of Milton Friedman and quickly achieved political dominance during the 1980's under the tenures of Ronald Reagan in the U.S. and Margaret Thatcher in the UK. Its hegemonic

aspirations were sounded early on by Thatcher's slogan "There Is No Alternative" (TINA) (George, 2000). Observers often note that it has since achieved the status of a religion, with its naïve faith in the benevolence of the "invisible hand" of the market, its high priests in the banking and financial sectors, and its dissidents excommunicated as heretics (Bello, Malhotra, Bullard & Mezzera, 2000; Cox, 1999; George, 2000; Rieger, 2009; Thistlethwaite, 2010). Rieger asserts: "The problem is not secularization—as is often assumed—but a kind of hidden religiosity that promotes the worship of the gods of the free market" (2009, p.68). For the purposes of this essay, it is crucial to recognize that neoliberalism does not regard itself as just one of many ideological options, or even the dominant alternative, but as the one true way. Thus, as Bourdieu has explained, it aims toward "the destruction of all the collective institutions capable of counteracting the effects of the infernal machine" (1998, para.14). It does not accomplish this, as Dufour (2008) has argued, by the brutal and direct coercion demonstrated in prior hegemonies, but by dismantling institutions, acquiring their assets for its own agenda, and rendering them obsolete.

This includes, of course, the symbolic systems and practices of the world's religions. *Theology—the lingua franca of religion—thus becomes irrelevant at best, or, at worst, a marketing liability.* I wish to identify five separate effects that work collectively, under the paradigm of neoliberalism, to marginalize theology: (a) The rendering of religion into "spirituality," (b) radical individualism, (c) the substitution of treatment of disease for the care of souls, (d) the substitution of technologies of care for pastoral presence, and (e) the legitimation of pastoral counseling outside the domain of religious institutions and communities, ultimately finding its authority in the market itself.

The replacement of religion with spirituality is perhaps the most pervasive, effective, and malignant strategy neoliberalism uses to marginalize theology and neutralize its prophetic potential. I intend to be quite clear on this point: *In the context of global neoliberalism, spirituality is not part of the solution. It is part of the problem.* The history and troublesome societal role of contemporary spirituality has been convincingly documented by Jeremy Carrette and Richard King, who observe that religion has become increasingly privatized throughout the modern era (Carrette & King, 2005). The first phase of this privatization, they note, began with the Enlightenment. Thinkers such as Kant, Locke, and Schleiermacher *individualized* religion and sequestered it from the domain of politics, economics, and science. This was extended with the *psychologization* of religion in the early twentieth century by figures such as William James and Rudolf Otto, and advanced more recently by psychologists the likes of Gordon Allport and Abraham Maslow. The second and radical phase, which builds upon the first, began in the late twentieth century with the rapid expansion and strengthening of neoliberal economics, particularly since the 1980's. In this current phase, they argue, we are witnessing the *commodification* of religion. Carrette and King describe this process:

> Let us imagine that 'religion' in all its forms is a company that is facing a takeover bid from a larger company known as Corporate Capitalism. In its attempt to 'downsize' its ailing competitor, Corporate Capitalism strips the assets of 'religion' by plundering its material and cultural resources, which are then repackaged, rebranded and then sold in the marketplace of ideas. This reselling exploits the historical respect and 'aura of authenticity' of the religious traditions….while at the same time, separating itself from any negative connotations associated with the religious in a modern secular context (rebranding). This is precisely the burden of the concept of spirituality in such contexts,

> allowing a simultaneous nod towards and separation from 'the religious'. The corporate machine or the market does not seek to validate or reinscribe the tradition but rather utilizes its cultural cachet for its own purposes and profit. (pp.15-16)

This, finally, is the meaning of "spiritual but not religious." The consequence of this commodification is "spirituality," a de-traditioned substitute for religion, which works for neoliberalism by improving efficiency and extending markets, and for the individuals living within its domain by soothing the alienation, anxiety, and depression associated with the social conditions imposed by the free market. Neoliberalism distributes to its isolated inhabitants a "spirituality" tailor-made and marketed to their individual tastes—one which relieves them of the burden of the search for shared truth, the inconveniences of maintaining a common life, and the demands of social justice—all the while preserving the illusion that they are living their lives in accordance with "ancient wisdom." The final result, Webster (2012) states bluntly, is that "contemporary spirituality makes us stupid, selfish and unhappy."

Carrette and King observe that spirituality has become firmly integrated into the practices of healthcare, especially within the mental health field. And they offer a word of warning, with a special nod to pastoral caregivers:

> The introduction of 'private' models of spirituality can be a dangerous move, especially in the helping professions and pastoral care. In the very desire to cure the addictions of modern living, patients are offered models of 'spirituality' to provide greater meaning in an empty world. This capitalist spirituality, however, only increases private consumer addiction. It offers personalised [sic] packages of meaning and social accommodation rather than recipes for social change and identification with others. In this sense, capitalist spirituality is the psychological sedative for a culture that is in the process of

> rejecting the values of community and social justice. The cultural hegemony of this kind of spirituality grows as market forces increase and as neoliberal ideology is unhindered in its takeover of all aspects of human life and meaning. (2005, p.83)

This leads the authors to assert that spirituality itself "has become a new cultural addiction and a claimed panacea for the angst of modern living" (2005, p.1). *In light of such conclusions, a pastoral counseling that simply coincides with some type of "spiritually integrated psychotherapy" unwittingly serves the neoliberal hegemony, the very system, which is intensifying and multiplying the sorts of sufferings that bring people to psychotherapists.*

As Carrette and King have noted, contemporary spirituality is facilitated through the invasion and transformation of religion by individualism. Although modern individualism precedes neoliberal society by centuries, the conditions of late capitalism are pushing it to ever more radical extremes and using it to serve the interests of the elite. Rieger (2009) observes: "Individualism is…not just a myth; it is the myth of the ruling class, as it covers up the relations of power that benefit some and not others, and is thus quite effective and powerful" (pp. 83-84). Individualism, in turn, by its very nature, reduces the scope and power of theology, rendering it trivial at best or irrelevant and obsolete at worst. The individualism of contemporary pastoral counseling helps me understand what has remained an enigma throughout my career as a pastoral counselor. My observation is that pastoral counseling as a movement has thus far not been able to identify how theology contributes anything to psychotherapy with specificity anywhere close to the clinical usefulness of psychological theories and psychotherapeutic techniques. Pastoral counseling has demonstrated a relative inability, in my judgment, to offer explicit ways in which theology alters how counseling occurs, what it construes as problematic (diagnosis), or to what end it is conducted. Most of our "theological perspective" has been limited to reflection *after the*

fact, thus outside the therapy itself. And most often this is restricted to vague or abstract permutations along themes considered safe or appropriate for progressive theologians—grace, love, forgiveness, providence, etc. These are the sorts of conversations we usually have during certification interviews, supervision, and case consultations. Many times I have noticed, during such meetings, that we discuss the clinical material with a sophisticated level of psychological analysis, but when it is time to talk about the "theological dynamics" of the case we are reduced to somewhat banal non-specific observations such as "in that moment the client was experiencing grace," or "he is searching for a sense of transcendence," or "she lacks a recognition of providence." Furthermore, there were whole areas of traditional theological concern rarely even mentioned, such as judgment or righteousness or what has often been understood as the prophetic (as opposed to the priestly) functions of faith. In these meetings I would often look about the room and notice that it was largely filled with individuals holding graduate degrees in theology, often at a doctoral level and frequently from some of the most prestigious schools, and I would find myself wondering, "What is going on here? Why are we talking like this?"

We have, it seems to me, been limited in ways that suppress our identity and betray our theological sophistication because of our individualistic assumptions. We therefore have reduced diagnosis and process to what is happening intrapsychically or interpersonally. If we expand our understanding of diagnosis and process to the individual's *social* world—including the economic and political environment—something else happens. And this something else is more congruent with the classical concerns of theology. This has been noted by theologian Edward Farley (2003):

> With the diminution of the great structures or entities of authority (church, holy book, dogma) as a priori locations and expressions of Gospel, contemporary Christians have more and more searched the region of the individual (the individual's religious experience, piety, existential cry, story) for a way of providing Gospel language with a reality base. *The artificiality, if not failure, of such attempts is due to the fact that the symbols of Christian faith (sin, redemption, hope, church, redeemer, God) refer more to realities that occur between rather than in human beings*. That is, human beings experience the realities and power of Gospel by having to do with each other in certain ways. (p.156, emphasis added)

It seems that Farley would suggest that our theological reflections in pastoral counseling have drifted toward the vague and banal because we have committed a category error. We have taken terms that traditionally refer to *social* realities and squeezed them into the tiny worlds of the psyches of individuals and/or into their private, intimate relationships (including their therapeutic relationships). These terms are simply not happy in these tiny habitats. Their original meanings might not disappear altogether in these environs, but they are certainly eroded to the point they have become mere shadows of their former selves. I am convinced that the modern pastoral counseling movement, with few exceptions, has been committing this error virtually from its inception. We have, it seems to me, finally pursued this approach to exhaustion. Unless we free these "words of power" (Farley, 1996) from the little cages in which we have confined them all these years, we will discover that we continue having the same old conversations over and over, with little additional light to shed.

Two of the three remaining effects, like individualism itself, existed prior to the advent of neoliberal domination but have been both extended in scope and strengthened through their

absorption into the neoliberal agenda. Thus their new transformations may reasonably be considered a consequence of neoliberalism. These effects—the dominance of the disease (or medical) model and its accompanying reliance on technologies of care—have themselves achieved a near-hegemonic status in the psychotherapy industry within just the past three decades. Indeed, Wampold (2001) wrote his controversial book *The Great Psychotherapy Debate* largely to document and contradict this development. The publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) in 1980 heralded the current dominance of the disease model within psychology and psychotherapy. If the timing of this document is coincidental, appearing simultaneously with the beginning of the rapid rise of neoliberalism (and the election of Ronald Reagan), it is surely nonetheless significant for the subsequent synergy between prevailing economic ideologies and practices and those of the mental health field. The fourth edition of the *DSM* (1994) brought even more afflictions within the territory of disease, and the soon to be published fifth edition promises more expansion. With these authoritative publications vast domains of human suffering—depression, anxiety, PTSD, ADHD, bipolar disorder, addiction, etc.—were defined as disease entities ultimately having their origin *within the individual.* Thus the extension of the disease model to the explanation of virtually all psychological suffering now functions to protect the free market from the possible accusation that it is causing untold suffering to individuals and communities. It allows neoliberal establishments and interests to *blame the victim.* The individual is perceived as either unlucky or as having refused to accept responsibility for improving her own mental health. In either case the free market appears as benevolent and indispensable as ever.

Pastoral counseling has found it necessary to adopt, or at least accommodate, the prevalence of the disease model in order to compete in the psychotherapy market. By doing so it

risks leaving behind the care of souls in order to address pathology, dysfunction, and disorder. The care of souls, we must recall, did not focus primarily on pathology. Rather, it attended to conditions of the soul, which had to do with what was believed to be the proper orientation of the self toward God, others, and the created order (McNeill, 1951). Its concern ultimately lay, for example, with the commitment to love and to social justice. Theology was the language and symbol system that communicated such orientations and commitments. The displacement of the care of soul in pastoral counseling by the contemporary preoccupation with disease (dysfunction, disorder, pathology) therefore *serves to marginalize theology and render it senseless.*

The emphasis on technologies of care to treat psychological conditions, mirroring the application of technologies to the care of the body, is the natural companion of the disease model. Such technologies include, of course, psychoactive medications and emerging clinical techniques such as hypnotism, EMDR (eye movement desensitization reorganization), and TMS (transcranial magnetic stimulation). They also include, in the now familiar age of managed care, the coupling of *DSM* diagnoses with psychotherapeutic "empirically supported treatments" (ESTs), typically the various methods of cognitive behavioral therapy (CBT). As useful as such technologies may be in given clinical situations, the problem is that responses to psychological suffering lying outside these technologies have increasingly been seen as illegitimate or even fraudulent. The appropriate response to such suffering is now *treatment,* which is completely identified with technological methods and clinical techniques. While Szasz (1961/2010, 1978/1988) was an early opponent to applying the disease model and its technologies to psychological suffering, others have recently been adding their voices to an ever-expanding chorus (e.g., Elliott & Chambers, 2004; Greenberg, 2010; Horwitz & Wakefield, 2007; Whitaker, 2002, 2010).

The technologies of care, as it turns out, just happen to accord quite well with the expectations and needs of free market society. The engine of such a society runs on *efficiency*, which depends on the quick correction of anything that impedes production and consumption (the market's way of understanding disease or dysfunction). The technologies of care, therefore, intend above all to restore functioning with haste. There is little patience for any recovery that requires time. Those who cannot become well quickly are soon relegated to the status of what Bauman (2004b) has called "human waste", people who are of no use for either production or consumption.

Again pastoral counseling, under pressure to survive in the marketplace, has been forced to accommodate. Thus technologies of care have progressively replaced what was once deemed *pastoral presence.* Oriented to the purposes of "healing, sustaining, guiding, and reconciling" (Clebsch & Jaekle, 1983), pastoral presence valued *wisdom* over technical knowledge. Wisdom, practical insight into the proper relations between the self, God, fellow humans, and the world itself, was acquired over time, perhaps even a lifetime. Its relationship to discrete circumstances, moreover, occurred through a process of discernment, which also occupied time. The emphasis was not on efficiency, but *sufficiency.* Much of this wisdom, in contrast to contemporary technologies of care, focused on forming proper relationships with what could not be changed—particularly matters concerning finitude and death. The rest attended to the personal and social changes needed to bring human beings into accord with the ways of God. This included, importantly, a prophetic critique waged against interpersonal and social injustice. This is about the last thing contemporary technologies of care will be caught doing. Thus the vast majority of psychotherapists, including pastoral counselors, do not see social injustice as falling within their professional responsibilities. Once again theology is marginalized. *If compliance with the*

ideology of the disease model renders theology senseless, accommodation to technologies of care renders it useless.

The final effect, the legitimation of pastoral counseling from outside the sphere of religion, is a direct consequence of neoliberalism's dismantling of traditional social institutions. For some time the decline of mainline Protestant churches was widely interpreted as a function solely of something endemic to those congregations and denominations. Recently, however, we are witnessing declines in evangelical, charismatic, and other conservative religious groups. Were it not for immigration Catholicism would be declining in the U.S. as well (Bass, 2012, pp. 11-20, 43-63). The marginalization of religion in free market societies means that professional pastoral counselors must seek legitimation elsewhere or else resign themselves to cultural and professional irrelevance. In the U.S. this has typically come to mean state licensure. Except in rare circumstances where states license pastoral counselors, the education standards established for professional licenses exclude any type of theological preparation. Academic programs in pastoral counseling that have survived have had to design their curricula to meet these standards. Given the reluctance of students to engage in graduate education programs of more than two or three years duration, this explains why programs such as the one at Loyola have largely dropped courses in theology. The disappearance of theology from training in pastoral counseling is producing cyclical erosion in which theology becomes more and more unnecessary.

What is at stake here? Perhaps bemoaning the erosion of theology in pastoral counseling is simply a nostalgic longing for "the good old days." The claim that radical free market ideology and practice is now grounding both a dramatic increase in psychological, relational, and social distress, as well as a diminishment of religion and theology, suggests otherwise. Something malevolent is at work here. While neoliberalism does not display forms of control as

unconcealed or as brutal as past hegemonies, it is the first one that is global in reach. It is also arguably far more effective in manipulating the internal lives of individuals and in fragmenting cultures and communities. The consequence is that we are witnessing an unprecedented loss of life and a diminution of meaning for the survivors, and perhaps even for the winners. Unless pastoral counseling recovers and strengthens its capacity for theological reflection we will unwittingly find ourselves in the service of this new imperialism. In other words, we will have lost our prophetic resistance to social injustice.

Describing precisely why and how theology grounds prophetic resistance to neoliberalism lies beyond the reach of this essay. For now I must simply observe that the idiosyncratic philosophies, activities and identities of isolated individuals are powerless to oppose a globally entrenched hegemony. Successful opposition to social structures, as always, will require *collective* resistance. Moreover, Couldry (2010) has persuasively argued that neoliberalism suppresses the narration of human existence, an activity he calls *voice*, and that resistance will necessarily involve the restoration of voice. In effect, Couldry points to the critical role of *meaning* in resisting neoliberalism. Neoliberalism, as I have already argued, suppresses both collectives and meaning. *Religions, I contend, are essentially historical communities of meaning. And the language of their collective narratives—their voice—is theology*. In my judgment the most promising recent theologies for prophetic resistance are those that (a) critique the ways in which theology often colludes with neoliberal agendas, and (b) draw upon religious narratives concerning idolatry and redemption to oppose systemic domination. Such an approach appears in the work of current scholars who are revising liberation theology toward the repudiation of neoliberal culture (e.g., Míguez, Rieger, & Sung, 2009; Rieger, 2007; Rieger & Pui-lan, 2012; Sung, 2007, 2011). I am particularly fond of Rieger's work (1998,

2009), which also uses Lacanian psychoanalysis to assert that resistance must go beyond conceptual discourse and address unconscious layers of desire.

Conclusion: Does embracing best practices mean the end of the care of souls?

Historically, pastoral counseling has been understood within the tradition of the care of souls. Lately the term *soul* has appeared to fall into disrepute, leading pastoral theologian Herbert Anderson to ask: "Whatever happened to *Seelsorge* (the care of souls)?" (Anderson, 2001b). While Anderson attributes the disappearance of the term from contemporary theology to its association with dualistic (body vs. soul) thinking, I suspect it also involves the current aversion to essentialist thought. For many "soul" connotes a substance or essence of the human that is eternal, universal, and beyond history. I share the opinion that dualistic and essentialist views of soul are no longer helpful. However, I believe the idea of soul deserves retrieval and reframing. First, even though many theologians now avoid the term, it remains in broad use in cultural literature, both in popular (e.g., Moore, 1992) and academic (e.g., Rose, 1999) settings. This presents an opportunity for theology to improve its standing as a public discourse. Second, such retrieval may counter the radical individualism within the neoliberal paradigm, including the individualistic assumptions that appear to swirl around alternative terms such as "spirit" and "spirituality." Third, this reframing might oppose neoliberalism's suppression of the category of transcendence, the near-elimination of the conviction that there may be a value more ultimate than the discrete agendas of both the "sovereign self" and corporations. Finally, a retrieval of the notion of soul promises to help reorient the identity and role of pastoral counseling for our time.

While self may be considered generally as individual self-consciousness and agency, I understand soul as a dimension of self, namely the capacity, or better, the *activity*, of self-

transcendence. But what sort of transcendence is intended here? Theunissen (1977/1984) identifies two strands within Western philosophy that attempt to account for relationship between self and other. Each implies, in my judgment, a quite different idea regarding self-transcendence. The first, which Theunissen calls "the transcendental project" (pp.13-163), originates in Descartes and finds articulation in Husserl's philosophy. Here self-transcendence is both *rational* and *individual.* It is a movement in which the individual, in an imaginative act of reason, exits herself and observes her own thoughts, feelings, and processes. It is thus objective and *objectifying*. Relation to the other is then mediated through an idea or image of the other constructed within this act of reason. My belief is that this project is congruent with understandings of knowledge as dependent on vision or "insight," which Ihde (2007) refers to as the "visualism" that has dominated Western philosophy since the ancient Greeks (pp. 6-13). In this instance self-transcendence appears as an activity of solitary individuals, and is fully compatible with the neoliberal paradigm.

An alternative understanding of self-transcendence is suggested in what Theunissen calls "the philosophy of dialogue," most completely developed in the thought of Buber (Theunissen, 1977/1984, pp. 257-344). Here self-transcendence is dialogical and intersubjective. It arises within what Buber (1947/2002) identifies as "the between". Self-transcendence occurs not from some neutral standpoint within an individual's rational act, but *from the standpoint of relationship with the other*. It appears as a form of knowledge that is intrinsically relational and, according to Ihde's typology, is *auditory* rather than visual (Ihde, 2007), depending on *listening* and *speaking.* This self-transcendence is an intersubjective, *social* act, and cannot be achieved by isolated individuals. It lies outside cost-benefit calculations and concern for efficiency, and thus is fundamentally incompatible with neoliberal culture. This is most apparent in what Johann

(1966) calls "disinterested love." "When love is interested," observes Johann, "when the attraction is based on a motive of profit or need, it has no difficulty in finding words to justify itself." Disinterested love, however, cannot explain itself: "Why do I love you? Because you are—*you.* That is the best it can do. It is indefensible" (p.19, emphasis in original). *It is this sort of love, not the "interested" attachment of romantic love or desire for benefit, which forms the heart of authentic soul.*

It is precisely soul in this sense that is crushed by neoliberal agendas. Attributing the erosion of dialogue to "the totalizing capacity of modernity-cum-capitalism", Brueggemann (2012, p. 29) concludes:

> The loss of dialogic articulation, rendered impossible in modernist rationality, has led to complete abdication of dialogic capacity….Either *cold absoluteness* or *totalizing subjectivity* leaves no possibility of mutual engagement of the kind that belongs to dialogic speech and life. (2012, pp. 26, emphasis in original)

Similarly, Dufour (2008) argues that life under "the Market" eliminates transcendence and non-utilitarian relationships (pp. 64-70). Furthermore, he contends that it is so efficient in this reduction that it has created a "historic mutation" of human being (p.13).

What this suggests is that soul, the activity that holds individuals in relation with self, others, and God, has all but disappeared. This should be of grave concern to any who are inheritors of the care of souls tradition. The human values, capacities, and experiences that were once the foci of pastoral care have become dispersed, diffuse, and perhaps even absent. Are we now increasingly caring for souls that are no longer there? Have we not now become T.S. Eliot's "hollow men" (1925/1930-1970), zombies of our former selves? Indeed, whereas Haraway (1985) once celebrated the "cyborg" as a version of liberated humanity, it seems now to have

become the mindless, machine-like fate of vacuous servitude to capitalist consumption and "flex worker" production. Thus Turkle (2011) laments: "We are all cyborgs now" (p.152). Both self and other are commodified and reduced to an object, an "it." What remains is a relationship Buber might not have imagined: not an "I-Thou" or even an "I-it" relationship, but an "it-it" relationship.

By re-grounding themselves in the care of souls, pastoral counselors can push back against this commodification of self and relationships. However, I must now mention two corollaries of the notion of soul. Otherwise I fear I will leave myself open to misunderstanding, as well as fail to clarify important characteristics of soul that have critical clinical implications. First, to speak of soul is to oppose all forms of fragmentation or compartmentalization that would otherwise create an absolute distinction between the care of souls and other types of care. To care for soul, for instance, resists the division of human beings into body, mind, and spirit. *Soul refers to whole, embodied persons, but this means persons as oriented toward and in loving communion with self, other, world, and God.* Care for soul, therefore, does not exclude needs and desires with regard to body or mind. Rather, it places these needs and desires in the context of this encompassing communion. Thus care of soul includes, in Jesus' words according to Matthew, "whoever gives even a cup of cold water to one of these little ones" (Matt. 10:42, NRSV). This means, obviously, that pastoral counseling is only one form of the care of souls. But it also means that *any* act of care motivated by love and the desire to increase or preserve communion constitutes care of soul. Pastoral care therefore has no monopoly on soul care. It does not even belong to Christianity, or any other religion for that matter. Pastoral caregivers, however, are obligated to the care of soul as their *primary* responsibility.

Care of souls, moreover, resists the compartmentalization that would separate the care of individuals from the care of society. Because this sort of care arises from and gives itself to the matrix of a loving communion, it does not countenance an estrangement between self and society. To refer to soul requires a refusal to accept that there are only individuals (vis-à-vis Margaret Thatcher[6]) or that there is only society (i.e., that human beings are mere constructs of society). Soul, we might say, is not subject to the individual versus society binary. It represents a viable *third way.* Within this third way the *individual* as we have come to think of the term—as a person separated from his or her social fabric—does not exist.[7] If we attempt to temporarily remove a person from this fabric for observation, then what we are observing bears no resemblance to a human soul. Persons exist, in the metaphor proposed by Miller-McLemore (1996), only within "the living human web." In Macmurray's terms (1961/1991), there are only persons as persons-in-relation. Viewed from the opposite direction, society is not a human society without persons. A society without personal agency is reduced to being a *hive mind.* Finally, what soul adds to this is that *communion* is a particular sort of social fabric—one knit together by what Johann (1966) calls *disinterested love.* A social fabric woven from any other form of power is simply utilitarian at best and, at worst, is oppressive and even hegemonic. Pastoral care, because it is the care of soul, is obligated to resist any force, whether emanating from social structures or personal agency, which would weaken or dissolve the fabric woven by love. Thus any form of soul care, including pastoral counseling, maintains a prophetic role in

[6] Thatcher famously insisted that there was "no such thing as society, only individual men and women" (Harvey, 2005, p. 23).

[7] This is, in my understanding, the basic meaning of H.S. Sullivan's controversial essay, "The Illusion of Personal Individuality" (1944/1964). Sullivan does not appear to deny personal agency, and in his writing frequently spoke of personality as an "enduring pattern." However, in this essay he asserts that speaking of an "individual," a human being that can be observed in isolation from interpersonal relations, language, and culture, is impossible. Within the essay Sullivan professes a fondness for Whitehead's word *nexus* as a fair description of the place in which humans exist as humans.

relation to whatever threatens the integrity of this communion. Consequently, there can never be a separation between pastoral counseling and social justice.

The second corollary, in addition to this resistance of fragmentation, is that soul requires a transformation of *desire.* The "free market" reduces human desire to a longing for goods and services, to what can be consumed. In neoliberal society this type of desire is what is given, what is perceived as normal (Sung, 2007). From the perspective of soul, however, desire is a persistent longing for *communion* (loving reciprocity) with self, other, world, and God. It is crucial, in offering pastoral care, to recognize two indelible features of this soulful desire. First, *what* soul desires—communion—cannot be provided by the market. This form of relating cannot be packaged, traded, sold, commodified, promoted, or otherwise "marketed." This is inherently the case, if for no other reason, simply because it cannot be objectified. Soul desires what, in a phrase economists sometimes use, is *external to the market.* This holds true as well for those realities theological reflection construes to be dimensions of this communion, such as faith, hope, and love. The market might and does offer fraudulent versions of these realities. If faith is reduced to *beliefs,* cognitive constructs that comfort or inspire, then it can be packaged and promoted. But if it is thought to be *trust,* as many classical theologies have claimed, then it is external to the market. If hope is reduced to *optimism*, this also can be marketed. We may, for example, package sophisticated workshops on "positive psychology" and sell them to psychotherapists and the public. But if hope is an *openness to the future* rooted in the trusting posture of faith, then it is off the market. If love is cozy affection for my intimates or people like me or those from whom I may benefit, then it too can be heavily promoted. But if it is a respectful and even sacrificial regard or appreciation for those different from me, much less an

obligation to them, then it has no market value whatsoever. What the market substitutes for these three realities are now "big business." But they are not what soul desires.

Second, *how* soul strives toward what it desires cannot be informed by the methods or techniques of the market. Advertising, in all its overt and covert manifestations, has developed ways to create, manipulate, and morph the desire for goods and services. It has learned to bend both cognition and emotion in its methods of promotion and propaganda. The desires of soul are, however, *vulnerable* to the market's methods, but only if it can succeed in corrupting these desires, transforming them into a longing for certain attributes that can be delivered by goods and services. The market can teach, cajole, shame, inspire, or seduce the consumer. What it cannot do is *love* the consumer in the *disinterested* way that I have previously discussed. And it is only the echoes of such love that can fan the embers in the heart of soul, thus encouraging soul to strive for what it desires. In the language of the Psalms, soul's desire grows into awareness and is strengthened as "deep calls to deep" (Ps. 42:7, NRSV). This has profound clinical implications. Technologies of care, such as cognitive or behavioral approaches that endeavor to teach or instruct at a conscious level, cannot hope to touch soul. As Rieger (2009) has observed, "…desires cannot easily be controlled and redirected on the conscious level, neither through the well-meaning adoption of a new set of rules nor through the training processes that go into the formation of habits" (p.115). What we can do is to form caring relationships, co-creations of intersubjective space in which we patiently and in a disciplined fashion listen for the reverberations of soul, carefully attending to the resonances that emerge. We have no techniques for creating them, but we can attend to them and respond to the timbres of soul when they whisper to us. Once heard, these echoes can be magnified, and our attention to them can be

nurtured. Only then can it become a "resisting desire" that pushes back against the "consuming desire" of the market (Rieger, 2009, pp. 89-121).

This last point brings us full circle back to a consideration of *best practices.* If what I have been describing regarding soul holds any truth, then pastoral counseling cannot be considered merely as a *provision of a service*. It is more about attending to soul than it is the exercise of a set of techniques that can be replicated. I am not suggesting that skill development has nothing to do with this, but my experience suggests that the vast majority of skills have more to do with *staying out of the way*, with not distracting from the process, than they do the *art of pastoral presence*. I have managed to find ways, in supervising pastoral counseling students, to help them develop methods and techniques for catching themselves not paying attention to what is going on. This is not an insignificant achievement. I must confess, however, that I have not been as successful in teaching students how to be present. I have finally come to believe this essentially cannot be taught. The aspiring pastoral counselor must, by fits and starts, by errors and omissions and recovery, find her own way. On a good day I manage to be present to people more than I miss them. But I cannot, by teaching the student to imitate my way, teach her how *she* can be present. This is, I believe, because genuine presence is as unique as the self that is present. It is a non-repeatable event. To make matters worse, presence is a moving target. What "works" with one person or at one time does not "work" with another person or at another time. Presence, therefore, is another of those values that is external to the market. It is perhaps best to consider it as another dimension of communion, of disinterested love. As such, the activity of authentic presence is as unique as the relationship in which it occurs, and as the moment in which it transpires.

If pastoral counseling is irreducible to the provision of a service, and if it rests fundamentally on the event of presence, upon listening for the resonances of soul, then it cannot be encompassed by a set of skills referred to as *best practices.* After all, a best practice is a resident of the market, and connotes a discrete skill that can be packaged, promoted, and taught. Like a McDonald's *Happy Meal,* it can be replicated and is similar in every place and on every occasion. Soul, on the contrary, inhabits a space beyond the reach of the market. Pastoral counseling, if it is true to the care of souls, actually constitutes a form of protest against the commodification of relationships. Training for this caring art will necessarily go beyond skill development to include *character formation.* However, if we remain on the path we are travelling, a path that remains safely upon the neoliberal terrain, we will continue to strive for a "spiritually integrated psychotherapy" which attends to an individualistic version of transcendence that replaces soul rather than strengthens soul. If we succeed in this journey, I fear professional pastoral counseling will likely never push back against the global empire of our time. And if we finally do manage to encapsulate pastoral counseling within a set of *best practices,* we can be sure that it has come at the cost of ignoring soul, and perhaps of losing our own.

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Playful Self-Discovery

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Abstract This article explores the benefits of play as an experiential process to enhance knowledge and awareness for care and counseling professionals. An examination of pertinent literature undergirds the analysis in this exploratory essay. The writing considers resistances to and opportunities for play as a freeing spiritual and self-care practice. As a perspective-altering and soul-renewing activity, play sustains care practitioners for the work of ministry.

Key Words Play theory, Ministerial identity, Spiritual and self-care practices

One spiritual teacher asserts that whole-hearted play has the power to transform our lives (Katagiri, 1998). What would it be like to experience play-induced change at the cellular level of our lives and not just hold this possibility as an abstract proverbial truth? Play as transformative activity immerses us in the fullness of experience, by plunging in, taking leaps, and forgetting ourselves. In playful abandon, we let go of our usual habits of ego-based control in order to access dimensions of energy that seem otherwise unavailable in daily life. This, I think, is the interesting thing about play: it cuts through illusion, even though the word illusion in Latin means 'in play.' In play, we see through the 'games' and 'tricks' and 'folly' of so-called normal life. We might wonder, then, what is really real?

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Imagining play as an immersion into life, or an entering into who we really are, suggests many possible practices. Thoughts of immersion into life may simultaneously scare and entice. We might have to think about and anticipate play for a while before we actually allow ourselves to engage. Yet our choosing of life-giving practices, when appropriate for us, can foster resilience and endurance for meeting the emotional and psychological demands of care and counseling. Care givers often take their work very seriously and give of themselves generously. The danger is not that we give too little, but that we give too much. To support our ministries of care, we draw on the deepest aspects of ourselves. When this occurs in the rhythm of a generally satisfying life, then all is well; otherwise, we may teeter precipitously close to burnout.

When over-burdened and on the verge of going over the edge, we take mental flights of fancy in our care ministries as either a conscious or unconscious escape. When aware of this tendency, we can make adjustments in our schedules to accommodate real play, not just thoughts about it that detract from thoughtful availability in listening (Justes, 2006). When we take mental flight while listening to others, and find we have missed whole segments of their story, this indicates a need for our own soul tending.

This pastoral theological essay invites pastoral and spiritual caregivers to play as a means of self-discovery that, in turn, can foster renewed vitality in ministries of care. Several themes weave throughout this article that focus centrally on means to encourage and sustain play as a creative spiritual practice in the lives of pastoral ministers. As theological practitioners, we participate in the well-being of creation as we tend to practices that open us to wonder and delight.

Starting points for play

Definitions of play stimulate our thinking on the topic. In my book on play, I offer the following definition: "Play as embodied theology is cooperative engagement within self and between self and others that heightens enjoyment of God and pulls more deeply into life experience; incorporates the new and innovative within already structured patterns of behavior; and, allows for making mistakes as we develop creative, and sometimes previously unimagined, pastoral leadership practices" (Koppel, 2008, p.14). This definition highlights the religious dimension of play as a capacity that fosters personal expression and enhances interpersonal relationships. During my early years teaching pastoral theology and care, I developed a much shorter definition: "Play as structuring chaos" (Koppel, 2004, p.257). This more simple naming of play emphasizes an ongoing intention to work within any given environment or situation to bring emotional and intellectual skill to influence an outcome. Structuring chaos is one way to name what care ministries and counseling often *feel* like. Taking time off from work and allowing ourselves to enter fully into unscheduled day can feel like structuring chaos.

Contours of play

We can work at definitions of play only to discover that precise naming may never quite fit experience. Insights from scholars fuel reflection on play's complex meanings, and hopefully extend thought. Nuances of play theory inform the development of our own definitions as seen below.

D.W. Winnicott (1971) argued that we live in the space between subjective and objective experience, constantly negotiating internal object and external phenomena. Play

involves the negotiation of this intermediate, in-between, or potential space between self and others based on the pattern established between mother and infant in the earliest stages of development. This "third area of experience" which is neither fully internal nor external names the "space where we live" (1971, p.14 & p.104). Our whole lives involve play as we traverse this tension-filled and paradoxical space, bridging the gap between as we negotiate, create, and make meaning through a multitude of forms such as art, culture, ritual, and music. Further, Winnicott suggests that the practice of psychotherapy with children is "the stuff of playing" as a therapist makes room for what he calls formless experience and creative impulses (1971, p.64). Winnicott imagined therapy itself as play, an avenue to self-discovery. The therapist witnesses and reflects back these creative impulses to the child so that they might take root in the organized personality. As caregivers, we similarly open ourselves to our own formless experience in play. As we are present to and able to tolerate what is not yet fully formed within us, we become midwives to our own souls (Guenther, 1992). When we let formless experience linger and as we pay attention, it eventually seeps into conscious awareness.

Johan Huizinga (1955), a social anthropologist, suggests four distinct characteristics of play: it is *voluntary activity*, which means that persons should never be forced to participate, and that play always maintains an aspect of freedom (p.7; italics added); it is a move *outside of real life* into a realm and "disposition all its own," which means that play is an "interlude" to daily living (pp. 8-9; italics added); it requires its own *separate, defined territory*, which means that play occurs in those spaces and settings that are clearly marked out for this activity (p.9; italics added); and finally, it *creates its own order*, which means that play operates by a structured reality governed by its own

internally consistent rules (pp.10-11; italics added). Play is an activity mainly for our enjoyment and pleasure, a "superfluous activity" not necessary for our existence (p. 8). Huizinga is largely concerned with the various ways that the play-form—by which he means the four distinct characteristics of play noted above—manifests in culture (p.46). Huizinga's analysis names social and cultural attributes of play, as distinct from Winnicott's interpersonal and intrapsychic description of play. Several aspects of Huizinga's theory, namely the way in which play emerges from our own free choosing and creates its own order, influence my definition.

Hans-Georg Gadamer (1989) approaches play from a philosophical perspective, describing how "play" occurs between a subject and an object that can be either animate or inanimate, such as a work of art (pp.101-134). Gadamer contends that the "to and fro movement" of play, not the achievement of a goal, is of importance (p.103). Play, in Gadamer's view, springs effortlessly from the experience of living beings (p.103). Play is not an activity that we do, but an experience that we live: "The being of all play is always self-realization, sheer fulfillment, *energia* which has its *telos* within itself" (p.113). Giving ourselves to play has an internal logic or sequence of its own as play's purpose unfolds in our playing. Gadamer's useful phrase "to-and-fro movement" captures what it feels like to be engaged in play.

Psychologist Brian Sutton-Smith (1997) examines play across many disciplines to demonstrate how it takes on a complex and ambiguous set of meanings. Sutton-Smith develops a perspective on play that he names "adaptive variability" (p.221). Adaptive variability refers to play's capacity to activate latent potential, to provide the energy that

affects the ability to engage other life activities, and to increase the ability to respond to change.

Play as adaptive variability is characterized by its quirkiness, redundancy, and flexibility (Sutton-Smith, 1997, p.229). Quirkiness broadly characterizes such phenomena as the seemingly chaotic and unpredictable movements of animals at play, to the nonsense of children at play, to the nature of sports and games of contest. Redundancy refers to the useful function of repetition involved in play. Redundancy or reproduction produces a kind of extra capacity for whatever uses the person or community deems necessary. Flexibility is the foundational principle that generates both quirky variability and multiple redundancy. In play, flexibility allows both for initially learning patterns of behavior and also for repeating them. Sutton-Smith, building on the work of biologist Lewontin, offers six psychological hunches about the purpose and function of play (p.229). First, in play human beings may "actualize" what are previously only "potential brain and behavior connections" (p.229). Play stimulates our unrealized potential. Second, in play we are optimistic, self-aware, and responsive (p.230). Third, play enhances the variability of cultural expression in human society (p.230). Fourth, skills acquired or exercised in play may be transportable to other areas of life; this is the 'trickle down' element of play (p.230). Fifth, play provides the necessary conditions for that which would otherwise remain nascent in human life (p.230). Finally, the variability of play reinforces our capacity to live with a greater degree of flexibility and adaptation in our daily living (p.230).

Sutton-Smith's theory of play underscores its complexity and elusive nature, and opens rather than closes the discussion on play's many meanings. Sutton-Smith

highlights the adaptive function of play, how it provides enjoyment, stimulates growth, awakens the wonder of childhood in adult life. In play, we both mimic and mock life as we exercise our capacity to survive and thrive in the world.

Fresh mind in play

The literature on play with its multi-faceted descriptions helps inform a perspective at the heart of religious traditions such as Christianity and Buddhism: to yield to what I call a "fresh mind for knowing" in every moment of existence. In the Christian tradition, this attitude is reflected in Jesus' words as recorded in Luke's gospel (18: 16-17, NRSV): "Let the little children come to me, and do not stop them; for it is to such as these that the kingdom of God belongs. Truly I tell you, whoever does not receive the kingdom of God as a little child will never enter it." In the Buddhist tradition, this perspective aptly named "beginner's mind" is captured in Shunryu Suzuki's (2006) poetic assertion: "In the beginner's mind there are many possibilities, but in the expert's there are few" (p.1). Play can help develop and exercise our capacity of "fresh mind for knowing" as we ask questions and reflect on our lives with curiosity and wonder. Play opens us like children who have not reached conclusions about how the world 'should' or 'ought' be, but rather receive it as a gift to behold. Beginner's mind is also connected with the Christian concept of *kenosis* or self-emptying. We do not reach this 'place' by thinking our way there through rational thought alone, but also primarily through non-rational practices such as contemplative prayer and meditation that allow for release of conceptual knowing.

As adults, we develop a proclivity to move toward familiar patterns and routines. We tap the well of life so that we do not become prisoner to the grip of predictability. Such fresh 'not-knowing' carries situation-altering power as we discover on the playground of our own choosing what nurtures and sustains health and well-being. Play offers experiential conditions that can make this open-hearted and curious perspective more available. Play, in a sense, is therapy that increases our soul size (Loomer, 1976).

Respecting resistance

We find it difficult to allow ourselves to play. Resistance—or what I like to call internal roadblocks—can halt our participation before we even begin. Instead of continuing to build up the internalized roadblocks to play, though, we can respect their presence, and by so doing, learn what it is that stops us from playing. Respecting resistance means that we exercise compassion for ourselves, and learn to maneuver around the blocks to discover an opening of the way.

Let's consider some of the resistances to play: 1) we constantly think about work and items on our 'to do' list. Many of us carry a mental checklist in addition to or substitute for an actual written list. We don't have enough time to play because we have so much work to do. Yet, it almost seems too trivial to acknowledge that life proceeds whether or not we accomplish all of our 'to do' tasks; 2) our sense of identity is often associated with and tied up with the productive tasks of lives and work. We may closely connect who we are with what we do, placing less emphasis or even no attention at all to the "being" or "non-doing" aspect of our identities. We like experiencing ourselves as productive and purposeful. In play, we lose ourselves only to find ourselves anew; 3) we

undervalue play because our religious communities, our culture, and places of employment often minimize, ignore, or dismiss its benefits. We take in the customs, norms, and expectations of so many external authorities that we do not even realize the deadening effect that normalized routine can have over time. The oft-cited phrase, "We've always done it that way" quickly hardens into "It has to be this way." We undervalue play because creative energy both excites and frightens us; 4) we have difficulty setting aside any role, whether in personal or professional life. Play can be unsettling for adults accustomed to rules and social customs that define what needs to be done and how to do it. Play can take us out of our comfort zone, leaving us exposed and feeling incompetent; 5) we think and feel that we do not deserve to play. We resist play because of the constantly nagging internal messages that we aren't good enough or ready enough. We work ourselves to exhaustion and then only begrudgingly acknowledge that there must be some other way. In this form of resistance to play, we unwittingly reinforce to ourselves and communicate to others that pain must always precede any experience of pleasure, if at all; 6) we want quick results from everything, asking "What can play do for me?" We resist play because we want first to know the material benefits. Allowing ourselves to play is difficult because we turn the experience into a self-improvement or improve others project, rather than letting it be what it is.

I have learned to respect my own resistance to play. Attempting to push through resistance is like careening through a roadblock: we can damage ourselves in the process. Or pushing through resistance may be like driving into heavy snow: that which we resist becomes compacted. Resistance may be eased as we neither maneuver around nor crash through it, but simply learn to see ourselves clearly and *to stop trying so hard*. Resistance

teaches us something about ourselves. We value being a "somebody" with an identity and purpose because we know our place in the world. In play, we relinquish this status of being a somebody and enter into the unknown of being a "nobody" or a person like "everybody" else as we become absorbed in the flow of existence, taking delight in sheer being itself, unburdened of the need to prove ourselves, to work through our own or other peoples' projections, or to respond to needs and expectations.

Knowing ourselves as fully alive

The words of a spiritual director colleague echo: "May I respectfully remind you that life and death are of supreme importance. Today your life is shorter by one day." Dying becomes a teacher for life and for all its playful possibilities, as a wake-up call to live more deeply, and not to waste ourselves in superficial pursuits.

Play as soulful self-discovery allows us to experience ourselves as fully alive. Ann Ulanov offers a helpful distinction between 'aliveness' and 'deadness' in the Self. Ulanov (2007) writes: "Aliveness comes down to one thing—consenting to rise, to be dented, impressed, pressed in upon, to rejoin, to open, to ponder, to be where we are in this moment and see what happens, allowing the breath of not knowing to be taken, wanting to see what is there and what is not there. Aliveness springs from our making something of what we experience and receiving what experience makes of us" (p.15). Deadness is the opposite of aliveness, and can be variously named as "no zest, crippling anxiety, a hole in us from something done to us that should not have been done, or from something not done with us that should have been done" (p.9). An experience of deadness, Ulanov suggests, comes from either a loss of subjectivity or objectivity.

Deadness may arise from a loss of subjectivity, our "capacity to invest reality with our energy, emotion, imagination, and make meaning of what happens to us….We make nothing of our experience" (p.11). Deadness can also come from a loss of objectivity, as reflected in the tendency "to grab hold of something and cling to it with fixity of purpose" because we fear "drifting into nothingness, afraid no one will be there to depend on" (p.14).

Discovering ourselves as fully alive through play is a deeply personal matter with reverberating consequences beyond individual selfhood. Our families, friends, churches, clients, neighbors depend on our play. They depend on us to be fully alive to fulfill our purpose for being in the world. Deadness depletes us and all the relationships that depend on us to show up in the world, ready to contribute, to interact, and to make a difference in whatever way possible.

One of the great blessings and privileges of teaching at a theological school is the ability to apply for and receive sabbatical research leave. During each of two semester sabbaticals, I have devoted myself to a retreat week of silence, a time set apart for contemplative practices of prayer and reflection. Silence is a time of playful revelry for me. Released from needing to produce words or to listen to others, I 'unhook' from these routines to enter silent space where the deadness within can be faced and experienced. Each time, the regular and committed practice of silence practice has given way to serendipitous play in writing, teaching, and advising. This space of playing in silence comes as a gift, for many of us live and work in environments crowded with words. As practitioners of care, we often listen to the struggles of parishioners and clients in pain,

distress, grief, and loneliness. Such experiences may not be 'dead,' but rather vibrantly alive. Deadness may lurk in other places.

Self-discovery and renewal known through play refuse to give into deadness. In periods of months or days or hours, we can freely devote ourselves to letting God do something new in and through us. Today our lives are shorter by one day.

Playing in the mirror

Play as self-discovery calls us to immerse ourselves in the material of our lives, not someone else's life. Just as children like to play make-believe by dressing up and seeing themselves reflected differently in the mirror, so we too can allow dreams, captivating waking images, and movies to reflect back aspects of ourselves. Play, in this sense, becomes a spiritual practice of seeing ourselves differently.

In a dream. I once taught a very small, week-long intensive class at a retreat center with only three students. Initially, more participants had enrolled, but dropped the course because of other pressing commitments. The class began on a Sunday evening with our eating a meal together and telling faith stories. That night, I had a dream in which I venture through a city enjoying myself as I explore many places, and stop to eat ice cream. I suddenly realize that class is ending, and I have not even begun to teach.

Upon waking, I recalled the dream and decided to tell the class about it. I saw a reflection of myself in the dream that carried implications for teaching the course. As an experience of playful vulnerability, I interpreted one possible meaning to class participants: 'the teacher' (the expert or authority) did not show up to teach the class. Instead, we could co-construct a classroom environment to meet the educational goals of

those present, sharing questions, experiences, and interpretations. So that is exactly what we did. In the course evaluations, students expressed gratitude for this unanticipated learning experience. One commented, "This class was like a 'think tank'," a statement I received as a compliment that we were, in fact, a cooperative learning environment sharing respect for one another as resident experts.

In a waking image. My next-door neighbor had a baby a few months ago. They welcomed the little one into their family that already included an 18-month-old son. One day not long after the birth, I greeted my neighbor, the baby, and the other son at their back porch. My neighbor asked if I wanted to see the baby. I immediately walked over to behold the baby. The older child, standing next to his mother and the newborn, had one pacifier in his mouth and another one in his hand. "He has a cold," his mother commented. While staring at me, the child moved his hand to pat his little brother's head. "It looks like this is a two-binky day," I said. My neighbor replied, "Every day is now a two-binky day." I can only imagine the shock waves absorbed by a young child as a new baby brother is welcomed into the family.

This image continues to grab my attention, and suggests the need we all have for soothing in times of stress. As a reflective question, we may ask ourselves what kinds of play objects, toys, or experiences do we need especially in times of stressful transition? The self-discovery of play invites continual reflection on images and interactions that capture us, while simultaneously not over-interpreting them. We can ask: where or how do I see myself reflected here?

At the movies. We see reflections of ourselves in the mirror of watching movies. The practice of viewing films can be an enjoyable and illuminative form of play. I have

gleaned beneficial insights from a couple of different movies, and invite readers to consider watching movies as an adventure in playful self-discovery.

The animated movie *UP* by movie directors Pete Docter and Bob Peterson (2009) tells the story of an older man charting a new course in life after the death of his beloved wife. The film's opening segment shows scenes of the couple's life together from childhood through a long marriage. Now a widower in his late 70s, Mr. Fredricksen escapes the fate of having to move into a retirement home by lifting his home off the ground with thousands of large, colorful, helium-inflated balloons. He finally embarks on a journey that he and his wife had anticipated taking together; they delayed the trip over the years because of needing to pay for unanticipated household expenses. Mr. Fredricksen experiences release from his own regret at not having been able to share this journey with his wife when he finds this sentiment in a photo album: "Thanks for the adventure; now go have another one." These words provide the permission he needs to find new meaning and purpose in life. An animated film that addresses the spirit of adventure appeals to old and young as well as those of us in our middle years!

For several years, I have showed segments of *Patch Adams* by movie director Tom Shadyac (1998) in my introductory course on pastoral care and counseling. The storyline of a doctor, played by actor Robin Williams, who uses humor and play as a means of relating with people draws students' attention and appreciation. Together we imagine ministers as playful soul leaders and healers, and reflect intentionally on care practices for ministry with people of all ages. The character of Patch Adams explicitly challenges a prevailing stereotype of the physician as an emotionally detached expert in medical care who renders patients as passive and uninvolved care recipients. Patch

Adams models for other care givers the capacity to meet people where they are, relating with their fears and anxieties as well as their joys and celebrations. While the movie captures moments of sheer cinematographic silliness, it also conveys the immense healing potential of what in pastoral theology we call care of the whole person. Competent care practices of all professional practitioners rely on an artful negotiation of both sound theoretical and empirical information as well as knowledge of an actual living person. Classroom participants often come away from viewing this film with a commitment to develop their own capacity for play, which I consider a good educational outcome.

Play as restorative and liberative care

Play restores us. Pamela Cooper-White (2004) outlines a beneficial pastoral method for care and counseling that advises self-care as the first step. Play in its many forms, suited to our unique personalities, is both a self-care and a spiritual care practice. Rather than a narcissistic or self-centered indulgence, the self and spiritual care practices of play provide the necessary grounding for our lives and ministries. We avoid or neglect them to our detriment. Our tendencies to act out our own unfinished business or life wounds are lessened when we take time to nurture ourselves. We listen with open ears and respond with fresh thoughts when our bodies and minds are quiet, not rushed and hurried with preconceived notions and agendas.

The restorative value of self-care and spiritual care practices comes when we make regular assessments (or check-ins) of what works. What proved helpful and sustaining at one point in our lives may no longer be the case, so we bring an adaptive

and creative spirit of play to self-care (Koppel, 2007). I used to love to read for pleasure, and I still read and enjoy it, but I don't think of reading as self-care in the way I used to. Now, I much prefer riding my bicycle throughout the many paths available in the Washington, DC area. Bicycle riding is a free-spirit activity for me. I enjoy being outside and hearing the pedals whirling and feeling the wheels rolling against the pavement. Breezes blowing through the trees and sunlight glimmering on the beautiful Potomac River bring me home to who I am and make me deeply glad to be alive. This shift in my own experience prompts a question: what playful adaptations do you need to make in your own self-care practices?

Sometimes students ask about the difference between a self-care and spiritual practice. While I can provide clear distinctions between them (self-care practices attend to personal needs and enjoyment; spiritual practices foster awareness in the presence and activity of God), I actually think the boundaries are much less clear. Playful engagement in the practices can stimulate a blurring of the boundaries between what is identified as spiritual or self-care. The restorative self-care practice of bicycle riding becomes a spiritual care practice as I become fully absorbed in the experience, sensing myself as one with God and creation.

Play liberates us. In previous writing, I argued that pastoral leaders and communities can benefit from claiming and celebrating neglected or disregarded aspects of themselves (Koppel, 2008). I used the term "misfits" – meaning persons, communities, qualities, and experiences that do not correspond to dominant perspectives or norms – as an identifying term. I have intentionally used "misfit" as opposed to a term like "marginality" because I think it names a frame of reference for many people and

congregations. In wider social and cultural contexts, the term is often used pejoratively, and I wince when hearing it because misfit people and congregations bring beneficial qualities and experiences that the larger church needs.

Play is liberating activity for healthy theological misfits. No longer shackled to expectations of the way things "should be done," we can explore and negotiate new ways of interacting, structuring community life, and forming church communities. The late Letty M. Russell, one of the first women ordained in the United Presbyterian Church, and Professor of Theology at Yale Divinity School for many years, served as a mentor for several generations of seminarians. Russell (1981) asserted that "God has identified with the misfits of the world and encourages us to become marginal to structures that operate by standards of domination, injustice, and competition" (p.159). As a feminist liberation theologian, she labored with communities seeking justice, and regularly encouraged people to celebrate small victories along the way. She knew how to play, and taught others to do so as well. Russell taught that we need to know what we are *freed for* after being *freed from* oppressive systems. One clue as to what we are *freed for* comes from the opening lines the Westminster Confession of Faith, the Shorter Catechism: "Q: What is the chief end of man [*sic*]? A: Man's [*sic*] chief end is to glorify God, and to enjoy him forever" (2004, p. 175). Our purpose is to enjoy God, and by extension to enjoy ourselves in the practice of knowing and loving God. Play becomes liberating activity as we come to know and enjoy God and ourselves more truly and intimately.

We embrace play because oppressive patterns can take over our lives and be replicated in ministry unless we intentionally interrupt them. Ministry can be exhausting and oppressive to ourselves and others when we can only envision the many more tasks

that need completion or the people who need our care and advocacy. Play as self-discovery frees us. Play as liberating activity frees us to discover the splendor of life and to draw deeply from what the Psalmist declares as the "river whose streams make glad the city of God" (Psalm 46: 4). Sometimes we need help in this discovery.

Covenant coaches for the journey

We may want to give ourselves to play, and feel unsure how to start. I suggest finding a friend, family member, or trusted colleague to serve as a coach, a person who can provide both support and gentle challenge. Developing covenant partnerships with friends and colleagues as supportive coaches can encourage and enhance play, setting us free to discover ourselves anew. An outline of steps for covenant partnership in play include the following: 1) **Choose** and establish a covenant with a trustworthy coach; select someone who knows you, including your strengths and challenges, or someone with whom you would feel comfortable confiding; 2) **Sort** priorities to consider where and how play might fit in; 3) **Develop** measurable goals for actually including play practices in your life, and create free space to allow for the opportunity to capture play opportunities; 4) **Celebrate** play when it happens for you, especially if you have moved through internal resistance and external obstacles to arrive at this place; 5) **Evaluate** the process by paying attention to and acknowledging what difference play makes, how you feel generally and experience other aspects of your life differently; 6) **Share** appropriate insights and benefits of your covenant to play with friends and colleagues.

Whether exercised by ourselves or in the company of others, play carries enormous potential for self-discovery. Through play we practice a forgetting of our

controlled and ego-based selves in order to delight, wonder, and remember the fullness of who we really are. In play, we catch glimpses of ourselves and of the Holy in previously unexpected and unimagined ways. Play teaches us to let go into the unknown so that we grow more comfortable in this 'not-knowing' as a habit of mind. As care practitioners, we witness to the movement of God's spirit in the lives of those people we meet in offices, clinics, hospitals, streets, or homes. We play to open ourselves to revelatory and transformative experience, and to support our ministries of care and counseling.

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Best Practices: Rethinking Pastoral Diagnosis

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Abstract Problem assessment has always been central to pastoral practice. The notion of pastoral diagnosis emerged in the mid-twentieth century, largely as a practice that emulated psychiatry by linking problems in living to broad theological, spiritual or religious metaphors. Pastoral counselors have never developed a diagnostic system that is consistent or widely accepted by either pastoral counselors or interdisciplinary colleagues. Several factors argue against pastoral diagnosis as a necessary element of practice. These include: (1) the limitations of theological anthropologies that center on human defect, (2) Michel Foucault's analysis of psychiatric power and the socially constructed nature of psychopathology, (3) contemporary debates about biological psychiatry and the new DSM-V, and (4) evidence that diagnosis can say little about either etiology or what therapy methods will be effective for any specific disorder. Conclusions suggest that it is time to retire the notion of pastoral diagnosis and replace it with a critical pastoral relationship with interdisciplinary diagnosis. This relationship would expose the hidden, often demoralizing, social power of diagnostic practices and highlight multitude pathways to human flourishing.

Keywords: Pastoral diagnosis, pastoral counseling, pastoral theology

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> *Interview question: "Can you describe how you do pastoral diagnosis?"*
> *Pastoral Counselor response: "Pastoral diagnosis? I'm not really sure I can. I think I do it, but I've never really tried to describe it. I guess I try to understand how spiritual issues play out in the problems people bring to therapy."*

My task in this essay was to propose "best practices" for pastoral diagnosis from a theoretical or philosophical position. At first glance this seemed pretty straightforward. Pastoral counselors have long relied on ancient Hebrew and Christian stories, examples from Jesus' ministry, and traditional practices of spiritual direction to provide diagnostic analogies expressive of human need (Clebsch & Jaekle, 1967; Gerkin, 1997). A modern tradition of pastoral diagnosis emerged in response to twentieth century medicine. This tradition: (1) affirmed the value of religious knowledge about human life in increasingly medicalized pastoral environments, (2) articulated a context for integrating medical/psychological and theological knowledge in acts of care, and (3) claimed a place in a field increasingly dominated by muscular medical-psychiatric-psychological institutions (Denton, 1997; Pruyser, 2005; Ramsay, 1998). However, saying something about pastoral diagnosis in *today's* pastoral, medical, psychiatric, and psychological context, is not easy. First, it is hard to locate pastoral counseling as a particular discipline with a specific set of practices. In 2013 the field is no longer unified by a discrete identity, clear paradigm of practice,[1] set of theories, or commonly-accepted theology that was typical of mid-twentieth century pastoral counseling. Second, "pastoral diagnosis" as a notion or discrete practice is elusive. Does it refer to the pastoral identity of the person diagnosing? Does diagnosis of a neuropsychological problem by a psychologist who is also certified as a pastoral counselor qualify as pastoral diagnosis? Is it pastoral diagnosis when a pastoral counselor is required to use the new DSM-V to complete an insurance form? Is pastoral diagnosis a particular *kind* of diagnosis that represents unique knowledge established through research and common agreement in the field? If so, what

is this knowledge? How was it constructed and by whom? Is it founded in theology? Religion? Specific pastoral practices? Conversations between behavioral sciences and religion? Where is this knowledge codified? What are its norms and how were they established? Is it generally available (like the American Psychiatric Association's DSM) so other professionals can use it in a more generalized psychotherapy practice?

These questions constrain any contemporary conversation about pastoral diagnosis. So, I begin with three observations. First, pastoral counselors in the second decade of the twenty-first century cannot claim any codified, unified, or generally shared practice of pastoral diagnosis based in widely accepted or empirically tested knowledge. Second, it is also clear that the modern, twentieth-century professional guild of pastoral counselors that might have accomplished this has been replaced by a loose confederation of variously trained and licensed professionals who show little interest in such a task. Third, pastoral counselors making up this loose confederation of variously trained and licensed professionals use a variety of diagnostic frameworks in their clinical practice. Most rely first on the American Psychiatric Association's Diagnostic and Statistical Manual. This reflects the medical community's control of diagnosis, especially as it relates to reimbursement for psychotherapeutic services. Many pastoral counselors also rely on discipline-specific assessment, such as couple or family assessment, vocational assessment, and psychoanalytic assessment. Several models of spiritual assessment are available to therapists across disciplines. Starting from these observations, my goal in this essay is to:

- Examine pastoral counseling's legacy of "pastoral diagnosis,"

- Explore several key theological, philosophical and behavioral science concerns that intersect with historic and contemporary diagnostic practices, and
- Suggest a direction for an alternative vision of how pastoral counselors might relate professionally and ethically to diagnosis in contemporary practice.

Part I: Genealogy

> *Interview question: "Can you describe how you do pastoral diagnosis?"*
> *Pastoral counselor response: "It seems pretty vague to me. When I was in training we read about it. It seemed like it meant matching psychological diagnoses with theological or spiritual principles. For example, a depressed person might be having a spiritual crisis of faith in the face of loss, or an addict with a chaotic life might be wandering in the wilderness…those kinds of things."*

Anticipation

Most spiritual traditions have stories of rituals, wise men and women, or prophets who discern life-giving from other kinds of "spirits." For example, my own Judeo-Christian tradition is defined by creation narratives of a deity who discerns between earth and sky, water and dry land, and humans motivated for health and destruction (Genesis 1-4). From creation narratives to the post-exilic prophets, the Hebrew scripture is rich with stories of leaders who, with varying success, discern between what is life-giving and life-robbing in the human spirit. New Testament narratives portray Jesus, the good shepherd or great physician, as one who was expert at discerning and intervening in matters of life-giving and life-robbing human experience. This extended into the early church practices of discipline and guidance. Each period of Christian history claimed standards to assess where God's spirit was, or more importantly, where it was not, in human behavior and thought. This is evident in narratives of care and healing (Clebsch & Jaekle, 1967), as well as exiled and executed heretics, the Crusades, the Inquisition, Galileo's imprisonment, Joan of Arc's burning, and reformers denouncing each other. For better or worse,

institutional standards to judge thought and behavior, right or wrong, demonic or God, is woven into the fabric of religious tradition.

Modern, North American pastoral diagnosis is rooted in ancient Christian narratives of care. Pastoral manuals from the *Didache* (60-120 CE) to those found in today's seminary bookstores outline procedures used to guide pastoral discernment and action. Until the late nineteenth century, these focused almost exclusively on guiding parishioners toward salvation and moral life. Late nineteenth and early twentieth century medicine, psychology and technology tipped the balance of educated clerical attention away from these concerns and toward cognitive and emotional well-being (Holifield, 1983). What once was madness, moral lapse, or demonic possession became loss of rationality, understood and treated best with medical knowledge rather than spiritual tradition. Emotional distress, once considered a religious issue related to salvation, was associated instead with very earthly, psychological concern for self-actualization. Historian John McNeill observed that pre-twentieth century pastoral care givers

> …would be astonished if they could suddenly enter our world of today. They would find themselves in an environment in which their assumptions are ignored by many earnest and highly trained men who undertake the reconstruction of personality damaged by the stresses of life....[The] territory of the old-time guide of souls…has been absorbed…[by] the empire of medical science. (McNeill, 1951, pp. 319-320)

Medical diagnostic paradigms were central to the development of the early twentieth century clinical-pastoral movement. In *The Cure of Souls*, Charles Holman (1932) claimed that pastoral ministers must be educated in the "scientific knowledge of human nature." They must behave like physicians with careful attention to "…sources of infection, conditions that cause

illness, and the measures which must be taken to bring his patient back to health" (Holman, 1932, pp. x-xi). Holman argued for a comprehensive program of religious diagnosis and treatment that would guide all religious work. He lamented that there has been "…no painstaking effort to analyze and classify the types of maladjustment with which the minister deals as has been done with those types of disturbance with which the psychiatrist deals" (Holman, 1932, p. 144). To remedy this he offered a system to understand "sick souls," a social case-work method for engaging "sick souls," and a diagnostic guide for assessing individual functioning. His diagnostic frame was forthrightly framed by psychoanalysis and anchored in pastoral discernment of two kinds of "soul sickness:" moral maladjustment and religious maladjustment.

In *Physicians of the Soul,* Charles Kemp (Kemp, 1947) observed that pastoral counseling needed its own theological authority. He traced care from New Testament times to the twentieth century and concluded that psychiatry and behavioral sciences had changed theological anthropology so dramatically that any successful model of care must be both scientific and religious. In particular, care must include a close relationship between ministers, psychiatry and counseling professionals. Though Kemp offered no diagnostic framework, he believed that identifying and classifying human problems was a central pastoral skill. However, pastoral counselors needed to transcend the limitations of medical or psychological sciences and attend also to theology and the practices of the church; to "…life as a whole, in terms of its total context, which includes faith and hope—in other words, God" (pp. 241-242) in order to understand those who are religiously confused, despondent, perplexed or unhappy.

Wayne Oates highlighted theology and religious practice in pastoral assessment. Unlike Kemp, he was highly attentive to the practical intersection of psychiatry and theology. Oates

worked within a psychiatric framework and saw theology and religious life as sources to deepen diagnosis. Playing off of Freud's claim that dreams were the "royal road" to the unconscious, Oates claimed that scripture was "…the pastor's 'royal road' to the deeper levels of the personalities of his people" (Oates, 1952, p. 60). How a client related to religious life could be used as a diagnostic tool to gather psychological information. By using such tools, "…[a pastor] can get a fairly clear-cut understanding of the life situation of the person with whom he is counseling as well as a feel for the purposive drift of his life energies"(Oates, 1952, p. 63). Oates produced more than 50 books in a half century of professional life. None offer a system for diagnosis. Instead, he (Oates, 1957) modeled practice that paid careful attention to religious dimensions of personality and how religiosity, religious symbol and religious content interacted with psychiatric diagnosis and psychopathology. His work—reflecting his debt to Carl Rogers—shows much more concern for client engagement and a theological frame for practice than for developing a diagnostic system. (Oates, 1970, 1987)

Anchoring the notion

In 1965 psychiatrist Edgar Draper (1965) coined the term "pastoral diagnosis" to describe a parallel he observed between medical psychiatry and pastoral ministry. He argued that the first task of becoming a physician was to become a diagnostician. To enter the medical profession a physician must "…invest his energies in developing his skills in diagnosis for one reason: *proper treatment depends on correct diagnosis"* (Draper, 1965, p. 25). Diagnosis, he explained, is to know (Greek *gnosis)* apart (Greek *dia*), or to distinguish between. In a medical sense, this is to know the difference between one disease and another or to determine the nature of a disease. Pastoral diagnosis, then, is

> …an orderly, structured approach to pastoral problems which taps all the resources of the minister, including his compassion (heart) and his objectivity (head). It eventuates in a tentative conclusion as to what the trouble is, opening the way for appropriate action….[T]he proposition that proper treatment rests on correct diagnosis should serve the pastor as usefully as the physician. (Draper, 1965, p. 31)

In nearly fifty pages of text, Draper constructed a framework to illustrate how psychological and religious/spiritual concerns are juxtaposed to better inform ministry. He showed how pastoral diagnosis is indebted to and linked to psychology but maintains its own identity by focusing on moral life rather than mental health. It is "…uniquely clerical and is molded from the various vectors of human experience that are familiar to the pastor" (p. 68). He proposed a set of useful "vectors" and pointedly avoided a classification system for pastoral diagnosis for two reasons. First, diagnosing clinical syndromes from signs or symptoms should be left to mental health professionals who are "far more enlightened" (p.70). Second, like Oates, he saw pastoral diagnosis as more of a "spirit of inquiry" about parishioners' moral life than a systematic way of assessing people.

British psychoanalyst Frank Lake (1965) took a quite different approach to pastoral diagnosis. His ponderous text *Clinical Theology* turns Draper's assumptions upside down. Pastoral counselors do not need a separate system of diagnosis. Instead, ministers should be highly trained in psychiatric diagnosis. By developing an intimate familiarity with the "disordered contents of the unconscious mind" (Lake, 1965, p. xxv), clinical theologians (ministers) can evaluate the "evil contents" that alarm psychiatric patients. According to Lake, the psychiatrist and the clinical theologian cover the same ground of human misery. Both equally

rely on psychiatric "truth." Drawing from Wesleyan theology, Lake suggests that a competent clinical theologian will compare psychiatric truth with the theological principle of Christ's normality. Competent psychiatric diagnosis becomes an avenue for the Holy Spirit to sanctify and purge troublesome, unconscious content. Pastoral diagnosis is indelibly welded to psychiatric practices and nosology. Lake was critical of the American clinical pastoral movement precisely *because* it maintained a boundary between psychiatry and theology. Where Draper avoided a classification system in favor of a "spirit of inquiry," Lake filled nearly 1,300 pages with dense description of psychoanalytic diagnostic categories and corresponding theological analysis. Draper overtly rejected "clinical theology" as undermining both pastoral counseling and psychiatry.

Edgar Draper coined the term "pastoral diagnosis," but psychologist Paul Pruyser (1976) popularized the concept with his publication of *The Minister as Diagnostician.* Pruyser expanded Draper's work by constructing a coherent rationale for pastoral diagnosis as a religious practice at the intersection of mental health and ministry. He made a clear distinction between pastoral diagnosis, a function of clergy, and medical or psychological diagnosis. At the same time he gave pastoral diagnosis credibility by inviting it to the case consultation table at The Menninger Foundation. Note how thoroughly Pruyser anchored pastoral diagnosis in clerical bedrock:

> Who has ever heard of ministers being engaged in *diagnostic* work?....The pastor will gladly help his people in trouble, benefiting from the diagnosticians, but he will surely not consider himself an expert in diagnosis…What if they want to place themselves in a pastoral-theological rather than a medical, psychiatric, legal, or social perspective? What

> if they wanted to be in several professional hands at the same time? [This] would make the pastor a diagnostician of a special kind. (Pruyser, 1976, pp. 9-10)

For Pruyser, pastoral diagnosis was separate from psychiatry or the behavioral sciences. It was firmly tied instead to religion and theology—ministry's "basic science." "Rather than imitate medical and psychological methods and categories, the pastor can guide distressed counselees and parishioners into making assessments of themselves in terms relevant to the religious perspectives they share and the implied contract between pastor and counselee." (Pruyser, 2005, p. 371)

Pruyser broadened the clerical, clinical-pastoral paradigm of the mid 1970's and provided a systematic analogical connection between the practice of medical psychotherapy and pastoral counseling. This connection legitimized an institutional place for pastoral counseling—the authority to diagnose stands hand-in-hand with the authority to treat. Pastoral diagnosis also came to the institutional foreground of pastoral counseling. Pastoral counselors were now expected to "do" pastoral diagnosis, though concrete standards for this practice were far from universal and generally left to the individual counselor's or training program's creative imagination.

Pastoral counseling texts published in the 1980s and 1990s showed two broad diagnostic attitudes. One trajectory never speaks directly of diagnosis. Instead, these texts show how pastoral counselors can use theological reflection to examine a client's behavior, thought, emotion, and religious location and describe religious or spiritual themes that might be addressed in counseling. Examples include William Oglesby's (1980) *Biblical Themes for Pastoral Care*, Archie Smith Jr.'s (1982) *The Relational Self*, Edward Wimberly's (1990) *Using Scripture in*

Pastoral Counseling, Merle Jordan's (1986) *Taking on the Gods,* and John Patton's (1983) *Pastoral Counseling: A Ministry of the Church.*

A second trajectory reflects formal diagnostic practices. These typically grew from a correlational model of theological reflection. Clinical and theological sources converged in a diagnostic frame to describe client experience and guide intervention. The pastoral counselor's task was to assess religious themes, spiritual pathologies, and spiritual dimensions of psychopathology that require treatment. Theological language and spiritual metaphor became tools to observe matches between religious/spiritual problems and problems in living. In its clearest form, discernment relied on a religious diagnostic schema that juxtaposed religious and psychotherapeutic language and produced seamless dual diagnoses and clinical strategies. Several examples show the diversity this trajectory produced. In the 1980's Carroll Wise brought together ego psychology and theology to propose a set of "…criteria for the purpose of evaluation, criteria that are concerned with ego processes" (Wise, 1980, p. 105), informed by the redemptive atmosphere of pastoral psychotherapy. Wayne Oates' work straddles the two streams. His early work was clearly influenced by the first trajectory of diagnosis, but his later work, particularly *Behind the Masks* (Oates, 1987) is much more diagnostically sophisticated and comes close to anticipating a clinical theology. In the early 1990s, Valerie Demarinis (DeMarinis, 1993) constructed an elegant model of pastoral assessment that used feminist developmental psychology and feminist theology to guide diagnosis. Larry Kent Graham (Graham, 1992) engaged liberation theology and family systems theory to build an elaborate, contextual system of pastoral assessment. In the late 1990s, Donald Denton (Denton, 1997) constructed a pastoral diagnosis system that juxtaposes the diagnostic language of the DSM-IV

with religious issues that frequently arise in pastoral counseling. (For example, a DSM Axis I diagnosis of Adjustment Disorder with Depressed Mood might be juxtaposed with an Axis I Religious Diagnosis of Ethical guilt.) Nancy Ramsay (Ramsay, 1998) provided an approach to pastoral diagnosis that moved beyond traditional categories of pathology to include sensitivity to a broad spectrum of contextual variables. Her approach was a refined and highly conceptual way of reflecting theologically on client assessment, goal setting, and selecting client interventions.

Though the diagnostic systems proposed in this second trajectory are diverse, they all produce the same tensions. All are hierarchical. That is, the client does not have access to psychological and theological knowledge possessed by the professional pastoral counselor. Like medical diagnosis, pastoral diagnosis is a professional activity that rarely invites the client into full participation. This can objectify clients, participate in diagnostic reductionism, support medical and psychological assumptions that oppress clients, and disconnect theological reflection from the broader life of faith communities.

Contemporary practice

The notion of pastoral diagnosis has changed substantially since 1965. Most pastoral counselors today would reject both Draper's and Pruyser's definitions. First, clerical identity is no longer central to professional pastoral counseling. Very few pastoral counselors practice as parish clergy. Second, few believe with Pruyser that their basic science is limited to religion or theology. Third, pastoral counselors have worked hard for professional parity--the right to practice on equal ground with other mental health professionals. This has shifted their attention away from ecclesial concerns and toward practices required by insurance panels and state licenses. Medical-psychological diagnosis using the Diagnostic and Statistical Manual (now in

its Firth Edition) is central to these practices. It is notable that the DSM-IV (1994) provided some interstitial diagnostic space (V-codes) for spiritual issues. Some pastoral counselors interpreted this as making room for pastoral sensibilities in interdisciplinary practice. Others experienced it as medical-psychological colonization of pastoral practice by defining spiritual conflict as a mental disorder. Editors of the new DSM-V paid more attention to and specific definitions for spiritual diagnosis.

While it appears that DSM editors are making increasing space for diagnosis of spiritual issues, pastoral counselors have had little, if any, influence in this medical-psychological process.[2] Spirituality is normalized as a psychological process in ways tangential to historic pastoral theological concerns. Pastoral counselors may offer a useful aesthetic language to describe religious and spiritual contexts, but it is psychiatry (Peteet, Lu, & Narrow, 2011; Sperry, 2001; Verhagen, Van Praag, Lopez-Ibor, Cox, & Moussaoui, 2010) and psychology (Aten & Leach, 2008; Miller, 2000; Pergament, 2007; Shafranske, 2006) that define the norms for spirituality and grant spiritual diagnosis professional legitimacy. Psychiatric colonization of spirituality functionally relegates "pastoral" to a niche market of folk with religious questions.

In sum, a generally accepted descriptive nosology for pastoral diagnosis has not materialized in a way that influences today's pastoral counselors or the contexts in which they work. Unlike other disciplines, pastoral counselors share no standard of practice for a method called pastoral diagnosis. Seminaries, universities and training programs that teach pastoral diagnosis are diverse and seem to share a common approach. They offer courses based in personality theory, family systems and psychiatric nosology (DSM) augmented by religious and theological reflection on the process of diagnosis, client relationships, and the psychology of

religious content. Supervision focuses on accurate assessment of psychopathology and problems in living. Spiritual and religious issues are important contextual concerns that influence pathology and treatment. My own study (Townsend, 2009, 2011) suggests that certified pastoral counselors today rarely use pastoral diagnosis separate from mental health diagnosis as a distinct practice. When they do, pastoral diagnosis is vague and used *post hoc* to help explain psychiatric diagnosis or enrich the therapeutic relationship. For most, pastoral diagnosis lurks around the boundaries of a niche psychotherapy practice as a "value added" option to conventional psychotherapy practice.

Part II: Hermeneutics of practice

> *Interview question: "How is pastoral diagnosis important to your practice?"*
> *Pastoral counselor response: "I think it should be very important. I was trained to think diagnostically in two directions—one, psychologically, and two, pastorally. We spent a lot of time thinking through how psychological pathology corresponded with spiritual or theological pathology. Ideally, the two should be integrated. In practice, though, everything seems to rest on psychological diagnosis. Psychologists and social workers on staff don't really care about pastoral diagnosis—some say it's just a word game that describes psychological problems in religious language. So, mostly pastoral diagnosis falls by the wayside. My supervisors used to tell me to expect that. The fact that the two are integrated in me informs my treatment."*

At this point I laid this essay aside to consider my ambivalence about pastoral diagnosis. Nine months of brooding resulted in a set of questions, a set of observations about pastoral diagnosis and a proposal for "best practices."

Questions

Is there a need to say anything at all about "pastoral diagnosis" in 2013? Do pastoral counselors have any real need for such a practice, or is the notion an interesting historical footnote that has little actual impact for most pastoral counselors? In today's multidisciplinary, multicultural context how would pastoral counselors show that "pastoral diagnosis" is credible,

legitimate and not limited to particular theologies, faith traditions or pastoral counselors' imaginations? Can pastoral counselors offer observable, definable and empirically verifiable data necessary to form a pastoral nosology to name and sort people's spiritual or religious pathology? Would "pastoral diagnosis" defined any other way have any meaning at all in the medical-psychological context in which most of us work? Is there any particular merit for forming such a system? Will this sort of "diagnosis" help as pastoral counselors seek public voices and interdisciplinary legitimacy?

Observation: Theological anthropology

For pastoral clinicians, diagnosis embodies belief about the nature, meaning and situation of persons seeking care. These beliefs guide clinical imagination. They ground causal explanations and suggest curative action. Historically, pastoral counseling has anchored its anthropology in modern or liberal protestant theologies (for example, Paul Tillich, Reinhold and Richard Niebuhr, Emil Brunner, Karl Rahner, and Rudolph Bultmann). Theologian David Kelsey shows that these theologies share a common anthropological theme: They understand humanity primarily through modern theology's "turn to the subject." That is, they highlight self-reflective rationality. The human person is a rational, acting subject who becomes fully actualized only by proper self-choosing in an internal struggle with untruth, inauthenticity, despair, or meaninglessness. These theologies are anthropocentric. They are "…exhaustively concerned with human failure, an exclusively intrahuman defect or distortion…that is in need of correction" (Kelsey, 2009, p. 118).

This theological lens provides a powerful analogy for pastoral diagnosis. The Genesis Fall is observed by a rational, knowing God. This God employs divine knowledge to rightly

diagnose the specifics of human depravity (pervasive sin). Correct diagnosis guides interventions to correct this indelible defect through the Law, the Prophets, the Christ event, the sacraments of the church, and the hope of *parousia.* This theological frame lends authority to a defect-centered approach to counseling and hierarchical practices of diagnosis. Kelsey points out that there is a cost to this theology and its associated practices. Our vision of both God and the human person is truncated. Humans are a problem to be repaired; God is limited to the One who redeems. We miss a far more nuanced and contextual (not to mention religiously plural) understanding of both God and humanity. We miss the mystery that God relates to ALL that exists, and that God values relationship with humans far beyond the limits of defect and repair. More specifically, when human becoming is focused in defect and individual choice, spirit is reduced to freedom and moral choice. This sets the stage for two serious problems: (1) dualism and the notion that all the important stuff in human life (e.g. spirituality) is internal to the human psyche/self's struggle to overcome inherent defect; and (2) a vision that a struggling human is not fully human (that is, humanity is not actualized) until right choices overcome defects of inauthenticity, despair and meaninglessness. Physical, social and contextual factors are pushed to the margins in favor of self-centered, intrapersonal conflict. Any life-sustaining relationship (with God or another person) that does not directly relate to self-actualization is overlooked. According to Kelsey, these anthropologies tend also to underestimate contextual realities such as one's location in a material world, one's relationship to embodied physicality and the powerfully constructive force of social relationships.

These kinds of anthropologies have guided pastoral counseling and pastoral diagnosis. They wear thin, however, in the scrutiny of multicultural awareness, human sciences, and new

philosophical anthropologies. Feminist theologies, liberation theologies, Queer Theology, polydox theologies, and a variety of other postmodern theologies propose far more varied, nuanced and contextual notions of what it means to be human, how self and meaning are constructed, where and how human soul and spirit are located, and how human trouble and alienation are to be understood. These positions require any pastoral practice—including diagnosis--to be accompanied by careful attention to how practices:

- construct or embody a defining theological statement;
- attend to theological and social locations;
- account for individual, cultural, gendered, sexual, ethnic, religious and social class difference; and
- activate culture-specific knowledge (e.g. human sciences) that exerts power over particular human bodies and privileges particular cultural visions of human life and meaning.

Nancy Ramsay (Ramsay, 1998) addressed many of these critical elements in her treatment of pastoral diagnosis. However, she did not go far enough in challenging the practice's anchor in modern theology, its modern evolution from psychiatric methods, and the meaning-constructing nature of the practice itself. Two examples below illustrate why contemporary pastoral counselors must critically examine any specialized practice of pastoral diagnosis. First, a brief description of Michel Foucault's analysis of psychiatric power shows how diagnosis is an instrumental mechanism of social control. His work is important for several reasons: it poses a serious challenge to modern anthropological assumptions, it is the foundation for several emerging postmodern theologies, and it is the basis for postmodern approaches to psychotherapy

(for example, Narrative, Solution-Focused, Collaborative) that now inform many pastoral counselors. A second example rests in contemporary controversy about the DSM-V. This controversy is important because modern notions of pastoral diagnosis structurally mirror psychiatry's diagnostic practices. Problems arising from psychiatry are likely to be reflected in pastoral counseling practice. Both these examples illustrate how diagnosis is a practice that constructs social meaning and is tied to particular anthropological assumptions, political mechanisms of power, and distinct cultural histories.

Observation: Foucault's analysis

Michel Foucault showed how mental health disciplines are part of a cultural technology of power that constructs norms to define, segregate and classify human experience. Power is created when social discourse forms and accumulates knowledge about a social problem. Those who experience the problem are objectified and examined. This produces a "domain of knowledge" to explain and regulate the bodies and behavior of those identified as problematic (Foucault, Rabinow, Hurley, & Faubion, 1997). For example, psychiatric discourse created knowledge that redefined deviance as illness rather than "criminal," "possessed" or "delinquent." This knowledge was set in the context of major social changes between the Middle Ages and modernity.

Perhaps more importantly, Foucault's analysis unmasked the illusion that "mental illness" was discovered through an objective, incontrovertible scientific process. He showed us instead how mental illness was constructed in response to culturally-specific and questionable social and ethical commitments. Psychiatry (representing the mental health disciplines) claims knowledge to predict and control the social problem of the "madman," "monster," "delinquent"

and “masturbating child” (Foucault, 2003). Though the notion “mental illness” borrows from a medical metaphor, it lacks foundation in organic, pathological process. Rather, it is a category of knowledge/power that “…has its reality and its value qua illness only within a culture that recognizes it as such.” Mental illness is illness “…only insofar as it is a form of behavior that is not integrated by that culture” (Foucault, 1987, pp. 60, 62). Diagnosis of a mental illness expresses a deception: it keeps us from seeing ourselves in the one locked up or treated. Put another way, psychopathology “…is the final outcome of all that is wrong with a culture” (Henry, 1963).

Diagnosis relies on normalization. This mechanism is political. It defines the center and margins of society. It subdivides social space by constantly observing the difference between those who are normal (healthy) and those who are not (the ill). It works by “…establishing and fixing [individuals]…of assigning places and defining presences….” (Foucault, 2003, p. 46). Normalization creates knowledge and then distributes the power of that knowledge differently based on personal characteristics. Mental health professionals create and exert knowledge/power by discriminating continuously between healthy and pathological individuals, groups, and ideologies. Though their power is expressed as medical knowledge, the norms that create psychopathology are based in deviation from administrative regularity, family obligations and social standards rather than organic pathology. Foucault observed that

> …there is a sort of explosion of the symptomatological field that psychiatry undertakes to cover in pursuit of every possible disorder of conduct. As a result, psychiatry is invaded by a vast range of conduct that had previously been accorded only a moral, disciplinary, or judicial status. Any kind of disorder, indiscipline, agitation, disobedience,

> recalcitrance, lack of affection, and so forth can now be psychiatrized. At the same time…psychiatry becomes firmly anchored in a medicine of the body...one that is concerned with all conduct…. (Foucault, 2003, pp. 161-162)

To wield such defining power, psychiatry had to: (1) codify "madness" as illness, (2) establish norms to pathologize conduct (behavior, thought and emotion), (3) provide a system of classification (diagnosis), (4) offer explanations for why certain individuals are not (or cannot be) disciplined to live within norms, and (5) establish protocols for correction. This technology promised to protect society and lent mental health practice the authority of medical knowledge.[3]

Foucault's analysis exposed a truth game: Mental health professionals use socially constructed knowledge as medical fact to enact social discipline--that is, to correct deviance. This power relies on three interacting techniques: Hierarchical observation, normalizing judgment, and the examination (Foucault, 1990, 1995, 2008). "Curiously," states Foucault (2008), these techniques of power are focused in "…the doctor [or therapist], the person who organizes everything and really is in fact…the core of this disciplinary system" (Foucault, 2008, p. 22). Liberation is promised through the therapeutic relationship. It is a relationship of subjugation and discipline. The doctor/therapist's gaze (hierarchical observation) obtains "…an exhaustive capture of the individual's body, actions, time, and behavior" (Foucault, 2008, p. 46) and submits them to normalizing judgment. Central to this gaze is the "examination," the codified system of questions and observations that focuses normative judgment, results in indelible written reports, and offers a schema for a client to "progress" toward "normal." The examination accumulates knowledge/power. It transcribes the character of an individual "him" or "her" into a "case;" it combines into one whole "the deployment of force and the establishment

of truth" (Foucault, 1977, p. 184). By so doing, it justifies and documents placing a body into a cell. This prison image allows Foucault to borrow Jeremy Bentham's concept of the panopticon[4] to show the penetrating and corrective quality of psychiatric power. While modern mental health practices released those who thought and acted differently from physical chains, Foucault suggested that they were released into a far more powerful and insidious bondage—normalization and the mechanisms of psychiatric power. One could be released from chains, but one cannot easily be released from the totalizing nature of psychiatric power.

Diagnosis is a central player in psychiatric power. It assumes: (1) control of normalizing knowledge; (2) the ability to objectify clients and know them better than they know themselves; (3) the ability to "subjectify" or attribute character to individuals who think, feel or act in particular ways; (4) the knowledge to predict and explain individual differences; and, (5) possession of knowledge to correct deviations from "normal." Though Foucault's analysis focuses on mental health practice, he observed that psychiatric power is closely connected to the "pastoral function" of religious traditions, especially in pastoral counseling and guidance (Foucault, 2003, pp. 167-199; 2008, p. 174 ff; Foucault, Gros, Ewald, & Fontana, 2005, pp. 331-412). Pastoral counseling uses the same technologies of power as psychiatry. The "pastoral function" assumes and creates normative knowledge. Pastoral practice employs hierarchical observation and normative judgment through control of doctrine and religious practices. The knowing gaze of the pastor in preaching, teaching and especially counseling and guidance observes and corrects deviation. Most telling are pastoral practices of confession and confidential pastoral conversations which assure social control through ever-present observation and pastoral presence.

Foucault's analysis shows that diagnosis—pastoral or otherwise--is never benign or unambiguously benevolent. It creates knowledge/power. It imposes precise norms, marginalizes whole classes of individuals and justifies technologies of correction. It is part of a cultural technology of power.

Observation: DMS-V

When considering best practices for pastoral diagnosis, the controversies about the new (May, 2013) DSM-V loom large. Work on this manual began in 1999 as a collaborative effort of the American Psychiatric Association and the National Institute of Mental Health. Eight years of research resulted in five further years of committee work to draft new diagnostic criteria. This process highlighted sharp controversies within the psychiatric community about research methodologies, the value and epistemological foundations of classification systems, economic conflict of interest with pharmaceutical companies, political tensions related to any DSM categorization (but especially the DSM-V), and the boundaries and limitations of psychiatric diagnosis. These controversies are complex and passionate (Frances, 2009, 2010b; Phillips, 2010; Sadler, 2010). A brief review of this psychiatric tension helps frame the question of best practices for pastoral counselors.

One leading critical voice in this controversy is Allen Frances, M.D., former chair of the department of psychiatry at Duke University School of Medicine, collaborator on the DSM-III and chair of the DSM-IV revision committee. He voiced deep concern about methodological procedures used to develop the DSM-V, the claim that the new DSM would represent a "paradigm shift" in psychiatric nosology, and how the new manual would influence public health

and psychiatric practices. The heart of much of his critique is centered in the fundamental nature of psychiatric diagnosis. Most branches of medicine rely on a diagnostic system grounded in demonstrable organic etiology, which is then directly linked to specific methods of treatment related to etiology. Psychiatry, however, relies on what Frances describes as a sloppy, primitive classification system grounded solely in symptom description (Frances, 2010a).

Frances defines himself as a critical realist who recognizes that it is necessary for mental health professionals to make interpretive judgments. He also acknowledges that the move from DSM-II to DSM-III was a substantial advance for psychiatry. It reduced psychiatry's diagnostic reliance on psychoanalysis and pointed toward a revolution of biological psychiatry. Underlying this shift was an assumption that mental disorders were real. They existed "out there" and were available for scientific study. New technologies in neuroscience, imaging, and genetics would finally be able to define the etiologies and pathogenesis (and hence treatment) of mental pathology. Unfortunately, the results of the hoped for psychiatric revolution have been disappointing. Frances points out that biological psychiatry has failed to document the real (biological) existence or explanation for any mental disorder. Schizophrenia, for example, has been the object of intense research for more than 50 years with no evidence of a prototype "schizophrenia" waiting to be discovered. Researchers are not even close to genetic or neurobiological explanations. Instead, schizophrenia appears as a group of disorders—perhaps hundreds—which make defining the "disease" and its boundaries practically impossible and probably arbitrary. The more psychiatry learns about schizophrenia, the more it resembles a heuristic and not a disease. Akil and colleagues (Akil, 2010) make a similar observation about depression. Twenty years and hundreds of millions of dollars of depression research have

produced no major breakthrough in diagnosing or treating depression. Frances draws the following conclusion:

> There can be no dramatic improvements in [diagnosis] until we make a fundamental leap in our understanding of what causes mental disorders. The incredible recent advances in neuroscience, molecular biology, and brain imaging that have taught us so much about normal brain functioning are still not relevant to the clinical practicalities of everyday psychiatric diagnosis. The clearest evidence supporting this disappointing fact is that not even 1 [one] biological test is ready for inclusion in the criteria sets for DSM-V. (Frances, 2009, p. 4)

Critical realism leads Frances to conclude that when it comes to defining mental disorders, or the conditions under which people qualify for a mental disorder, we enter a "world of shifting, ambiguous and idiosyncratic word usages. This is the fundamental weakness of our field." (Frances, 2010a, p. 22) He further suggests that classification of mental disorders will continue to be little more than a collection of fallible limited constructs seeking, but not finding, elusive truth. At best, diagnosis is a call to action with immense and unpredictable outcomes.

A second related concern about the DSM-V is that it introduces a number of new diagnoses and lowers the threshold for several disorders established by DSM-III and IV. Critics insist that proposed new disorders, (such as Psychotic Risk Syndrome, Minor Neurocognitive Disorder and Binge Eating Disorder) and lowered thresholds for disorders such as Attention Deficit/Hyperactivity, Autism Spectrum Disorder and grief-related depression blur boundaries between normal and pathological. By redefining normal variations in thought, emotion, and

behavior as mental illness, the DSM-V will exacerbate an over-diagnosis problem created by the DSM-IV. Critics see three serious potential problems:

- Redefinition encourages wholesale imperial medicalization of normality by "…applying the term 'mental disorder' to the expectable aches and pains and sufferings of everyday life" (Speigel, 2010). This could be a huge windfall for pharmaceutical companies paid for by false-positive patients who should never have entered the mental health system. Just as important, medicalization implies diminishing tolerance for imperfection and normal variability. It also suggests reduced faith in personal responsibility and human resilience.
- New diagnoses and lowered thresholds increase the potential for unintended consequences, particularly false epidemics. Frances points to his own complicity as chairperson of the DSM-IV in creating three false epidemics. (Frances, 2009, 2010a) A seemingly harmless change of a "word or two" about Autism and Attention Deficit Disorder resulted in an epidemic of false positives for both disorders. Adding Bipolar II coalesced with the interest of pharmaceutical companies and became an "enormously popular" diagnosis. Prescription rates for drugs that have serious side effects jumped dramatically, and rates of childhood Bipolar Disorder increased forty fold. A simple editorial change in Paraphilia NOS created a "forensic nightmare" that resulted in extended sentences for sexual offenders. Changes in diagnostic criteria quickly show the political dimension of the diagnostic enterprise.
- Finally, biological psychiatry is committed ontologically to the idea that mental pathology exists. It also assumes that there are qualitative differences between mentally

> disordered and "mentally healthy" people and between discrete mental disorders. However, without a foundation in biology or organic pathology, mental illness is instead defined by
>
> …what clinicians treat…what educators teach and insurance companies pay for….[D]iagnostic classification is the result of historical accretion and accident without any real underlying system or scientific necessity. The rules for entry have varied over time and have rarely been very rigorous. Our mental disorders are no more than fallible social constructs (but nonetheless useful ones if understood and applied properly)." (Frances, 2010a, p. 23)

Critics of the DSM-V point out that these facts necessitate great care (even conservatism) for any attempt to recalibrate thresholds or create new categories of illness. Such action can easily blur the boundaries between normal variation and illness.

Proponents of DSM-V changes respond to critics by vigorously defending the studies, methodologies and procedures that guided thirteen years of DSM-V development. Many claim a "liberal" position that any risk of over-diagnosis is offset by a more inclusive mental health safety net and faster medical response to those developing mental illness or suffering from problems not yet diagnosable.

A striking footnote runs through the DSM-V debates. The most frequent users of all DSM versions are researchers and neophyte psychiatrists and psychotherapists. Full-time experienced clinicians are less likely to see DSM diagnoses as important to treatment, even though such diagnosis looms large for health insurance payment, disability and forensic evaluations, and meeting bureaucratic requirements. In actual practice, a descriptive nosology

that cannot tie disorders to specific social or biological etiological factors has little to offer treatment. Schizophrenia and depression provide examples that resonate throughout the discussion: Nearly a century of research shows that there may be several hundred social and biological pathways leading to any of the schizophrenias identified in the DSM-IV-TR, and perhaps an equal number influence any depressive disorder. The most precise description of symptoms says nothing about how a disorder developed; neither does it predict which of a multitude of possible treatments will benefit any individual client.

Six decades of research has shown that psychotherapy is effective. However, that same research also shows that "psychotherapy does not work the same way as medicine….Bluntly put, the existence of specific psychological treatments for specific disorders is a myth" (Duncan, Miller, Wampold, & Hubble, 2010, p. 28). Rather, results show that a wide variety of treatments are effective for any constellation of client problems. Instead of accurate differential diagnosis, the most critical factors for positive outcomes in therapy are (1) a therapist who has a coherent rationale for treatment she or he believes in, (2) a client who accepts this rationale and expects treatment to be effective, and (3) a good working alliance in the therapy relationship. These factors are also active in how and if psychotropic drugs are effective in treating any particular disorder or set of client problems (Sparks, Duncan, Cohen, & Antonuccio, 2010). Taken together, the evidence suggests that therapists must give up belief that clients are carriers of diagnosable illnesses best treated by specific interventions. This is best replaced with a collaborative, contextual approach to therapy that ties therapeutic effectiveness to a remoralizing, resource-enhancing and motivating relationship with a therapist who can be both supportive and challenging. "The therapist's procedures are important but become effective largely by

contributing to the formation and development of this relationship in the patient's experience (Duncan et al., 2010, p. xxi).

Part III: Best practices for pastoral counselors

Interview question: "How is pastoral diagnosis important to your practice?"
Pastoral counselor response: "I guess I have to be honest. I haven't thought about pastoral diagnosis for years. I'm not even sure what it means anymore. When I think diagnosis, I think DSM-IV-TR. I try to assess people's spiritual problems, but if you asked me to 'pastorally diagnose' one of my clients, I'd be at a total loss. Is there a manual now that tells you what the diagnoses are and what criteria to use?"

Realities

- Any practice of care or counseling requires some kind of frame to assess problems, guide treatment and observe outcomes.
- If pastoral counselors are to work or be reimbursed for services in North American, medicalized contexts, they must (at least for the foreseeable future) have some expertise in DSM and other psychologically-based diagnostic procedures.
- Pastoral counselors are expected to have something uniquely "pastoral" to offer their clients and interdisciplinary colleagues.

Proposition

I now return to one of the questions posed in Section II. Do contemporary pastoral counselors have any real need for a practice called pastoral diagnosis? On one hand, the notion is part of our history. On the other hand, there is no evidence that pastoral counselors today have any substantial interest in investing the time, research, money or collaborative capital necessary to establish a widely accepted diagnostic system with interdisciplinary credibility. Pastoral diagnosis is inescapably linked to psychiatry conceptually and historically. Perhaps more than

psychiatry, which still hopes for biological foundations for its nosology, pastoral diagnosis would always be a system of fallible social constructs lacking any direct relationship to treatment methods. Forty years ago Pruyser (1976) warned pastoral counselors to be skeptical of psychiatric diagnostic systems and avoid emulating them. It is clear today that any such system would be plagued by the same deeply embedded ethical and practical problems that confront contemporary psychiatry. These concerns raise serious questions about whether pastoral counseling, faith communities, clients or the interdisciplinary mental health community would be well served by any system of diagnosis that expands the potential for medicalization of religion or spirituality, particularly in the light of psychiatry's colonization of spirituality in the DSM-IV and V.

I propose that the time has come to retire the notion of a specialized "pastoral diagnosis" in favor of "pastoral engagement with interdisciplinary diagnostic practices." There is little to lose in this exchange. There is no evidence that attempts to construct a system of pastoral diagnosis have had much influence on either the field or on therapeutic outcomes. What little evidence we have suggests that few pastoral counselors in practice today claim to use it or claim to know how to do it (Townsend, 2009, 2011). What pastoral counselors do in everyday life is engage with interdisciplinary diagnosis (DSM, family systems, social work, etc.) appropriate to their vocational location. In this space, for better or worse, we pastoral counselors participate in systems of power that act on human bodies, shape human minds, allocate resources of care, and make life-defining distinctions between people. This power works by pathologizing human differences. This, as David Kelsey (Kelsey, 2009) points out, blinds us to multitudes of pathways leading to human flourishing. Best practices for pastoral counselors, then, would be critical

pastoral engagement with self, clients and colleagues that challenges the truth claims of socially constructed diagnostic frameworks, exposes systems of power expressed in any act of diagnosis, and discloses how diagnostic power works on bodies, minds, spirits, and communities in specific contexts. This engagement takes the shape of a public theological voice that unapologetically asks: (1) how social forces of marginalization, alienation and demoralization participate in any individual diagnosis of psychological, social or spiritual pathology; (2) how this particular diagnosis expresses intolerance for difference and robs meaning from personal experience; (3) how this particular diagnosis obscures, undermines or disguises client resources and strengths; (4) who benefits (personally, professionally, financially) from this particular diagnosis; and (5) what effect will this particular diagnosis have on the client's flourishing and the well being of his or her community? These questions are also apropos of any pastoral assessment that uses religious or spiritual metaphors, themes or categories to sort client experience and identify religious or spiritual pathology.

Practice of critical pastoral engagement deconstructs misleading truth claims expressed by medicalized care. These claims often obscure pathways to human wholeness. This deconstruction creates space for more hopeful interpretations of human problems and differences that coalesce with what we now know about effective therapy. Clients are not carriers of discrete diagnosable illnesses that warrant precise intervention. Instead, there are many complex paths leading to client problems and there are innumerable paths leading toward human wholeness. Consequently, any act of diagnosis must be assessed for how it participates in stimulating client hope and a remoralizing therapeutic relationship. As best practice, critical pastoral engagement would reject hierarchical assignment of diagnosis by a clinician in favor of full collaboration

between clients and counselor. This means that pastoral counselors and clients talk about what problems mean in a particular context. Recognizing that any DSM diagnosis are socially constructed interpretations of classes of human experience, counselors work with clients to examine how diagnosis (or a particular diagnosis) will improve her or his life and facilitate a therapeutic relationship. It may be that a diagnosis will allow access to care or medication not otherwise available. It may be that a diagnosis can provide relief by normalizing troublesome experience. It may also be that a diagnosis needed for an insurance claim (or to justify treatment in a particular clinic) may have immense unforeseen consequences for sense of self, marriage, family relationships, future vocational opportunities, or access to public office or religious service. Critical pastoral engagement requires full disclosure and equal access to diagnostic power.

Conclusion

Diagnosis is here to stay, at least as long as our culture prefers medicalized explanations of human difference and deviation from social norms. Pastoral counselors must participate in diagnosis if they are to be culturally relevant or survive professionally. However, this participation does not require pastoral counselors to have their own system of pastoral diagnosis that mirrors, competes with, or enhances psychiatric diagnosis. Instead, best practices require pastoral counselors to be vocal colleagues in interdisciplinary contexts. A pastoral voice will engage all practices of diagnosis in a critical way that exposes their immense power, highlights alternative pathways to human wholeness, and advocates for care expressed in positive, remoralizing therapeutic relationships.

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[1] Historically, pastoral counseling was limited to ordained clergy with specialized psychotherapy training who were endorsed to specialized ministry by their denominations. This clerical description was normative for AAPC certification through the mid-1990s.

[2] One noteworthy exception is psychologist Ken Pergament(Pergament, 2007) who acknowledges consultation with psychologist/pastoral counselor Carrie Doehring. Conversely, psychiatrist Lyn Sperry (Sperry, 2001) laments that pastoral counselors have focused on psychotherapy models to the neglect of religious and spiritual priorities.

[3]Foucault does not dismiss neurological and other organic explanations for some mental symptoms. His analysis does question, for instance, how neurological differences are compared to social norms and interpreted as "normal" or "pathological" rather than "different." However, he is particularly concerned to show how psychiatric/medical knowledge/power works to classify social and physical deviation (such as homosexuality, opposition to one's parents, ADDHD, odd thinking, deep emotional swings) as a mental illness with all the unsubstantiated neurological assumptions and social consequences that accompany such a diagnosis.

[4] Bentham proposed that social control could be established by structuring authority and observation. For example, a prison could be built around a central observation tower (a panopticon). This allowed an observer continuously to see every action in every inmate's cell. Control relied on the fact that inmates would never know when they are being observed and so must act as if they were always observed. Control is distanced from physical restraint and becomes a matter "…of mind over mind." (Bentham, 1995, p. 95)

Beyond Axis II: More Compassionate Views of Personal Distress[1]

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Abstract

The theoretical core of Axis II of the *DSM*™ is a trait-based view of personality. Using psychodynamic and characterological labels, a diagnosis of personality disorder locates the cause of personal distress as relatively permanent patterns within the individual. I argue that this is neither a compassionate nor useful way of understanding the people diagnosed or the behaviors involved. Utilizing a liberative and critical pastoral theology of personality, I outline a competence-based assessment of personality functioning that attempts to account for situational factors critical to understanding and treating socially divergent behavior. Components include: personality and interpersonal strengths; social support; commonly used defense mechanisms; and other behavioral tendencies. This type of assessment provides a holistic starting point for more effective treatment plans, while potentially reducing the stereotyping and other stigmatization that hinders progress. I also explore how such an assessment can fit into the forthcoming diagnostic systems.

Keywords Personality disorder, compassion, contextualize, competence-based, assessment

Introduction

How do we best respond to people who don't fit social norms and regularly upset others, people whose actions and even their views of life and themselves are different? Do we identify such persons as deviant, defiant, sinful, maladaptive, or mentally ill? If their behaviors are more

[1] I am appreciative for the helpful feedback on these ideas by participants in a workshop at the AAPC Midwest Regional Conference in September, 2011 and Dr. Matthias Beier.

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troubling to others than to themselves, how much of the source of the distress should be located within the individual's personality or their context? Would their actions be more acceptable in other circumstances? Does society play a role in producing or encouraging such behavior? These questions surround best practices in assessing and offering care to those who are typically given the label of personality disorder.

Best practices first and foremost must be moral. Ethics are about the ethos of a community, the values of how we live together. Such values are reflected in the evaluation and treatment of those whose behaviors often don't fit the expectations of others. In other words, diagnosis is an ethical matter. Thus, this paper examines some of the moral implications of the category of personality disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*™).[3] In the most recent published edition *DSM-IV-TR* (APA, 2000), these conditions were classified in Axis II. A carefully scrutinized proposal for the *DSM-V* eliminates the multiaxial distinction (APA, 2012a), but was not approved at the final board meeting (APA, 2012b). However, this new diagnostic model, which I discuss throughout the paper, will be a supplement for further study in the first printing; I believe it will be adopted, to some extent, in a later edition. This paper also offers alternative suggestions for assessing the distress usually labeled as personality problems that I believe have better moral grounding.

I will use compassion as a fundamental principle in evaluating these questions. Compassion is a widely held value within secular counseling professions, even lauded as one of the basic characteristics for effective helpers (Corey & Corey, 1989). This norm is not just one of clinical effectiveness, but it has moral qualities. Although compassion is far less common of a criterion than love and justice in Christian ethics, I believe its use is fitting for pastoral care and

[3] The critique of the *DSM-IV* is drawn from my previous work (Higginbotham, 2005) where more information is available.

counseling, as well as for the persons and behaviors that are the topic of this study. Compassion is an ethical and pastoral response to personal distress, because it reflects God's response to human suffering and hopelessness. "Compassion is love as it encounters suffering" (W. L. Farley, 1990, p. 79). The root sense of compassion as "suffering with" intimates a deep concern for the painful aspects of the human condition, and an unwillingness to distance oneself from persons who suffer.

Furthermore, I contend that compassion conceived within a theology that recognizes the goodness and brokenness of all people allows one to empathize with the suffering of others more wholly. Described anthropologically, all persons are tragically flawed: our very attempts to fulfill ourselves also hurt us and others (E. Farley, 1990). Thus, we can have compassion even for persons who are the source of suffering – theirs and others' – since all of us are muddling our way through a tragic story. Compassion seen through such a lens resists two common extremes that are especially prevalent in the discourse of the *DSM*: identifying the origin of suffering solely within persons and labeling those who have been wounded in a manner that does not usually aid healing.[4] In general, psychiatry defines such persons as having a fundamentally defective character. Other well-intentioned perspectives reduce them to victims of a traumatic childhood. Either extreme would seem to be a diminution of personhood, and therefore limiting caregivers' ability to have compassion and better understand the suffering of another.

Like many other pastoral theologians (Browning, 1987), I base my moral reasoning on the assumption that embedded in all human practices are fundamental commitments and related ethics. Social science is never purely objective, so the *DSM* has implicit morals. Moreover, value has no independent reality; goods only exist in a relational context based on what is fitting within

[4] Although an Axis II label can seem to externalize the problem and thus reduce shame, I believe that the overall effect is usually negative.

a web of interrelations (Niebuhr, 1946). Moral actions occur in response to interpretations of other persons' acts. Thus, I argue that descriptions of aberrant behavior and distressed persons are contingent on the values of the responder, including the cultural assumptions that are foundational in determining what is normal and abnormal.

Deconstructing a Personality Structure

I will begin with a brief examination of the discourse of the *DSM*; room does not allow a detailed analysis, but I believe that the values of the diagnostic system are readily evident. The *DSM-IV* puts forward a "general definition" of a personality disorder:

> A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (APA, 2000, p. 685).

Note the language of "enduring pattern," "pervasive" and "stable." These adjectives and adverbs presume that humans are exceedingly predictable in their behavior. This theorized consistency is due to personal dispositions, described among various psychological models as: traits, cognitive schemas, patterns of interpersonal interaction, innate needs based on genetic makeup, or emotional predispositions. The *DSM-IV* and *V* proposal uses the concept of traits as its basis of behavioral consistency. Here is how the *DSM-IV* describes the concept:

> *Personality Traits* are enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Only when personality traits are inflexible and maladaptive and

> cause significant functional impairment or subjective distress do they constitute Personality Disorders (APA, 2000, p. 686).

The diagnostic language that was proposed for *DSM-V* qualifies the level of stability: "The revised criteria for PD require that the core impairments in personality functioning and the pathological personality traits are *relatively* stable across time and consistent

> The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose a trait specified personality disorder, the following criteria must be met:
>
> A. Significant impairments in self (identity or self-direction) and interpersonal (empathy or intimacy) functioning.
>
> B. One or more pathological personality trait domains **OR** specific trait facets within domains, considering **ALL** of the following domains:
>
> 1. Negative Affectivity
> 2. Detachment
> 3. Antagonism
> 4. Disinhibition vs. Compulsivity
> 5. Psychoticism
>
> C. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.
>
> D. The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment.
>
> E. The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).

across situations" (APA, 2012c, p.10, emphasis original). Yet, justification for the proposed new criteria asserts, "as early as age 3 years, personality traits are moderately stable" (APA, 2012c, p.8). In the box below are latest criteria for a personality disorder (APA, 2011b). The language of "pathological personality traits" and "pathological personality trait domains" seems to stress the diseased nature of such persons, such that it is a part of their very makeup.

Thus, the *DSM* postulates that lifelong traits coalesce into a pathological personality structure, which essentially is determinative of behavior, generally even apart from circumstances. The metaphor of structure for personality is not explicitly used in the diagnostic criteria of either *DSM*, though it is part of the rationale for the stability of traits in the proposal for *DSM-V* and the traits themselves:

> Human personality… [emerges] from the confluence of personality traits that form a robust, hierarchical dimensional structure (Markon et al., 2005) which, in its broad outlines, is culturally universal in both self (McCrae & Costa, 1997) and observer (McCrae et al., 2005) data, suggesting that fundamental biological processes underlie its component dimensions (APA, 2012c, p.1).

Although this quote suggests physiological origins to personality disorders, possibly similar to that of other mental illness, the presumed consistency and enduring nature of personality disorders have implications for how such persons are perceived. To expand the structural metaphor, a personality disordered patient is not understood like one with depression or anxiety in which the central processor's wiring is misfiring and can be slowly reconnected by the use of medication and therapy. Rather, that which makes a person a person is misassembled such that they are incapable of functioning well, effectively creating a "certain fatalism among clinicians" (Alarcón, Foulks, & Vakkur, 1998, p. 141).

Therefore, I contend that compassion is decreased by the use of the diagnosis of personality disorder. There is little hope of change if the personality has an unfixable structure. The hegemonic and stereotypic use of these labels is widespread, even in pastoral discourse (Higginbotham, 2005). Since 2001, more than 30,000 military service members have been discharged using this diagnosis (Dao, 2012), including many who are the victims of rape

(Martin, 2012). Clinicians frequently look for personality qualities "beneath" schizophrenia, another permanent mental illness, but less often a personality disorder. Instead, the diagnosis nearly defines the patient totally. For example in my experience, "borderline" regularly generates reactions similar to an infectious disease: "I don't want to have anything to with that client!" Too often, the term is used with recklessness: a difficult female patient may be stamped with Borderline Personality Disorder even without meeting the necessary criteria, especially when there is countertransference (Becker, 2000).

Thin description

> *Global traits and states are excessively crude, gross units to encompass adequately the extraordinary complexity and subtlety of the discriminations that people constantly make… The traditional trait-state conceptualizations of personality, while often paying lip service to [peoples'] complexity and to the uniqueness of each person, in fact lead to a grossly over-simplified view that misses both the richness and the uniqueness of individual lives* (Mischel, 2004, p.18).

Trait concepts can be useful for describing aspects of human complexity, what is often called the self. My concern regarding Axis II does not mean I am arguing against the existence of a somewhat consistent personality. However, I am asserting that the trait model of personality disorders is a rather "thin" description of human behavior, making it morally questionable. In particular, the *DSM* has not taken social dynamics into account nearly enough and is inattentive to the sociocultural conditions that shape it.

There is a long-running dispute over the role of sociocultural and personal factors in human behavior, often termed the person-situation debate (Kenrick & Funder, 1988). This disagreement is held on several levels. One is the epistemological/ontological that parallels the nature-nurture debate: do persons develop primarily due to innate factors or are the self and

meaning constructed socially? This theoretical level shapes how research is conceived and interpreted.

Personality theorists broadly agree that traits develop from the interaction between biological temperaments and environmental conditions. Nonetheless, traits are formulated as intrinsic factors of personality often emphasizing inheritability (Bagby, et al., 2005), the gold standard of the medical model of the *DSM*, as well as personality structure (Widiger & Mullins-Sweatt, 2009). As a result, there is too little research on how these traits function situationally. One of the most praised articles that examined factors in context (Fleeson, 2001) concludes that traits are expressed on a continuum of changing social or temporal circumstances. Yet, the continuum of the *DSM-V* proposal rates healthy to impaired functioning, without accounting for social situations. This range is useful, but not as "thick" as possible.

A neglect of context is reflected in the recent history of the *DSM*, particularly in describing those with personality disorders as having difficulty adapting to circumstances. Although the *DSM-V* proposal clearly acknowledges the potential normativity of a sociocultural environment (criterion D in the box above; APA, 2011b), it has discarded language of adaptability, which was present in the *DSM-IV*'s general definition quoted above. In fact, references to persons' difficulty adapting were steadily removed as the *DSM-V* proposal developed. One criterion in Obsessive-Compulsive Personality Disorder citing an inability to adapt was discarded, seemingly as the focus on global traits increased. Two of the official rationales for the development of the *DSM-V* proposal (APA, 2010, and APA, 2012c) discuss early language that mentions adaptability and alternative proposals that encourage contextual dynamics. Their reasons for rejecting such possible situational sensitivity include, "inconsistent with more recent views of personality pathology" and "not sufficiently integrated with the other

parts of the proposed model" (APA, 2010, p.1). Even though understanding adaptation is useful to treatment, one should be surprised at its exclusion; clinical effectiveness is not a primary consideration for the development of the *DSM*, especially in this arena.

Here we see what I would consider a positivistic epistemological and research methodology determining the outcome. Personality theorist Theodore Millon (2012) seems to share my apprehension when he expresses concern about the move to inductive/statistical methods of defining personality. Millon emphasizes that theories of the nature of persons must be considered, such as his own based on evolutionary natural selection: a lack of theoretical principles means less integrated views of personality. Another critique concerned about the magnitude of change in the diagnostic system challenges the theory behind the *DSM-V* proposal retaining some of the traditional personality types:

> The current proposal remains unclear as to the purpose of making concurrent prototypicality and dimensional trait ratings, the relationships among the various ratings made (including potential reconstitution of less prominent types via specific trait profiles), and the potential mechanisms linking PD types and pathological traits." (Pincus, 2011 p. 47)

The proposed elimination of five of the prominent personality disorder types is supposed to limit comorbidity and improve validity, yet the basis of these taxonomic decisions is the criteria of *DSM-IV*, not the proposed new criteria. Why would the remaining types (Borderline, Obsessive-Compulsive, Avoidant, Schizotypal, Antisocial and Narcissistic Personality Disorders) remain valid?

The debate about social construction is not always esoteric. At the fundamental level of assessing someone, the inference of personality from observing behavior non-situationally risks

circular reasoning. For example if a person seems aggressive more than once, a counselor, without noting the contexts, might infer an aggressive personality. However, that assumption of aggressive personality might promote further observations and counselor-client interactions to substantiate it. Additionally, subtle shaming signals of the person reinforce negative designations, indirectly undermining self-sufficiency and self-esteem (Scheff, 1997). Alarcón et al. (1998) describe how this downward spiral functions in those labeled with a personality disorder:

> There is much evidence that psychologization is socially constructed in clinical encounters over time. As happens with so-called psychosomatic patients, personality-disordered individuals tend to reify pathogenic emotions and hence their own personality traits. As they separate those traits from an idealized concept of their social self, their pathogenic emotions or personality traits can only worsen. (p. 19)

This iatrogenic process is well-known, but particularly important with personality features. For example, research shows that many people are aggressive primarily in one type of situation such as when they feel powerless, while others demonstrate aggression in the opposite situation (Mischel, 2004). I am not suggesting that difficulties with interpersonal functioning are created *ex nihilo* in the counseling room, even though meaning-making does occur interactively. However, inattentiveness to these concerns of social psychology limits compassion. Empathy is attuned to the particularities of a person's suffering in context. Compassionate care offers hope, not an unchangeable label: as social constructivist research notes, the perception of permanence alone hinders change (Neimeyer & Raskin, 2000).

Whether persons are termed to have a pathological trait, or whether they have context-specific patterns of interpersonal behavior that do not permit the fulfillment of individual and social needs, people are evaluated based on implicit social norms. Accordingly, personal or interpersonal habits are valued positively or negatively. Given that one needs to understand the social context to determine ethicalness, the question arises: what are these norms?

Personality is primarily a social construct created in the 20th century. I believe that this concept has been and continues to be defined and maintained in a manner that orders culture, and controls issues that are constitutive to existence, but which people cannot fully understand. According to psychologist Philip Cushman's (1995) history of psychotherapy as a social practice in the United States, the two key social forces that covertly drive the helping professions are consumerism and individualism. Cushman concurs with my premise that psychology is an implicit moral discourse that replicates and supports the prevailing cultural norms. His psychosocial chronicle attempts to establish that most clinical theories have advocated a "self" which is more amenable to the economic and cultural biases of this country. "Healing technologies in the United States have been subtly complicit in the sexism, racism, and economic injustice of their eras" (Cushman, 1995, pp. 35-36).

These claims are too complex to be explored in depth here, but there is some evidence in the *DSM*. Many researchers (Becker, 1997; Bjorklund, 2006; Higginbotham, 2005; Linehan, 1993; Wirth-Cauchon, 1993) have argued that there is a gender bias in the diagnosis of Borderline Personality Disorder (BPD). Although three to seven times as many women are diagnosed with BPD as men, research (Trull, 1995) suggests that borderline characteristics are more numerous among non-clinical (no psychiatric diagnosis) men than similar women. This curious disparity suggests that the diagnostic category reflects and helps guard the boundary of

male definitions of what is considered appropriate behavior for women. One example is controlling negative emotions. A criterion for BPD in *DSM-IV-TR* clearly supports this hypothesis – "inappropriate, intense anger or difficulty controlling anger" (APA, 2000, p.710) – given that Premenstrual Dysphoric Disorder (proposed) is the only other adult diagnosis in *DSM-IV-TR* in which there is reference to **inappropriate anger** as a criterion. I suspect that the *DSM* ultimately will not make such a distinction: the proposed criteria for both BPD and the predominantly male Antisocial Personality Disorder (ASPD) use language about hostility and being easily angered. Another focus of the critique of BPD is the manner in which certain traditionally male-preferred styles of engaging others is favored, including relatively rigid boundaries. It's been argued on theoretical (Chodorow, 1989), clinical (Becker, 1997) and philosophical (Keller, 1986) bases that women's ego boundaries are generally more permeable than men's. As seen in the in the proposed *DSMV* criteria (box below) for personality functioning (APA, 2011a), this view of rugged individualism as opposed to interconnectivity continues to be reinforced: the ideal personality is represented by "clear boundaries between self and others."

LEVELS OF PERSONALITY FUNCTIONING

Self and Interpersonal Functioning Dimensional Definition

A review of the empirical literature on the dimensional models pertinent to individuals' mental representations of self and others (Bender et al., in press), and subsequent empirical analyses (Morey et al., in press), suggest that the following components are most central in comprising a personality functioning continuum:

Self:

Identity: Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience

Self-direction: Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to self-reflect productively

Interpersonal:

Empathy: Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding of the effects of own behavior on others

Intimacy: Depth and duration of positive connections with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior

Self and Interpersonal Functioning Continuum

Although the degree of disturbance in the self and interpersonal domains is continuously distributed, it nonetheless is useful to consider levels of impairment in functioning for efficient clinical characterization and for treatment planning and prognosis. Patients' understanding of self and others affects the nature of interaction with mental health professionals and can have a significant impact on treatment efficacy and outcome. The following continuum uses each of the dimensions listed above to differentiate five levels of self-interpersonal functioning impairment, ranging from no impairment, i.e., healthy functioning (Level = 0) to extreme impairment (Level = 4).

Ethnic biases and stereotypes are also likely factors in the diagnosis of personality disorders. There are indications that most personality traits are cultural preferences, which vary dramatically from ethnic group to ethnic group (Alarcón et al., 1998). One study (Iwamasa, Larrabee, & Merritt, 2000) found that university students consistently attributed particular personality disorder criteria to certain ethnic groups. This research suggests why the diagnosis of

personality disorders varies depending on the ethnic background of the person being assessed. For example, significantly more Hispanic males are diagnosed with Borderline Personality Disorder than other ethnic males (Alarcón et al., 1998). Alarcón et al. also assert that race is a risk factor for the diagnosis of ASPD, related to the prejudice of our society. Given the disparity in incarceration rates is it hard to believe that ASPD is best understood as a vestige of our culture's oppressive economic and ethnic structures, which are partially maintained through the mental health and criminal justice systems? Interestingly, research (Roberts, Kuncel, Shiner, Caspi, & Goldberg, 2007) has found that socioeconomic status has comparable predictive effect on typical measures of functioning (mortality, divorce, and occupational attainment) as personality traits.

Therefore, I believe it is reasonable to state that hegemonic forces in our culture shape the social norms underlying the DSM's view of personality functioning. Even the most critical view of human life has trouble avoiding these pervasive influences, but compassion demands that we do everything we can to account for them. Two active participants in the research supporting the *DSM* have publicly raised the question whether other new diagnostic categories "will further promote what is already an alarming overuse of antipsychotic medication in children" (Frances & Widiger, 2012, p. 123). I worry that such messages are too often ignored, as they seem to have been in this case to date.

Maladaptive versus abnormality

As I have indicated, the conventional view of mental and emotional difficulties, epitomized in the medical model, largely identifies the source of difficulty within an individual's makeup: a mental illness. The scientific claim that many intra-/interpersonal troubles can be traced to

physiological abnormalities encourages such attributions. Socially, such behaviors are more easily considered deviant. A relative balance between person and social milieu is strained in this assessment: the onus is placed on a person to adjust to the surroundings. Society is privileged, while the individual is seen as disordered and abnormal. The concept of pathological traits reinforces the ongoing perception of deviance.

I believe that an alternative paradigm of maladaptability can be a more compassionate basis of pastoral care to such persons. Generally, there is greater empathy for a misfit, than for one who is abnormal; seeing a person as deviant promotes an even less sympathetic response. I am not suggesting that maladaptability and abnormality/deviance are mutually exclusive. A person who has difficulty fitting in acts in a manner that is not completely acceptable to the circumstances, and consequently deviates from the norm.[5] The differences between these paradigms are primarily those of social perspective and inference, but these can be critically significant. Labels of abnormality and deviance necessitate internal change, which is defined as unlikely in personality disorders.[6] These persons are trapped by the terms of their identity, but told that they should change anyway. This is one of several Catch-22s created by the diagnosis of a personality disorder. Alternatively, perceiving behaviors as maladaptive encourages a greater hope of change, reframing the cause of suffering from a permanent trait to a set of conditions regarding which someone might have an ability to change. In this paradigm, many possible liberative actions exist: altering circumstances so that more people can find fulfillment, providing additional resources, teaching the person to adjust better to their cultural context, and creating new structures in the community to prevent future problems for others.

[5] In principle, deviation from what is typical can be preternatural. In very limited circumstances, potentially symptomatic criteria are sometimes seen positively, such as the benefit of being "obsessive-compulsive" as a student and in some professions.

[6] Whether or not a person's fundamental personality is changeable is a debatable depending on one's theory of personality. *DSM*'s trait model assumes that personality is relatively consistent through time.

Accordingly, a maladaptive model makes fewer assumptions about the relative moral quality of the individual versus the situation; it does not necessarily implicate the person more than the culture. Maladaptability frames the ethical dimension in social terms rather than the moralistic dichotomy of normal versus abnormal. The *DSM-V* proposal provides a dimensional scale for personality disorders, which is an improvement. Nevertheless, personality will still be given a diagnosis or not: the label will continue to be used for insurance, communication, and other clinical purposes. Of course, society has a responsibility to define appropriate behavior for its citizens. There must be some level of social control at least to prevent anarchy. However, the overwhelming majority of the persons given Axis II diagnoses are not a threat to others or even to themselves.

The question for pastoral care and counseling is how to assess the behavior and context both clinically and morally, and how to respond in a compassionate manner. A maladaptive perspective would appear to provide greater "sympathetic knowledge" (W. Farley, 1990) than deviance, by furnishing a common ground of understanding: everyone adjusts to their cultural context. Community psychology has been informative to the author for this perspective. Community psychologists often describe mental illness as an improper fit between persons and their environments (Dohrenwend & Dohrenwend, 1981; Levine, Perkins, & Perkins, 2004), invoking a new set of potentially compassionate methods and models. Prevention and social change are two of community psychology's primary supplements to traditional methods of mental health treatment, making this discipline useful for a liberative, pastoral view of persons.

There are many other resources for assessing situational factors of personal and interpersonal distress and developing treatment plans using contextual dynamics. Social cognitive theories provide insightful situationally-sensitive perspectives on personal

characteristics and functioning. For example, Marsha Linehan's (1993) well-known dialectical behavioral therapy (DBT) emphasizes the importance of environment-person systems in making sense of personality. She argues that despite emotional dysfunction and invalidating environments, persons with the most challenging personality dysfunction can be taught skills to better adapt to and even change their systems. Mindfulness, conflict-resolution, tolerating emotional distress, and self-validation and self-regulation of emotions are some of these personal and interpersonal skills.

The psychologist who essentially started the person-situation debate more than four decades ago, Walter Mischel (2004), continues to assert that the situation must be incorporated at every level of understanding traits to have a coherent view of personality. Mischel stresses contextual cues:

> In this social cognitive view of personality, if different situations acquire different meanings for the same individual, as they surely do, the kinds of appraisals, expectations and beliefs, affects, goals, and behavioral scripts that are likely to become activated in relation to particular situations will vary. (p. 5)

There has been substantial research on the impact of contextual cues on children's personality (Wentzel, Filisetti, & Looney, 2007, e.g.) and development including how self-perception and self-presentation are shaped by cues about social acceptability (Gee & Heyman, 2007). One can see how repeated person-situation interactions become well-integrated into the habits of individuals. Nevertheless, the clinician should be attempting to understand environmental triggers, even of behavior and self-concepts that seem less variable.

Social cognitive theorist Albert Bandura (1986) has developed a positive, context-specific model of self-efficacy. People regularly reassess their capabilities; changes in self-efficacy can occur through social influence and from learning to control emotional arousal in situations that create anxiety or fear. Many unhelpful habits are anticipatory and can be modified with cognitive-behavioral techniques. Freeman, Pretzer, Fleming, & Simon (2004) offer other ideas for the clinical use of self-efficacy.

Situational factors are regularly considered in clinical practice, but some may be quickly forgotten when a person is given an Axis II diagnosis. In particular, social marginalization due to demographic factors and hegemonic systems disempowers, reducing one's ability to function well in more stressful conditions than those who have greater social control. This strain on self-efficacy contributes to the self-defeating and troubling behavior characteristics of these persons. For example, Pamela Couture (1996) compellingly describes how cultural assumptions of self-sufficiency combine with systemic disadvantages like poverty and sexism to undermine a woman's sense of competency, contributing to symptoms that result in a diagnosis of personality disorder.

Social location is especially important for the interpretation of aberrations in personality, as Alarcón et al. make clear:

> Defining or labeling deviances from normal personality is a culturally relative exercise whose boundaries reflect society's specific values, ideas, worldview, resources, and structures. What may be adaptive in a traditional cultural context may be maladaptive in a different cultural system. (1998, p. 176)

Or put another way: what is adaptive in marginalized contexts often is rejected by the broader society as deviant.

One of the most important ways that hegemonic social forces contribute to the development of personal and interpersonal distress is the greater risk for trauma, which is often associated with this population. For example, as many as 85% of persons diagnosed with BPD report a history of trauma (Venta, Kenkel-Mikelonis, & Sharp, 2012). Childhood maltreatment and neglect, along with poverty, are considered the highest environmental risks for the development of antisocial and violent behavior (Cohen, Crawford, Chen, Kasen, & Gordon, 2012).

I suspect that pastoral caregivers are more likely than other professionals to assess clients for a history of trauma. Moreover, the theological, communal, and faith dimensions of pastoral care and counseling have the potential to enable greater resilience for lessening the impact of traumatic events and even enabling growth. Jan Holton (2011) offers a rich, contextually-sensitive understanding of resilience. She provides an outline of some qualities of resilience that might be useful for distressed persons who have been traumatized: the importance of a relatively safe space, creating greater agency, helping persons learn to tolerate ambiguity, enabling meaning making, community sources for healing narratives, and the need to name and/or claim justice. The model of Strategies for Trauma Awareness and Resilience (STAR) developed at Eastern Mennonite University stresses that justice is healing on both the individual and communal levels (Yoder, 2005). Of course, for many persons oppressed by institutional bureaucracy or with a history of child abuse, justice can seem elusory. Nonetheless, participation in healing communities frequently is a critical component for creating a sense of contributing toward the good of others; this solidarity may help to right the wrongs that have been experienced, imparting meaning for what may have seemed to be meaningless events. When a

spiritual element is added, the effect on one's personal identity can be profound. Social support is layered upon transcendent hope, which can build resilience.

A more compassionate appraisal

At the heart of a best practice with those traditionally labeled with a personality disorder is a strength-based assessment and treatment of personal and interpersonal functioning. This is a growing, popular direction for counseling theories and methods, but the moral assumptions of the discourse must be examined. For instance, the famous researcher Martin Seligman and his colleagues have developed a system for classifying character strengths and virtues (Peterson & Seligman, 2004) involving six categories, called core virtues: wisdom, courage, humanity, justice, temperance, and transcendence. Within each of these categories – considered relatively cross-cultural – are two dozen specific virtues like creativity, persistence, kindness, fairness, prudence, and playfulness. At face value, this system based in positive psychology seems like an attractive resource for identifying personality strengths. However, the implicit values of positive psychology (McDonald & O'Callaghan, 2008) signal caution in its use. It probably falls victim to the individualism and consumerism prevalent in American psychological discourse. At least one can argue that positive psychology is not as value-free as it claims. Pastoral theologian Mary Moschella (2011) has provided a helpful initial guide to using its resources, such as encouraging contextual sensitivity in utilizing these virtues.

One potentially very effective approach for working with persons experiencing personal and interpersonal distress is to assess and develop strategies regarding their coping mechanisms. These survival systems are often unrecognized strengths. The *DSM-IV* (but not the *DSM-V* proposal) included this dimension as an axis of assessment for further study. The Defensive

Functioning Scale (APA, 2000, pp. 807-813) included a hierarchy of adaptability and list of definitions of defense mechanisms. Unfortunately, this summary seemed to assume global, negative usage. Coping strategies, like personality traits, are likely far more context specific. An assessment of coping must consider how the strategy fits the particularities of the situation and persons involved (Folkman & Moskowitz, 2004).

With persons who are typically given Axis II diagnoses, clinicians seem to have a tendency to forget that all coping mechanisms are useful in some circumstances. Of course this population tends to overuse certain styles of dealing with anxious situations: some persons called borderline employ splitting nearly every time abandonment is sensed and others called narcissist over-utilize self-aggrandizement in similarly fearful situations. Yet, the idealization of splitting is helpful for social learning, if one is emulating the right person. Exaggerated self-esteem can be effective when interacting with highly critical people. Understanding the triggers, patterns, and other distinctive dynamics of the individual and surrounding systems is key to helping persons develop more adaptive reactions. Additionally, coping qualities that are more reliably adaptive often go unrecognized. In my work with many who were labeled with a cluster B personality disorder, I observed a determination, a will-to-survive that was amazing. This type of strength can be utilized for a wholistic approach to teaching such persons alternative strategies when signs of increased anxiety arise. Moreover, the reinforcement of personal and social strengths increases resilience.

Pastoral caregivers can help persons identify religious coping resources. Belief systems are valuable for meaning-making, including finding hope in the face of past suffering and seemingly intractable personal and interpersonal problems. Tenets of faith can provide a sense of control even when agency seems lacking: trust in God's presence or a better future often

empowers people. However, the counselor may want to help persons assess their religious coping styles in relation to their identity and their context. Pargament (2001) has observed that religious beliefs involving less internal locus of control are associated with poorer problem-solving ability. This is a delicate matter since it isn't a pastoral counselor's job to preach a good theology. Nevertheless, it can be good pastoral practice to compassionately observe that a pie-in-the-sky theology might be contributing to distress: for example, by encouraging someone to be in denial about the destructiveness of the context and/or the manner in which it is engaged.

Therefore, the approach I'm inviting as an alternative to the diagnosis of a personality disorder can be summarized as follows:

<u>Competence-based assessment of personal functioning, accounting for situational factors</u>

- Personality and interpersonal strengths
- Commonly used coping mechanisms in context, identifying adaptive and maladaptive styles
- Social support and possible lack thereof
- Tendencies to self/other-destructive behavior situationally
- Tendencies to socially unacceptable behavior situationally
- Other situational factors:
    - Social and other systems that may disempower or otherwise limit self-efficacy
    - Historical events: trauma, invalidating environment, etc.

I believe that this is a far more compassionate appraisal than the traditional diagnosis of a personality disorder. Appreciation for the uniqueness and beauty of an individual leads to greater empathy and deeper understanding of the distress. Context-sensitivity also provides the counselor with more avenues for treatment than the *DSM*, across a wide range of clinical orientations. It is challenging to offer care to those whose personal and interpersonal distress

often troubles others. A holistic, particularized appraisal can help empower everyone involved, in ways that mitigate the effects of stresses that contribute to these and other mental health problems.

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Pastoral and Spiritual Care across Differences that may Divide and Oppress

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Abstract This article provides theological, clinical, and theoretical resources for pastoral and spiritual care providers who wish to be effective in providing care across embodied differences such as sexuality, gender, race, and class. The article assists care providers in naming and resisting the oppressive inequities of power and privilege that accompany and complicate these experiences of difference. Resources to assist the care provider's reflections on her or his own social location with regard to these differences are also provided.

Keywords Ally, five faces of oppression, intersecting oppressions, privilege, power, social identity development, sin, imago dei, relational justice, embodiment

A Case

George and Pearl are each 20 years old. They live in a metropolitan area in north Texas. They met at a local community college where George had enrolled in a computer technology program and Pearl was in a secretarial program. George and Pearl each identify as African American. They married last year after graduation from their programs and live in an apartment not too far from the airport where George has gotten a job with Thrifty Car Rental as a front desk customer service employee. Pearl has to drive about 30 minutes to an elementary school where she has a clerical job in the office.

George's parents live in the city. George's father is employed on an assembly line in the automobile industry as was his father before him. George's mother is a cook in an elementary school. Pearl's father is a plumber with a local company and her mother is a faculty secretary at

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the local community college. Pearl's parents were not thrilled when she introduced them to George because they had hoped she would marry someone whose employment prospects were better. They worried that George would not be able to provide for her as her father had. George's parents worried that Pearl might have ambitions their son would not be able to satisfy.
George and Pearl each worked while in their courses of study and lived at home to reduce costs, but their combined incomes after graduation only allowed them to rent an apartment. Pearl's parents had other children to help, and they could not loan them any funds for a down payment on a small home or condominium. George's parents had no extra savings. The rent and insurance take a third of their monthly income.

Pearl and George want to start a family, but Pearl cannot risk losing her job and childcare is too expensive to manage. Pearl has already begun to ask George about promotions at his work that would allow them to save for a down payment on a home or condo. George tries to describe the tension he feels at his job due to the working environment. His supervisor is Paulette, a 40 something European American woman. The others at the desk are Paul, a Korean American man who is getting a college degree while he works there and Theresa, a European American woman who just finished her community college program and started 3 months ago. George thinks promotions will be tough to come by given the tightening competition in the industry. He also worries that Paulette has some bias against him since she repeatedly points out small ways he can improve. She is less critical of Paul and is forgiving of Theresa's efforts as a new employee. He worries that Paul will get the Assistant supervisor promotion that should be coming up soon. He knows he can't prove any bias even though he thinks it is there. George doesn't want to whine at home, but the anxiety about work is always on his mind. Pearl is the only African American in the office at her school. She also acknowledges unease in her setting due to the comments

sometimes made about African American parents and children by others in the office. These are highly insulting. She knows that if she complains about the racist comments, her work environment would become much worse.

Pearl calls you, an EAP (Employment Assistance Program) counselor through the school system because she and George are beginning to take out their tensions about work on each other. They need their jobs, and they find the constant subtle and not so subtle racism on top of their economic worries is doing them in.

Naming the situation

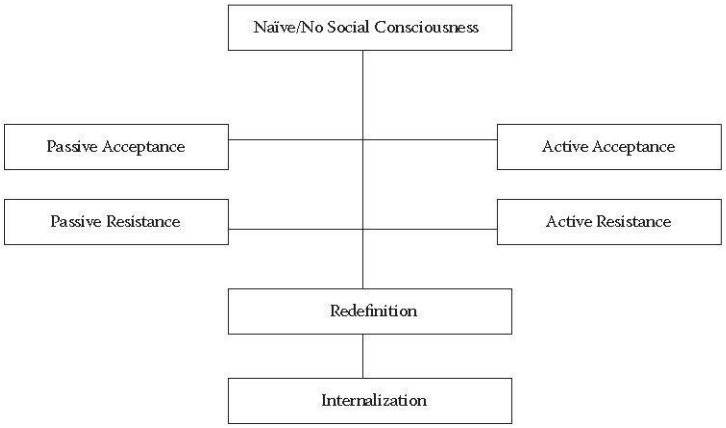
As the counselor to whom this couple is referred, providing effective care will require several kinds of knowledge, including the implications of such knowledge for our own critical self-awareness about our embodied experience of differences such as gender, sexuality, race, and class. These intersecting differences are often treated oppressively in church and culture in the United States. As a provider of spiritual care, it also will be important to be familiar with the theological themes that inform the dilemma that Pearl and George are confronting. In particular it is crucial to recognize that embodied differences such as gender, sexuality, race, and class are not the problem but simply part of the context for the difficulties this couple are experiencing. This case illustrates the way in which brokenness arises as inequities of power and privilege insinuate themselves onto such intersecting differences. Inequities of power and privilege at personal, relational, systemic, and cultural symbolic levels will be part of our analysis. We will also identify useful theological resources for resisting the dehumanizing consequences of intersecting oppressions such as racism, sexism, and classism that we and our clients experience.

Strategies and Resources

Fortunately for spiritual caregivers there is a helpful convergence between theoretical resources and theological ones in identifying the origin and enduring character of the brokenness that is apparent in the experience of George and Pearl. For millennia, theologians in Christian tradition have identified the way in which the context of the human community into which we are born is already distorted by patterns of distrust and enmity that predispose human beings to reproduce these distortions, usually initially without awareness that we have been shaped by such destructive forces and subsequently with some level of awareness about our complicity (Augustine, 395/1964). Wendy Farley (1990) describes this process using the metaphor of "sin as lie." She rightly notes that human freedom is not finally constrained from acting on behalf of an ethic of mutual love and care but, especially for those relatively privileged by patterns of inequity, making choices to resist such patterns is difficult. Fumitaka Matsuoka (1998) offers a slightly different metaphor for the effect of sin as lie: "the negation of relation." His point is that when those with privilege accept the lie that the patterns of inequity in power and privilege are inherent and thus unavoidable in the human community, they negate God's intention for a human community shaped by the ethic of neighbor love. Their behavior objectifies the other with all its related material and political and spiritual consequences. Unwittingly such behavior also diminishes the humanity of the privileged in whom God's image is diminished. From the context of critical race theory, Bobbi Harro (1986) helpfully augments the work of and Farley and Matsuoka with her cycles of socialization and liberation. Like Farley, she rightly describes how our freedom to enter into relationships that cross differences such as gender, sexuality, race, and class that are deeply distorted is compromised by patterns of socialization that precede our

critical awareness. That means that everyone begins the work of resisting these sorts of oppression not from guilt but from a desire to be freed from the constraints of oppression and freed for love as mutual regard. Both theologians and critical theorists note that the goal of freedom from oppression is true whether persons find themselves in the position of victim marginalized by oppressive patterns of socialization or as those whose agency reproduces oppression wittingly or unwittingly.

Social Identity Development Model



Rita Hardiman and Bailey Jackson, III & Griffin (2007) articulate a social identity development model that well describes the possible developmental trajectory for persons who intend to resist their complicity in the oppressive treatment of one or more forms of difference. Like Harro, Hardiman and Jackson note that this process of intentional change happens, if it happens at all, when a person has one or more experiences that precipitate recognition of the possibility that the marginalization of some identified groups in culture is a "lie," to use Farley's language. When that happens the person moves from a status of active or passive acceptance of such status to passive (that is, not public) or active resistance of their earlier understanding. For persons who

may have enjoyed a privileged status vis-à-vis that difference this means deconstructing a privileged identity. For those who were victimized by such an identity, it means deconstructing their "victim" status. In either case, such work obviously would be difficult and more likely successful in the context of communities of confirmation and support. If they are successful in this resistance eventually persons find their energies more focused by redefinition from either privileged or victim postures toward embracing a commitment that all should enjoy full rights and privileges as equally valued members of the human community. This constructive process also requires considerable support. Eventually, the focused work of reconstructing an identity yields to a new identity in which a revised sense of self is internalized. This identity development model is highly valuable for teaching and clinical practice. Spiritual caregivers can identify the status of our own social locations and "homework" regarding our own processes for resisting differences treated oppressively. Similarly we can listen for the locations of those such as Pearl and George who seek our care and for whom such issues of difference are locations of brokenness. It is important to note that working one's way through one aspect of difference such as racism or classism does not resolve the work of resisting oppression related to other types of difference. Janet Helms (1990) has developed helpful models for clinicians who may underestimate how important it is to be vigilant in addressing our own efforts to deconstruct internalized privilege or stigma and reconstruct an identity that is alert to the work of supporting those harmed by the oppressive treatment of difference. While her work focuses on differences between African Americans and European Americans, it is transferable to other racial groups and a wider range of experiences of oppression.

As the case of Pearl and George suggests, in lived experience intersecting differences inevitably give rise to a certain messiness in which we must find our way toward approximations

of just and loving outcomes. No person or group is immune from the distortions that arise in and accompany experiences of gender, sexuality, race, and class. For example, George and Pearl both know the oppression of racism. Their family backgrounds also reflect real socioeconomic class distinctions that have insinuated themselves into the African American community. For example, Pearl's parents imagine Pearl has "married down" because she is marrying the son of a factory worker and cook while her father is a skilled craftsman and her mother a secretary in a college setting (Orr, 1997, 2000). The fact that neither set of parents can assist George and Pearl with a down payment on a house discloses a real economic consequence of marginalization and discloses a predictably diminished economic trajectory for George and Pearl that has long term consequences (Kliman & Madsen, 1998). As George's parents feared, we find Pearl wanting her husband to "move up" the promotion ladder. George finds himself in a work context where he shares his work status with persons who have subtle differences in status from his by virtue of intersecting differences in race, class, and gender (Wimberly, 1997). Paul is working on a college degree and as an Asian American is associated with a more "successful" minoritized racial group while Theresa seems to share George's class status and has her own minoritized status as a woman but the situation suggests her identity as a European American may be a benefit especially with a supervisor who may unwittingly identify with Theresa. George believes he is experiencing less equitable treatment from his Euro-American supervisor, but it may be too subtle to prove and too dangerous to name if he wants to keep his job. How can George convey the reality of the oppression he experiences and the support he needs to Pearl who is in a context where racism is not at all subtle?

Effective care for this couple will require that a spiritual care provider be able to draw on several aspects of critical theory. For example, critical pedagogy resources such as the Group

Membership Profile help us recognize that each person's apparently personal identity is in fact a dynamic composite of multiple dimensions of social group identity: ethnicity, race, class, gender, sexuality, age, and so forth (Hardiman, Jackson, & Griffin, 2007). These are not benign differences. Rather, they predictably disclose our vulnerability to the distortions of inequities in power and privilege as patterns of dominance and oppression play out. Moreover, as George and Pearl's experiences demonstrate, these differences modify one another such as class differentiating within race. It is helpful for persons offering skilled care to be well acquainted with the way these competing differences arise and complicate personal and interpersonal experience as well as distorting the possibilities for structural and systemic justice. Of course, alongside noting how the identities of persons such as George and Pearl reflect this complex construction, it is also crucial that caregivers consider the construction of our own identities. The group membership column is self-explanatory. The status column may be less so. In this column we note whether a person's particular aspect of social group membership is targeted or privileged by the prevailing norms of the dominant culture. In some cases status is dynamic such as with age and ability/disability. In other cases status is nuanced such as for Pearl's status with her gender. Clearly women continue to have a marginalized status in this culture. However, Pearl is well aware that her status as an African American woman differentiates the status of her gender relative to the European American women in her work environment. Similarly, George recognizes that his status as a man is modified by his racial status and his class in his work environment. As these illustrations suggest, this model offers multiple resources for caregiving. For example, it gives helpful insight into the internal experiences of individuals and couples. It also assists them in identifying ways larger structural and systemic forces that carry the "lie" of stigma and privilege predictably become internalized in persons' sense of self and in their

relational systems, as we see with this couple and larger family system. Further, this model helps caregivers do the important work of identifying relevant dynamics in their own lives and relational systems so that they are more likely to be effective with those who seek their care. Hopefully, such a model also encourages caregivers to accept opportunities for advocacy and for resisting oppressive structures and systems as allies.

Group Membership Profile

Social Group Membership Profile

Social Identities	Social Group Membership	Status
Ethnicity		
Race		
Sex		
Gender		
Sexual Orientation		
Age		
Class		
Religion		
Ability/Disability		
Other		
Other		

A spiritual caregiver working with George and Pearl may well invite them to explore the dynamics of class and race in their own experience. Perhaps such exploration may help diminish the way the internalization of class differentiations seems to be problematic in their marriage and larger family context. Alongside such exploration, the "status" column of this chart will allow the couple to identify ways they can externalize possible internalization of stigma. George, for example, may more confidently recognize the external factors operative in his office setting and act strategically regarding his hopes rather than internalize shame. Pearl may also recognize how her expectations and pressures about promotion deny the oppression George is experiencing. Each may be able to support the other in the oppressive struggles that characterize their work environments. Caregivers whose group memberships and status vary from those of George and

Pearl will find this model useful as it points them toward information and possible consultation in order to be effective. For example, resources on African American marriages and families such as those authored by Nancy Boyd-Franklin (2003) and W. Sue and D. Sue (2008) and those written by pastoral theologians such as Edward Wimberly (1997), and Lee Butler (2000) will be important to review. Similarly, resources on socioeconomic class will also be valuable, such as those found in Rothenberg's *Race, Class, and Gender in the United States*, 8th Edition (Rothenberg, 2009), Kliman and Madsen (1998), Leondar-Wright and Yeskel (2007), and the work of the late pastoral theologian Judith Orr (1991, 1997, 2000).

Hopefully any caregiver, and certainly spiritual caregivers, will realize that care for persons who describe the pain of differences treated oppressively cannot be offered from a stance of neutrality. As Edward Wimberly rightly notes, care is a political act (Wimberly, 2006). This pain arises from systemic, structural injustice that is felt at individual and relational levels as well as among entire identity groups. Theologically, the negation of relation describes ontological loss that includes as well losses related to political, material, and economic rights and resources. Offering care to persons experiencing oppression calls for the readiness to accept the role and privilege of being an "ally." When persons who experience privilege in one or more aspects of their identity choose to support those for whom aspects of identity are treated oppressively, such a choice opens the door both for personal transformation described above in the social identity development model and for advocacy regarding change in the structures and systems that maintain such inequities. Allies will not be effective who do not recognize and step into a process of transformation of their own identity and behavior. Similarly, allies do not empower others but rather support those who experience oppression in the process of retrieving their

rightful agency. To be an ally is to work for everyone's agency including a revised experience of one's own (Hardiman, Jackson, & Griffin, 2007).

Another challenge that accompanies care in the context of forms of oppression lies in the realization that there are multiple, intersecting, often competing forms of oppression, as the story of George and Pearl illustrates. How do we learn to see oppression in its complexity and avoid reducing that complexity by forcing it to be one or another manifestation? Iris Marion Young (1990) addresses this well in her essay, "The Five Faces of Oppression." Young notes that these five aspects of oppression are at once interdependent in effect while each on its own is oppressive. This means there is no hierarchy of oppressions though we caregivers may find an accrual of consequences across various forms of oppression that creates a more problematic effect. She identifies five "faces" or aspects of oppression that assist caregivers in naming, assessing, and responding to experiences of oppression. Exploitation describes a structure of inequitable exchange in which the labor of one group benefits another. Marginalization describes the structural effects of refusing whole categories of persons' meaningful participation in the culture. Powerlessness negates the authority and status of persons at institutional and structural levels. Cultural Imperialism has a structural and symbolic consequence in that the history and identity of a group become relatively invisible. Finally, violence, which intersects with one or more of the other four aspects, allows random, systemic violence against some identity groups without accountability on the part of perpetrators and their dominant group. These five "faces" of oppression offer caregivers a helpful frame for effectively engaging the complex intersections of oppression such as the ways in which we find marginalization, powerlessness, and cultural imperialism especially evident in the experience of Pearl and George.

Theologically, we have earlier identified several relevant theological themes that inform social science and critical theory resources in the work of caring for those who experience oppressive treatment of difference. Because I have developed these theological themes elsewhere I will address them only briefly here (Ramsay, 2010). The themes of Imago Dei, love, relational justice, sin, and embodiment are certainly central resources for spiritual caregivers.

Foundational in Christian and Jewish sacred texts is the claim that human beings are made in the image of God for relationships with our neighbors that are shaped by mutual regard and care. We are essentially relational so that what diminishes one diminishes the other. This insight that our well-being is so intertwined as to function ethically is also evident in critical theory sources about the work of being allies with those experiencing oppression. Allies recognize that their freedom is intertwined with that of others who experience oppression. Neutrality is not an ethical option.

The idea that our human relationality has ethical force is reflected in the sacred texts of the three Abrahamic faiths. We read in each about the ethical centrality of hospitality. As early as Leviticus 19 we find the imperative for neighbor love and the reminder that we will find ourselves in the face of the stranger/alien. Christian scriptures also point to our inextricably connected well-being through the three-fold command to love God, self, and neighbor.

Relational justice is now a well-established norm in pastoral theology (Graham, 1995). When Larry Kent Graham first coined this phrase, he challenged spiritual caregivers to recognize the intimate connection of love and care with justice. Justice emerges as the ethical trajectory of our claim of the *imago dei.* Justice seeks to make neighbor love possible. The phrase relational justice helps underscore the work of allies who join in the struggle of transforming public policies and practices that reproduce material and political inequities such as Pearl and George

encounter. Linking justice with love also reminds us that power is a deeply theological concept. Relational justice is the *telos* of human agency as it shapes our energies in behalf of love.

Much earlier in this article I noted the relationship of oppression and sin, and I suggested the helpfulness of two metaphors for sin: "sin as lie" and sin as "the negation of relation" that describe the ways human beings who enjoy privilege obscure our complicity in the oppression of others (Farley 1990; Matsuoka, 1998). Both these metaphors point us more toward sin as omission; sin as the unwitting participation in the oppression of another. Iris Marion Young (1990) helpfully differentiates oppression and dominance. Dominance, she suggests, is intentional action to control and limit another. Farley's typology of sin as a progression of rationalizations (lies) that protect us from our witting participation in the suffering of others discloses how effectively privilege functions to protect us from the obligations of neighbor love. Our work continues in finding and refining metaphors that will be effective in disclosing the seamless way oppression slips into dominance.

The theme of incarnation in Christian sacred texts points us toward embodiment as an important aspect of differences that function oppressively. Gender, race, and sexuality, for example, are aspects of creation that reflect the creative imagination of God. Class does not arise as an embodied difference. Rather it reflects the practices and consequences arising from various economic policies. However, the relational consequences of differentiations among persons based largely on arbitrary economic policies does quickly and indelibly shape embodied experience in ways that privilege some and oppress others. Clinicians and pastoral theologians have helped us recognize how class shapes/distorts self-understanding and relational expectations (Orr, 1991, 1997, 2000; Kliman & Madsen, 1998). The consequences of oppression and domination disclose how differences in embodied experiences particularly as the absence of

privilege may well have serious consequences. For example, inequities in health care, education, and housing predictably lead to lifelong physical, material, and political inequalities.

Concluding reflections

These brief explorations surrounding experiences of difference treated oppressively underscore for spiritual caregivers the priority of equipping ourselves to discern the markers of oppression and privilege and to develop the skills and resources to walk beside those who seek release from the painful consequences. It is equally apparent that to be effective in such care, we need to embrace the journey of deconstructing sources of stigma and privilege that limit our own freedom to offer love and seek relational justice.

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Exploring Forgiveness of Veteran Guilt through Collaborative Pastoral Conversation

Larry Kent Graham[1]

Abstract

Collaborative conversation between combat veterans and their friends, family members, and spiritual caregivers may disclose multiple layers of shame and guilt connected to moral trauma generated in warfare, enabling veterans to become the experts of their own experience and to co-create with their conversation partners a sense of self-forgiveness, forgiveness of their communities, and forgiveness by their God for the moral distress they carry in the aftermath of war.

Keywords Moral trauma, moral injury, collaboration, forgiveness, spiritual

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"Some events take a lifetime to reveal their damage and influence."
Michael Ondaatje[2]

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Addressing moral trauma in pastoral and spiritual care

The number of US war veterans and persons in active military duty is large. In 2010 the United States Census Bureau (2012) identified a total 22,658,000 veterans in the United States, 16,886,000 of whom were combat veterans whose service ranges from World War II through Afghanistan and Iraq. The Department of Veterans Affairs' Office of Public Affairs (2011) reports that 41,892,128 citizens have provided US military service during wartime from 1775-1991. This study indicates that 16,962,000 veterans of past wars were living in 1991. In addition to this large number of living veterans, as of December 31, 2011, there were a total of 1,414,000

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[2] Ondaatje, 143.

active duty military personnel, including 152,000 deployed to Iraq and Afghanistan (Vet Friends, 2012). These men and women will soon become veterans. Put simply, going to and returning from war is a longstanding fact in American life.

The long-term damage that war inflicts on combat troops and others deployed in their support is receiving much attention in the media, professional literature, and public policy initiatives. There is a genuine desire to honor soldiers from former wars and to welcome home the troops from current deployments in Iraq and Afghanistan. There are growing efforts to invest them with honor for their service and to help them find a significant role in society. The nation is increasing resources to help war veterans address the enduring physical, relational, and psychological injuries arising from their deployments.

Veterans require a variety of health-care resources. Over twelve million veterans are enrolled in the Veterans Affairs (VA) Health Care System; nearly eight and a half million are receiving health care, with three and a half million receiving VA disability Compensation (US Dept. of Veterans Affairs, 2012). Included in these statistics is the growing prevalence of veteran care for spiritual and psychological damage. The National Center for PTSD (2012) estimates that thirty percent of Vietnam veterans, ten percent of veterans from the Gulf War and from eleven to twenty percent of those from Afghanistan and Iraq will develop PTSD. David Wood (2012), writing in the Huffington Post, states:

> Roughly 2,413,000 young Americans have served in the Iraq or Afghanistan war, so far. More than 600,000 of them may be struggling with PTSD and major depression. The Department of Veterans Affairs (VA) has formally diagnosed 207,161 Iraq and Afghanistan war veterans with PTSD. But experts believe many more are affected because of shortcomings and defects in screening and diagnosis. A recent study by the RAND

> Corp., a Pentagon-funded think tank, suggested how many undiagnosed veterans there might be. It estimated that some 14 percent -- or about 337,820 -- of post-9/11 veterans suffer from the headaches, sleeplessness, irritability, depression, rage and other symptoms of PTSD, whether or not they are formally diagnosed. An additional 14 percent suffer from major depression. The VA's National Center for PTSD confirmed the numbers as accurate.

We also know that suicide rates for veterans are extremely high, and climbing. The VA estimates that eighteen veterans take their lives every day (Wood, M., 2012) [3] and Nicholas Kristof (2012) indicates that there are twenty-five suicides by veterans for every soldier killed in Afghanistan:

> Here's a window into a tragedy within the American military: For every soldier killed on the battlefield this year, about 25 veterans are dying by their own hands. An American soldier dies every day and a half, on average, in Iraq or Afghanistan. Veterans kill themselves at a rate of one every 80 minutes. More than 6,500 veteran suicides are logged every year — more than the total number of soldiers killed in Afghanistan and Iraq combined since those wars began.

To their credit, the military and the Veterans Administration have taken strong initiatives to promote resiliency and to treat without stigma the onset of relatively short-term Post-Traumatic-Stress [PTS] and the more chronic Post-Traumatic-Stress-Disorder [PTSD] that often underlies these dire situations. Civilian initiatives for veteran education, employment, and reintegration are on the rise.[4] Churches and religious communities have begun to recognize their role in receiving veterans back into the community and supporting their transition.

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[3] For a fuller discussion of military suicides, see Harrell and Berglass (2011).
[4] Intersections International sponsors a Veterans-Civilian Dialogue, with links to other similar resources: http://www.intersectionsinternational.org/our-work/veterans-civilians.

The mental health field has awakened to the special needs of veterans and their families, particularly in research and treatment of PTSD (Shay, 1994; Surfield & Platoni, 2012; Tanielian & Jaycox, 2008). In addition to programs to help veterans address PTSD, psychologists such as Edward Tick (2005) and Maguen & Litz (2012a,b), are identifying spiritual and moral trauma as a particular arena of care. Pastoral and theological caregivers such as Carrie Doehring (2012) and Rita Nakashima Brock and Gabriela Lettine (2012) are focusing upon the moral and spiritual elements enduring after combat.[5] In the spiritual care literature, moral trauma is regarded as a standalone matter, connected to but not synonymous with PTSD, that requires special attention if veterans are going to be relieved of the burdens they carry and restored to a life energized by a sense of worth.[6]

As used in this article, moral trauma is the feeling of shame, guilt, and failure that occurs when an individual witnesses, performs, or is impeded from performing acts that violate the sense of right and wrong at the core of their personal and social identity. Moral trauma, moral distress, and moral injury are used synonymously in this writing. Moral trauma is a component of spiritual crisis, along with questions of meaning, hope and despair. Moral trauma may be temporary or chronic, as well as latent or manifest.

[5] Carrie Doehring is my colleague at Iliff School of Theology and is the Director of Iliff's Master of Arts in Pastoral and Spiritual Care, which includes a special one-year MAPSC (Master of Arts in Spiritual and Pastoral Care) for Military Chaplains, developed at the request of and in collaboration with the United States Air Force. Rita Nakashima Brock co-directs with Herm Keizer the Soul Repair Center focusing on Moral Injury Recovery at Brite Divinity School at Texas Christian University. Information on this program is available at http://brite.edu/programs.asp?BriteProgram=soulrepair.

[6] Not all veterans have a religious and spiritual foundation. About 25% of active duty military personnel have no religious affiliation or their affiliation is unknown (see http://ac360.blogs.cnn.com/2009/11/12/raw-data-religious-preference-in-the-military/, accessed August 30, 2012). But, one does not have to be in a religious tradition to raise the fundamental human question of whether life is good and whether humans are good or evil and whether I am a moral person. Our Western monotheistic culture also defaults to these questions and mental furniture, whether or not persons are committed to a religious tradition. It is part of our assumptive world, or at least is an entry point to the assumptive world of morally distressed veterans.

Pastoral and spiritual caregivers are recognizing our unique role in addressing the explicit moral and theological challenges that war has brought into place for veterans. We are recently discovering that the territory of moral distress and trauma as a dimension of pastoral and spiritual care.[7] Our training allows us to respect the pre-verbal angst that renders speechless and isolates the spiritually distressed veteran. We have a communal context and an enduring loyalty that empowers us to walk alongside one another as a "fellow-sufferers who understand…" for as long as it takes no matter what does or does not come into being (Whitehead, 1929, pp.411-413). [8] And when images, memories, words and stories begin to emerge out of the silence we are there to receive and share their burden and to explore their promise.

Spiritual distress and the question of goodness

What, then, is the spiritual and moral landscape that pastoral and spiritual caregivers find among veterans? And how do we walk with those who are morally injured by war? Based upon my research, teaching, and caregiving with families touched by war, I have concluded that the moral and theological challenges are variants on one central anguish-driven question about the meaning of life. That central question is, "Is life good?" In one way or another veterans ask, "Can I still feel and believe that life is good? Given the massive destruction of nature, innocent people, and human habitats that I have seen and contributed to, can I really say that the universe is a good place to be? Do my efforts on behalf of a higher good make sense any longer?"[9] How this

[7] To say that spiritual and pastoral caregivers have a unique role in addressing questions of meaning and morality does not mean that 1) we don't have a role with other elements of veteran care and that 2) other helping professionals are not trained to skillfully address religious, theological, spiritual, and ethical matters.

[8] Alfred North Whitehead (1929, pp.411-413) argues that God's being is always present to every molecule of existence and receives "feelingly" directly into God's nature the beauty and the evil that occurs moment by moment in the unfolding of the universe. Because there is so much pain and suffering in the world, God too suffers as a "great-companion" with every aspect of experience in the cosmos, including every element of human reality.

[9] In the West, the question of the "good" is not the only philosophical and moral question about the nature of life. We also search for the beautiful and true. Beauty, Truth and Goodness seem to be the core values dominant in the

question is managed at the soul-level determines if veterans will recover hope, languish in despair, or teeter between them.

The social corollary to the philosophical question of meaning of whether life is good is, "Is my country good and does this war we are fighting (or that we fought) reflect my country's commitments to the common good or is my country wrong to engage in this war? Can I continue to have pride in my country and regard myself as a good citizen given what my country is doing and what it has made me do in war?" Another form of this question is, "Can I forgive the enemies of my country for what they have done to us and to my fellow-soldiers? How can I settle the moral accounts between enemies?" Moral trauma and distress is exacerbated when a veteran believes that their country's actions were wrong, or when they carry hatred and feelings of revenge toward the groups against whom they fought.

The personal corollary to the question of whether life is good is, "Am I good? Given what I did in war, whether or not I think it was right for my country to send me to war, am I a good person? How do I balance within myself the commandment 'Thou shalt not kill' with the moral obligation to defend my country against its enemies? Can I be forgiven for what I did when what I did as a soldier was little more than organized murder and I am haunted by my part in it? Did I lose my humanity in fighting for my country? How do I regain it?"

The anthropological corollary to the question of whether life is good is, "Is humanity good? Given what war has disclosed about human cruelty, violence, and destruction of life, is the human race a positive moral reality on behalf of whose improvement I might invest my life? I had to set aside my innocence in order to kill my enemies; can I regain my humanity now? Will

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West. In the case of war, I think that all these values coalesce in the question of "goodness." Thus, in common parlance, it is a bad thing when war's ugliness defaces life's beauty, and it is a bad thing to base warfare against others on outright lies or other untruthful judgments about them. Put positively, war is regarded as a moral good when viewed as an instrument to insure that "God's truth is marching on."

my enemy forgive me for what I and my people did? Can I and my people forgive their actions? Why do all our efforts to learn from past wars to deter future wars seem so ineffectual? Is the human race a decent race when it invests so much of its resources preparing for and conducting war and invests so little in what makes for peace and rich human life? Does it make any difference to try to make the world a better place, to increase its goodness?"[10]

The family systemic corollary to the question of whether life is good is, "If you knew what I did in war and how I felt about doing it at the time, would you still love and respect me? Do my actions and decisions about war make me a valued member of my family, or have I trespassed against our family's moral order and sense of right? How do I dare tell you what I have done and what I have become?" And, from the family side, there is the strong question, "Who is this father, this son, this daughter, this lover, who has come back so different and is impossible to understand and live with? What is the right way to relate to him or her now?" Negotiating the moral trauma inherent in these changed relational circumstances is essential if the veteran is to be reintegrated and family relationships healed and renewed.

The theological corollary to the question of whether life is good is, "Is God good? If God could prevent war why does God not do so? If war is a part of God's plan, how can God be good if God uses such destructive means to accomplish higher purposes? If God is good, why does God protect bad people and not good people in war? Given how arbitrary death and survival seem to be in war, is God capricious or indifferent to what happens on earth? Is divine goodness or impersonal fate controlling the world? Is belief in a good God still an option for me? If so, who is the God I believe in now? And, who, really, is God when groups warring against one another frequently claim God as their champion and their cause to be divinely guided?" Another

[10] I noticed a display at the United Nations in New York indicating that the amount of money devoted annually to peacemaking in the world is only .5% of what the world devotes to armaments.

common morally distressing question about God's relation to war is, "I was spared by God in war, when many others were not. What are my moral obligations to God and to life now that I have been spared? It would be wrong not to fulfill God's purposes in sparing me if I can discern what they are." The veteran's view of God or of "ultimate concern" (Tillich, 1957) is a core spiritual element in moral trauma and requires sensitive exploration.

Of course, individual veterans may not ask all of these questions, or even recognize that they are carrying guilt, shame, and hopelessness. But the questions I have articulated have come to my awareness through actual conversations with veterans struggling to make moral sense of their war experiences. They rarely ask these questions as disembodied, abstract theological and moral propositions. Sometimes they do not see a connection between the way they live their lives and the underlying despair about their worthiness or goodness. At other times they are well aware of their personal feelings of condemnation. Sometimes they feel intensely judgmental toward the social order that sent them to do what they now believe to be immoral actions on its behalf.

But whether or not the veteran is aware of their level of distress about their spiritual struggles, when nurtured by trust and safety within the context of a fully-affirming environment, some aspect of the question of goodness inevitably comes into focus. Veterans are well-served when they have a setting where their soul's struggle to feel morally right about their actions in war can be honestly explored and respectfully shared. It is a significant act of spiritual care to assist veterans to resolve or positively accommodate the challenges to their sense of goodness and worth that have resulted from their participation in war. Discovering and mediating the possibility of forgiveness through collaborative conversations is one possible resource for settling the moral accounts demanded by war.

Discovering collaborative conversations

Spiritual caregivers are uniquely positioned to help veterans settle moral accounts. Spiritual caregivers have natural access to veterans and their families in the lives of our congregations, hospitals, clinics, and educational settings where veterans gather. It is not foreign or intrusive to inquire about the soul or spirit level of distress carried by veterans. We are comfortable in the presence of physical suffering and spiritual angst. We are taught to empathically attune to another's pain without the anxiety of fixing or removing it. Because of our context of ministry and our particular training, the unique role of the spiritual and pastoral caregiver with returning combat veterans is to be an attuned companion, joining the veteran in whatever state his or her life exists, with special emphasis upon receiving, sharing and exploring the dimensions of moral trauma and spiritual meaning-making arising in the psyche, soul, or spirit of those seeking the ministry of our faith communities. We can assist veterans to bridge and connect with the multiple institutions in their social network because we too have easy access to them.

How then do we join, attune, and journey with traumatized combat veterans? What, in precise terms, does attunement with the moral landscape of veterans look like? And what might it bring about? To be sure, there are many spiritual and therapeutic practices that address this question. There can be no "one way" or "one size fits all" approach, or one "best" practice. But I propose that whatever modalities we use or combine to engage veteran moral distress, ongoing collaborative conversation and mutual dialogue are central to effective care.

The practice of collaborative conversations that I utilize in professional caregiving with veterans and others derives from my research on families recovering from war and a post-

modern theory of knowledge (Graham, 2011). Collaborative theories assume that all knowledge arises from socially-situated interactions and mediates power, influence and value. Knowledge doesn't exist objectively "out there" in the world, to be discovered, named, and employed for instrumental purposes. Rather, knowledge emerges from human interaction in a network of intentional conversation. Accordingly, because knowledge comes into being through dialogical processes, including non-verbal processes, all the conversation partners have equal status in constructing knowledge and determining what counts as true, right, and authoritative. The expert-non-expert duality does not pertain in this approach. Each conversation partner is the authoritative expert with regard to his or her own experience. There is mutual transparency and mutual self-disclosure as appropriate to the collaborative context.[11]

In collaborative conversation there is no authoritative body of prior knowledge or diagnostic criteria from which to draw and no predetermined plans or strategies for changing outcomes on the basis of diagnostic assessment. All of these resources are background and informative, but not determinative, in the collaborative process. Rather, efficacious spiritual and moral understandings are generated innovatively through interactions in unique social contexts, and the way forward is discovered cooperatively and situationally.

In post-modern collaborative theory, the self and its spirit and soul are neither fixed nor autonomous, but are continually coming-into-being through interactions in local situations. Conversation partners co-create one another's identity and shape the quality of our individuality and environments through building alliances that establish meanings and reformulate the various connections we have within our multiple contexts. In the words of Harlene Anderson (2007), one of the leading teachers of collaborative family therapy:

[11] As I was writing this section, I happened onto a marvelous photo-essay on human nature as conversational. It is available at http://stevemccurry.wordpress.com/2012/08/27/to-be-human/ accessed August 27, 2012.

> We can only know the world through our experience; we cannot have direct knowledge of it. We continually interpret our experiences and interpret our interpretations. And, as such, what we create (e.g. knowledge) is fluid, continually evolving, shifting, broadening, and changing. Thus, there is no finality to our knowledge—our meanings, understandings, or realities. What we create, we create with each other. Knowledge is not an individual activity or passive process: knowledge cannot be sent to or received by another. (p.9)

A collaborative spiritual care conversation with war veterans means, then, that the veteran is the expert on their own experience and controls how it will be shared and interpreted. The veteran's self-knowledge and identity emerge from a process of discovery through sustained collaboration with a variety of other persons: friends, families, ministers, fellow-soldiers, and the wider community. As conversation expands and leads into new directions, moral dimensions of war may come into focus and take on fuller dimensions as collaborative conversation partners inquire about what interests them and give open feedback about what they hear and how they are affected by the disclosures and about their experience of the conversation. Out of this mutual dialogue in which experience is shared new knowledge, new identities, and new social relationships come about. Moral injuries often surface in this collaborative milieu. The conversational milieu becomes a part of the relational web that sustains the moral life of the veteran at the same time it fosters a re-positioning of the veteran's moral landscape.

When applied to pastoral conversations, collaborative conversation recycles four basic dialogical questions. First, "What is my inner dialogue as I encounter this person, hear their stories and experience their being?" Second, "What am I curious to learn more about and how do I ask what I want to know openly and directly, especially in the areas that seem most dangerous to ask about?" Third, "What insights or suggestions can I share that intersect my own experience

and draw attention to my collaborator's positive qualities and particular strengths?" Fourth, "How does this conversation suggest new ways for me to think, feel, believe, and behave?"[12]

The outcomes of collaborative conversation are often surprising. They not only change meanings and moral sensibilities, they bring into being a fuller sense of belonging and connection in living. Collaborative conversations might best be conceived as building nets that hold us together and allow us to share the heavy spiritual and moral lifting that life sometimes requires of us. But collaborative conversations, like all nets and networks, also provide spaces for some things to leak out as well as for the empty and torn spaces to be woven into a larger and stronger totality. Selections from an extended interview in my research illustrate the way collaborative conversation illuminates, supports, and ameliorates spiritual distress related to post-combat shame and guilt.

Collaborative conversation with Jack Meiners

Jack Meiners was thirty-two years of age when I interviewed him.[13] Jack is a veteran of the United States Navy. He entered the Navy right after he graduated from high school and qualified as a nuclear submarine communications specialist. For reasons of conscience he asked to be transferred. He was subsequently stationed on the USS Missouri and saw combat in the First Gulf War. He is the youngest of a family of two sons. His father was in the Army during the

[12]For a fuller description and employment of these questions, see Anderson, H. (2007), Andersen, T. (2007), White & Epston (1990), and Smith & Riedel-Pfaefflin (2004).

[13] Jack Meiners is a pseudonym. He has reviewed this text and approved its use. The interview lasted two hours and fifteen minutes. I am selecting, paraphrasing, and reordering some sections for the purpose of this article. My interview with him was conducted as a part of a larger project on the impact of war on the pastoral care of families. A fuller account of Mr. Meiners' narrative will appear in a forthcoming volume on families and war. My research was approved on August 17, 2012 by the University of Denver's Institutional Review Board for the Protection of Human Subjects in Research. This information must be updated on a yearly basis, upon continuation of my IRB approval for as long as the research continues. The current IRB Chair is Dr. Paul Olk. The research is funded by the Ford Foundation in New York, and by the Association of Theological Schools in the US and Canada. Iliff School of Theology provided generous research leave time to pursue this project.

Korean Conflict and the Vietnam War, but did not serve in combat. He is not aware of military service in other members of his family through the generations.

> [Interviewer] Now that you have talked with me and Professor Smith about my study, what were some of the first things that came to your mind about this project? *[I am asking to join his inner dialogue about what he found interesting or about which he is curious in my work.]*
>
> [JM] I was fascinated because the sermon that I wrote, that you read, was one of the first times that I had ever preached. My parents came for the first time ever to see me speak publicly and in speaking to my father afterwards, he was overwhelmed because he didn't realize that the war had made such an impact on me and he said that it really answered some questions that he had about my behavior after I had come back from the Persian Gulf war. My parents just kind of figured that that was a lot of the behavior that I was exhibiting which was a little self-destructive but a lot of wandering type behavior, lot of just travelling around, unable to keep a girlfriend, keep a job, stay in one place, that kind of behavior and a little distant from my family. They were not real open to even listening to or hearing about my experiences over there. *[The sermon gave access to his parents to have a collaborative conversation about his experience, after ten years.]*
>
> [Interviewer] Yes, and you had to give a sermon for him to know this. But it opened the possibility of some deeper conversation?
>
> [JM] Yes, for him to hear it, and he was really shocked and then concerned. Then he wanted me to tell him more about it. He said, 'Tell us what was it like. I didn't know. How did we not know that you were struggling like this?' So I think that is what struck me the most. *[His father becomes curious and verbalizes his curiosity in an open question.]*
>
> [Interviewer] That is a dramatic episode.
>
> [JM] And I think one of the most telling signs that my family just didn't know how to deal with it and didn't understand the impact that the war made on me was when I came home, the first thing they did as a loving family would do, not knowing, was they threw a party for me… I get a little emotional about it because it is weird after being a part of destroying peoples' lives and killing people, you are being a part of just killing people. It is weird to be celebrated for that, it is weird to then have a party because you have been a part of this massive oppression and injustice to these people who were largely innocent and didn't know what they were doing and didn't understand why America was coming after them…So I remember sitting at…this is an interesting story, I don't know if this has anything to do with anything or even if you are interested.
>
> [Interviewer] Yes, I am. *[This is precisely the collaborative question: "What interests you?" And I was indeed very interested and curious about this point. He quickly introduces personal moral distress from what he did in war.]*

[JM] Okay, so I am at the party, I had been home about two weeks and I am at the party, I am just kind of in a daze, why are we having a party, friends and family came over, there was cake, and my parents have some old friends that I have known since I was four years old, his name is Jerry--Jerry and Dorothy, old family friends. And Jerry is a Vietnam War veteran. And towards the end of the party it was just Jerry and me out on the patio sitting at a picnic bench and he started telling me Vietnam stories. I didn't say anything about my experience. He just went on and on. I bet we were out there for three hours and he told me horrific stories about people he had to kill, villages that he had to go into. I didn't say anything at the table. He just went on and on. Periodically, about every half hour or so, his wife would come to the screen door that looked out on to the patio. She would look and listen for a second and then just go back and visit with my parents for the rest of the evening. They finally left. The next day Dorothy gave me a call. She said, 'Jerry has never spoken about Vietnam to anyone.' They were married for thirty years and I didn't know that! He had spoken to nobody. I think he saw the look on my face that day and I think he got it. He lived a productive life. He was kind of crazy, but raised a family and held a great job. I think he saw that look on my face and knew I was wondering how I am supposed to transition back into society. They take your gun away from you and one day after you have killing people you are back home. It is ethical and it is right and it is patriotic and you are a hero when you are killing people. And the next day that life is done and you need to transition back into society and be a productive member. You are not to have anger issues and not be confused and not have any guilt and shame about what you did over there. You are to just switch. You know I never talked to him about it again after that, but that day, for whatever reason, he just went on and on.

[Interviewer] This is a really interesting story. *[I affirm my collaborative interest in the story of his collaborative conversation with Jerry. The conversational network is expanding. And the moral distress of shame and guilt for what he did and what Jerry did are coming into focus. By sharing their stories collaboratively they are helping one another to bear them.]*

[JM] Yes, it is strange to throw a party for a person who didn't realize then that I was going to be carrying that guilt and shame with me for the rest of my life. Ten years later I knew, twenty years later I knew, but I didn't then. I have to deal with that in some meaningful way.

[Interviewer] Just as you are recounting it, I really get it. And even you enabled Jerry to say something important for him and at some intuitive level he was probably tuning in to you too. Maybe you could not have said or done any more. Did he ask you what you brought back or how was it for you? Or was this his story? *[I share my inner dialogue about "getting" his story and I ask openly what I am curious about.]*

[JM] He just started talking. It was his story. It was really powerful. And the other thing was for whatever reason it was somehow comforting. I was at this party with friends and family that did not know; they loved me and they were trying to show their support for that one day after I got back. But they didn't understand that I was going to need support

for a long time. Jerry was the only guy that understood. There were forty to fifty people there and there was one guy that understood what I was dealing with. He was the guy. [Tears up and seems a little embarrassed.]

[Interviewer] It brings tears to your eyes as you tell it and tears are a relief. Tell me what your tears mean for you. By the way you never have to apologize for tears. *[We emotionally attune at this point. I disclose as a non-expert the way my humanity is touched by his. It was a relief for him to connect his story to Jerry's and to feel like a part of an emotionally significant world, as opposed to the disconnect he felt in the welcome home party where there was no conversation or awareness of the moral distress that he was carrying.]*

[JM] I just think it is the guilt and the shame of being a part of what I didn't believe in. This is the part that I would want to remain anonymous. Essentially the reason I went into the military was because I didn't want to take responsibility for my life. The military said, 'Hey, we will make all those decisions for you!' I said, 'Great!' I wasn't mature enough; life was too overwhelming for me. I wasn't mature enough to go ahead and make decisions for myself. So I signed up but I was very against war. I was just a gentle person, I didn't believe in killing and war and anything like that. But a year prior to me even going to the Persian Gulf War I was on a nuclear submarine, and nuclear submarines have the biggest missiles we have on the planet. They can annihilate the entire world. I went to the Captain of that boat and said, 'There is no way I can be a part of this.' These bombs that we have on these submarines, one of them could just really ruin things for probably the entire world on some level. And so I had left the submarine world with a lot of notes on my permanent records. I was guy never to be trusted again. And so I ended up on the USS Missouri. There was not even a hint of war in the air when I got there. But then a year after I get there they say we are going to war. And since I have been already sort of crucified by going through the submarine experience, I was hesitant to go through that again. So I went ahead and just stayed in there. I just said, 'Okay, well, I will go.' I didn't want to fight the fight again because it was such a hard fight. And then they say that we are going to war! I said, 'You have got to be kidding me! This is everything that I am against!' So the whole time I am over there, all I keep thinking is, 'I am not even supposed to be here. This is not what I believe in at all.'

I did the best I could over there. I did my job properly, So out of that came this incredible guilt and shame that I didn't fight the institution again; that I didn't stand up for my morals, for what I believed in. That I didn't stand against why I thought we were over there. I thought we went over there for oil and for economic reasons. I didn't think we went there for doing something great for Kuwait; I didn't think we went over there for that. I don't think that it was the case at all that we were there for some patriotic ideal. Most of the guys I was around did. But not me. I came away from the whole experience with shame, with guilt, with sort of a cowardly feeling that I didn't stand up for what I believed in. The results are just dramatic.

I was not face to face with the enemy. I didn't have to shoot anybody directly. But we shot people and I saw it. There were television monitors in every compartment. And whatever came on the television came from the central TV station within the boat. The boat is like a city and we would send this remote controlled airplane that had a little

camera on it. We would launch it off the back of our boat, and we would fly it over Iraq. The video feed went to the televisions in every compartment. We were able to see what was going on; it was a decision the captain made just to keep us informed and to keep us in the game kind of thing. A lot of what we did was with a RPV, an unmanned remote piloted vehicle. It was maybe eight feet wide. It was pretty big. It would fly over and take video of an area that we suspected needed to be blown up. And sometimes that area was just a speck in the desert. We would start launching these 2,000-pound bullets. And sometimes you would see from the video feed where we needed to hit. And if we were short of it we would need to adjust appropriately. And, Bam! You could hit it exactly. Sometimes it would be an ammo dump that would look like a speck originally but once you hit it there would be a small explosion and then bigger and bigger and bigger. And this is how it would go out in the desert.

And because the Iraqis had gotten used to the sound once they heard the little buzz of the RPV they knew that it was not going to be long before some big shells started coming. And so you would see guys running out of these little specks in the desert with white flags and their hands in the air looking at the RPV, waving their hands, you know, shouting, 'Don't shoot! Don't shoot! Don't shoot!" And we would just blow them away; we would just obliterate them. We watched it happen on TV.

Talking to some of the marines that were on the ground after this was all said and done, they would tell us that they would find these pieces of shrapnel that are as big as that desk from some of the shells and the sand would be melted, almost was just such into glass. These guys were telling me that it amazing to be a part of this! And inside I am going, 'Yeah, I was a part of that and it is horrible to me.' But to that guy, he thinks it is cool.

[Interviewer] Though you were a part of a military team, you didn't see things the same way as some of your peers.

[JM] Yes, and I am just horrified, I am just thinking, man, how could I have been a part of such destruction and misery for the Iraqi people, for what, for oil? So it is just horrible…

When we got back, I went right to a Kung Fu temple and I started doing martial acts. And so instead of getting addicted to drugs or alcohol which virtually every one of my friends did when they came back, I got addicted to Kung Fu and martial arts and sort of an Eastern religion kind of way. That is really how I dealt with it when I came back. It was a long, slow process of ten years but that was my salvation.

[Interviewer] We may have a huge cultural disconnect going on about how to respond to post-war consequences. The cure for traumatic stress disorder supposedly is talking things through, but often the people who have post-war issues are not talkers. *[Collaborative conversations open space to share what one is coming to mind in the conversation. Here I share a bit of my inner dialogue about the limits of the "talking cure" so endemic to the caregiving profession. I had not thought of this until Jack shared that contemplation and physicality rather than orality was his means of processing his moral trauma.]*

[JM] That was definitely my experience, I didn't want to talk about it, I didn't even know what was wrong with me. And, again, because my family didn't know what was wrong with me they would say things like, 'Why don't you just get your act together? Why don't you just pull yourself up by your bootstraps? It is time to grow up! Why don't you take on some responsibility?' That was the feedback I was getting from my family. *[His family took an expert rather than collaborative approach; they would not let him be the expert of his own experience or explore his life dialogically.]*

I think the thing that helped me the most was just experiencing God, so just having an experiential relationship with God. And for me that came through meditation and it came through Kung Fu. I see my life working now. I don't get angry any more. During the first five to ten years there were times when I would have to pull over a car that I was driving on the side of the road and just bang the steering wheel because I could not get my emotions under control. I was red with rage and could not bring it down. I was completely out of control. If someone had cut me off at that moment I would chase their car and try and peel the trunk off. That is how angry I would be. So those days are gone. I am able to focus. I was able to go to college and focus and study every day and write papers. You just can't do that when you are in that state back there; it is impossible. There is a certain level of confidence that I have now that I didn't have then.

This new state has come with forgiveness of the guilt and shame that I felt before. I never felt that I was worthy of anything. I had severe self-esteem issues. That has changed. Being able to focus has changed. I know things have changed because I have been able to accomplish things over time, starting at about age thirty-two, which was ten years after. I was twenty-one or twenty-two when I got out. And finally at about age thirty-two things are better.

[Interviewer] I want to ask you more about your experience of forgiveness; tell me how you came to that. *[I am genuinely touched by the depth of his guilt and shame and truly curious about how came to a feeling of forgiveness that seemed to balance the anguish he displayed.]*

[JM] Well, I didn't realize that I felt guilty about it. I didn't realize that I had so much shame about it. [Tears up] And now I am going to get emotional again….But I can't imagine telling a veteran that you are forgiven for what you did. I can't imagine that coming out of my mouth because it goes against what we were taught and why we were there. And it goes against what American culture would say about why we were there. The culture says that you were right to go over there, you were right to blow those people up, you were right to kill those people because they were going to hurt you. Better them than you. If there were ways to bring to the surface the feelings of guilt and shame that they don't even know that they had and to tell a serviceman or woman that they are forgiven for what they did over there would help them. But, again, I don't know if that direct approach would be appropriate at first. But I think at some point along the way that needs to be done.

[Interviewer] Forgiveness of guilt is the core psychological and spiritual issue that is on the surface for you. And from what you know of vets you believe that it is true for them too, but that is not often named by them or by our society.

[JM] It is not. After I shared this in my sermon, there were people that completely rejected the idea. There was a World War II guy that completely rejected that idea. He got mad at me for saying that. And more than asking for forgiveness, I took forgiveness one step further. I would ask the serviceman or woman to forgive society for throwing us into the bus.

[Interviewer] I have heard that before but you said it as succinctly and clearly as I have heard it said.

[JM] So forgiveness on both ends, I think, is critical. That made all the difference for me. I think how I got there was that I began this process of just helping people, in serving, in the smallest way: 'Hey, do you want to borrow my car?' Or, 'Hey, do you need help moving?' Or, 'Can I help you across the street; can I open this door for you?' Those little actions gave me such a sense of making up for what I did. And after a long enough period of that I finally got into the place where I could question why I felt the need to constantly make up for something that I did. I was able to make the connection that was doing this because I was responsible for a lot of death and destruction. That is why I feel this urge, this compulsion, to serve and to make up for that. When I realized this, I was able then to just take that into meditation and feel that experiential forgiveness. It was not just the words, but the feeling of experiential forgiveness in meditation that helped me. That changes everything. I think that this would make sense for any veteran.

[Interviewer] And that was a discovery more than an achievement. I mean it sounds like you went through this long process that you needed to do but you didn't know until a certain point why or what it was for.

[JM] I was heading down that road anyway, it wasn't guided.

[Interviewer] One of the places I thought you were really profound and that was really important was that not only do many vets have to find a way to forgive themselves, but they also have to find a way to forgive the community that sends them to war and receives them back from it. These thoughts are really complicated but very astute.

[JM] Can I tell you where I got that from; I wished that was mine, it is not. I got it from Dr. Sidney Luminary. Do you know Dr. Luminary?

[Interviewer] Yes, I know him well.

[JM] I grew up across the street from him and I am very good friends with his son.

[Interviewer] With Roger? You are really good friends with him?

[JM] Yes, we are same age. We went to school together and everything. I was talking about this with Dr. Luminary and talking about forgiveness. And he was the one, who said to me, 'And you also need to forgive society for,' the term he used was, 'making you

do things against your nature.' And click, the lights go on! So I need to give credit where credit is due.

[Interviewer] Giving credit where credit is due is always a good thing. But in terms of what I am trying to do, it is also important to try to see the network, the social network in which these stories and these realities emerge and how they influence how these stories and experiences of war get interpreted, I am also very interested in where these perspectives come from and their religious dimensions. So in your case you have Dr. Luminary's Hindu influence, you have a strong Buddhist influence, and you have a Protestant Christian culture that you are working out of. In the end you have to put all these traditions together in some meaningful way. This network of influences and resources is a rich mix. It is wonderful to hear all this, and to see where credit is due. You show a rich network to give credit to. *[The insight about multiple conversational networks came to me for the first time at this very point in the conversation. It was truly knew knowledge created interactionally, like the postmoderns assert is always the case.]* But there is another dimension about forgiveness that I want to ask you about. You have been talking about forgiving the community, forgiveness from the community, and forgiveness from God. I also sense a dimension of self forgiveness that you are working with. Is that true? Can you talk about that dimension, forgiving yourself? *[I have become curious about this dimension and wanted to hear more about how he negotiated his internal moral calculus.]*

[JM] Yes, maybe it goes to those ten years. I just wasn't very nice to myself, was a bit self-destructive, and I wasn't living up to my potential. And so giving myself a break on those kinds of feelings, that I should be somewhere that I am not, I should be further along than I am, in some regards. As I come to the end of my Seminary career that is kind of coming to a head. It is almost like I pushed so hard to get through my undergraduate and now my graduate school just so I could say that I was in a place where I could say to myself, "Okay now I have caught up!'

[Interviewer] Sure, that makes so much sense that you feel that way.

[JM] And so forgiving myself for taking that time and doing the important work and actually maturing into this healthy mindset, not only am I caught up, I have a greater understanding of self, my relationship with the divine, and what it means to be compassionate of others. Because I have made such diabolical mistakes, not only am I caught up but I am probably further ahead than my brother, than the people who seems successful around me that have a very shallow understanding of any of that depth of feeling, never had to experience that emotion, that deep shame and that guilt that comes with ending a life. I mean it is earth shattering to be a part of that.

[Interviewer] You had to find your own way. It is so illuminating to hear you talk even though I know how excruciating it is for you to relive some of this.

[JM] Well you know again it is surprising to see how many layers are there are. You know them because you talk about it. I am not afraid to talk about it anymore. I can even

stand up and give a sermon about it. But I could barely get through that sermon, as I was talking about it again. It is so emotional. And you think, 'When is this emotion going to go away?' It changes every time; sometimes it is more, sometimes it is less even over time. Today I feel more emotional than I have in a long time about it. Maybe it is just that I think—this is what occurs to me right now—is that maybe it is because I am telling this story to someone who can actually do something about it. Up to this point I have questioned what could be done about it; there is no hope, there is no glimmer of hope that talking about it would do any good. But now I am thinking that if I tell this story to this person, wow, maybe he can really help people. So now the tears are more tears of joy than just sadness. In the past my tears were dominated by this feeling of just utter hopelessness: we have got to stop going to war, we have got to stop going to war, we have got to find a better way to deal with our conflicts because we are hurting people, and you are hurting poor people, you are not hurting the rich, the people that make the decisions, you are hurting the young people, our best and our brightest but also our poorest, and our minorities and our marginalized people. *[Note how collaborative conversation extends the network of knowledge and support; he is not as alone with the moral responsibility he carries and feels relief and hope that by sharing it with an influential authority something positive may occur in the world.]*

[Interviewer] Can I stay with that self-forgiveness thing for just one more minute? I want to come back to something you said that really grabbed me before we went off to someplace else. Where you went was exactly where your logic was going so I wanted to go there. I felt if I had gone back to the forgiveness discussion, I would not have been listening to where you were going. So this is more my question than something that is an issue for you, but I want to ask you about it. *[I ask his permission to pursue something that seemed interesting to me.]*

[JM] Okay.

[Interviewer] It was when we were talking about self-forgiveness. This might be a place where you are a little vulnerable and so I want to ask you if it is okay if I talk to you about it.

[JM] Absolutely.

[Interviewer] Because as you were talking about that, I thought you have all this empathy and all the really good feelings of love and sadness for those people whose lives were lost by what you were involved in. You have terrible feelings of remorse about that. And shame and sadness. I was also hearing several other things. One is a question: 'What is wrong with the universe? I mean I tried to get out of this very thing when I left the submarines! I should have stayed on the submarine because I would not have killed anybody. And so what is it about the universe that got me there, when I tried so hard to get out?' Then I also heard you asking, 'What is wrong with me? I didn't try to get out again.' And so these intense feelings of failure or of some kind of a flaw might lead you to conclude that fate or the universe is against you. But you also seem to feel that you have your own self against you since you didn't try again to leave the Navy. But damn it,

you did try once, so what does it take? So it would be hard to know whether to be mad at the universe, to be proud of yourself for trying really hard and succeeding one time, or to be mad at yourself for not trying again to leave. As I listen to you, there is just this whole cluster of moral struggle and cosmic assessment all tied together. As you spoke, I was thinking, 'God, at some level, he might just feel like he has been had, and yet there was probably opportunity for him to do something more and he feels terrible that he didn't.' It all sounded like a really complicated mix. I mean, here you are just a little kid who did all this so you can avoid being mature morally and psychologically and you end up with an array of huge moral issues and questions. So, do you think that the universe picked you out to fuck you over? I ask that somewhat laughingly—it seems like a pretty dramatic question--but this is really pretty big stuff that you are describing. *[I provide an enormous amount of information about my inner dialogue about what he has been saying and I share it with him for his consideration, to keep the conversation going at the level he seems to have taken us.]*

[JM] Yes, you described it perfectly. I am mad at myself for not taking responsibility for my life in the first place and going into the military, I didn't believe in the military, I didn't believe in war, anything like that in the first place. Well at that point on the submarine I had made up my mind. 'No, I am not coming back and you can do whatever you want.' So I am still in the Navy. And then, like you said, then I get to the boat, and a year later, we are going to war. I have to begin again to confront this. I have fought the good fight, but I am still in a place where I am not supposed to be and we go to the war. What's a guy got to do? I did go for it. No I appreciate what you are saying about that.

[Interviewer] And that is not saying that I am getting how you are experiencing this; I am just telling you that is what my mind was doing with what you were saying.

[JM] Absolutely, I couldn't believe I was back in that situation where I would have to confront the military again. I was courageous. I did the whole thing, I thought. But apparently I didn't. So we didn't annihilate the world. I take solace in that.

[Mr. Meiners described how far apart he felt emotionally from his family for a long period of time. Then he took off on a long cross-country bike tour to search for himself. During this trip many experiences of divine protection became transformative for him, and evoked a sense of forgiveness and restored esteem. He was especially nurtured by a "collaborative conversation" with a man walking to Alaska to fulfill a dream before he died from recently discovered terminal cancer. He had recounted earlier in the interview that alongside his shame and guilt he also had a sense that God was with him and that he would finally "come out okay." The bike trip was for him a test of this divine presence and tied in to his search for forgiveness or healing from the moral distress and trauma that underlay his spirit.]

[JM] This bike trip with a lot of little angels and moments of grace when I had absolutely nothing left was an experiential situation and boy that goes a long way when you finally ask for forgiveness from God for what you did. If you have that foundation of knowing that God exists, and God really cares and does take care of you, you know it, on a deep,

deep, deep level, then forgiveness takes on a whole other form. It just makes you feel truly transformed at the experiential level.

[Interviewer] As I am listening to you it sounds like you know the power of the God who is standing behind that sense that you will finally be okay. And that power is big enough to receive your need for forgiveness and to offer and to actually give the forgiveness that you need. For you it has to be a pretty big God at the experiential level for forgiveness to feel real because it is a pretty big sin that you are wanting forgiveness for, if I can put it in those terms. You can't bear it yourself, it is so big. *[I share my inner dialogue and frame his experience as a positive strength.]*

[JM] And it does not work on an intellectual level.

[Interviewer] No, this is pre-rational and you had to trust it with everything, I mean your whole being, your butt on the bike, no money, strange little angels along the way, several little angels along the way.

[JM] Yeah, sleeping in peoples' barns.

[Interviewer] What you ran into when you had the encounter on the road with the dying walker.

[JM] You are really good at this, I feel very comfortable sharing it with you.

[Interviewer] Well I am so moved and I am so touched and so enriched by what you are sharing; you are real easy. I do not mean that in a trivial way. I hope you don't take that as a big slip. I don't mean it that way. What you are sharing is really moving and I feel it is a great gift that our lives came together because I didn't have a clue who you were before this interview. My colleague had told me you had read about my work and were interested. And then the next thing I know there you are. So this is a real gift, not only for the work I am doing but I feel that it is just a gift to know you, to speak to you, and then to let you know me a little also. *[A forthright disclosure of my inner experience of him and the influence of this conversation on me personally.]*

[JM] I appreciate the experience. You know I have got to tell you that I feel better having talked to you for the last couple of hours. I really do. You know, maybe another layer just got lifted. I am sure there is a thousand more but really I feel better. I am not necessarily sure what it was that made me feel better. I think it had more to do with the fact that you are genuinely interested in me. I am not sure, but maybe you are being dipped by every person that you talk to and I pick up on that because I don't get the sense that you haven't been in the military. I get the sense that you really understand what I am talking about so maybe over time and over all these interviews that you had, maybe you are being dipped each time. Maybe you are just getting this profound appreciation for what these guys have gone through. So thank you for doing that work. And maybe that projects out to people who haven't been in the military and are on this side of the gap. Maybe it does get close by being genuinely interested in humanity and the pain that we

> are feeling. If you stay in that long enough, if you are able to. I would think it would be kind of hard to stay in that. I certainly don't get the sense that there is a gap in our understandings of what I went through, and it may just be that you have so much experience in pastoral counseling that you are so good at this. But the way you were able to articulate back to me really what I felt sort of mirrored back to me what I was saying to you was extremely helpful to me. Yeah, thank you, that is exactly what I am trying to say. I needed to get that off my chest but I would say again, the place to start is to experience it and not talk. That is the starting point. *[Mr. Meiners articulates much of what I also experienced from this collaborative conversation: mutual appreciation, a sense of caring, the power of shared knowledge to relieve distress, create human bonds, generate new insights and knowledge, and evoke hope that all of this will make a positive difference beyond the local context.]*
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> [Interviewer] Absolutely.

Outcomes and conclusions

The interview with Mr. Meiners brings to light several features of moral trauma and collaborative conversation. Moral trauma and recovery from war is not a simple process, negotiated within prescribed timetables by pre-set modalities. Mr. Meiners, who regarded his traumatic exposure as minimal, lost ten years of his young adult life. And he was still "tearing up" and feeling the pain of the moral accountability and other costs of war nearly ten years after he had returned from combat. Recognizing the life-long and transgenerational consequences of trauma is essential for caregivers and for veterans.

A second conclusion is that collaborative conversation focuses on strengths and stories not on symptoms and causes. Collaborative conversation is not diagnostic conversation. It is not aimed at curing or healing as much as at "sharing and bearing." Sharing stories helps us bear our stories and renegotiate our histories. Silence about them drives them underground where they drain our agency and sap our vitality. Pressing technologies or instrumentalities of healing into the lives of traumatized persons may create unrealistic expectations that they are able to reactivate something that has been permanently lost. But sharing whatever stories or story

fragments that can be brought into mutual dialogue, with a respectfully receptive conversation partner, might bring into being new relational conditions where healing or some better-balanced accommodation between hope and despair becomes possible.[14]

Third, because collaborative conversation is an expression of what human beings do by nature, the pastoral and spiritual caregiver can be a facilitator and model of engaging difficult subjects in a variety of contexts, including the clinical setting. By modeling an approach to others that discloses our inner dialogue, engages people at deeper levels of mutual interests, and frames our responses from a positive or affirming standpoint, we are in a position to bring about a culture of care in and between our various communities. Such a culture of care may destigmatize the veteran and attune us to the fundamental human need for renewal and reintegration. By expanding our conversation partners and letting curiosity and interest be our guide to creating knowledge, we might discover and bring into place a relation to other resources in the clinic, congregation, and individual souls that enables us to affirm the goodness of life and our capacity to contribute to it.

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[14] See Kosslyn (2006) for an astute presentation of the prosthetic neurological effect of sharing narratives in stabilizing and healing from various traumas and life challenges.

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Providing Pastoral Counseling for Alcoholism Recovery: Understanding Mind and Spirit in the Alcoholics Anonymous Twelve Step Program

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Abstract

Although individuals and their families suffering from the scourge of alcoholism often seek solace from pastoral counseling, numerous clergy members feel at a loss since substance abuse issues were not part of the pastoral curriculum. This article informs the pastoral counselor of pertinent information designed to help with regard to 1) assessing the severity of the abuse/dependency, 2) examining the etiology of alcoholism, and 3) exploring the spiritual dimension. In addition, specific information details the impact of alcoholism upon the brain and how the 12 Steps of the AA program and daily sponsorship combine to evoke a spiritual experience associated with recovery.

Key Words Alcoholism, addiction counseling, pastoral counseling, brain function

Introduction

Pastoral counselors have served a wide array of emotional and psychological needs of their parishioners including those struggling with alcoholism. Although most of the scientific research involving alcoholism has focused upon biological and social learning aspects of addiction and recovery, the spiritual dimension has gained notoriety since the origin of 12 Step groups like Alcoholics Anonymous (AA). This article shall examine the various etiologies of alcoholism and explore the growing popularity of the spiritual solution as offered within AA.

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What is alcoholism?

Members of Alcoholics Anonymous (AA) believe that a person is an alcoholic when life becomes unmanageable (Alcoholics Anonymous, 2001). This idea makes great sense to those who are familiar with the 12 Step program, but not everyone has an in depth knowledge base unless associated with AA or Al-Anon. Perhaps a closer look at this definition is required: 1) to fully appreciate what alcoholism means to the average person, and 2) to promote a deeper understanding of the mind/body issues for the counseling of those with addiction issues. For pastoral counselors trained to examine spirituality, in a practical sense, alcoholism actually begins when an individual places a higher priority on drinking than upon the care for loved ones

or personal responsibilities. However, researchers and clinicians in the United States usually rely on the diagnostic criteria, which differentiate alcohol abuse from alcohol dependence through the current standards of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). The DSM–IV includes non-overlapping criteria for dependence and abuse by providing for the sub-typing of dependence based on the presence or absence of tolerance and withdrawal.

The DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders-Text Revision, 2000) criteria for Alcohol Dependence includes a maladaptive pattern of alcohol use, which leads to clinically significant impairment or distress, as manifested by three or more of the following seven criteria, occurring at any time in the same 12-month period:

1. Tolerance - a need to consume increased amounts of alcohol to achieve intoxication.
2. Withdrawal - including the need to consume alcohol to relieve withdrawal symptoms.
3. Alcohol - consumed in larger amounts over a longer period than intended.
4. The persistent desire to control alcohol use.
5. A great preoccupation with obtaining, consuming alcohol, or recovering from its effects.

6. A marked reduction in other activities because of alcohol use.

7. Continued alcohol use is unaltered despite knowledge of having a persistent or recurrent physical or psychological problem that is caused by alcohol consumption).

Various etiologies and theoretical frameworks explaining alcoholism

Most studies of alcoholism etiology have focused on genetic factors or psychosocial aspects (Jacob et al., 2001). Other factors have included genetic (Cotton, 1979; Heath et al., 2001), learning (Johnson, 1973), and stress (Glavas & Weinberg, 2006). Spear et al. (2005) suggested two broad theoretical frameworks to explain the increased affinity for ethanol based on: 1) effects of mere exposure, and 2) associative conditioning between ethanol's odor, taste and pharmacological consequences.

Based upon the observations of Dr. William Silkworth, Alcoholics Anonymous (2001) described a two-fold aspect of the disease as a mental obsession and a physical allergy. Other theories (Johnson, 1973) include learning, seeking and harmful dependency. Initially one learns that consuming alcohol produces euphoria. Subsequent use can lead one to seek ever-increasing opportunities to consume alcohol until harmful dependency leads to physical damage.

Spiritual etiology

There are specific issues that pastoral caregivers and counselors should be aware of regarding this malady. Within the fellowship of AA resides a belief that alcoholism affects a person physically, emotional and spiritually (Alcoholics Anonymous, 2001). Clinebell (1998) and Kurtz (1979) believed the addiction to alcohol has its roots in the realm of spirituality. Specifically, those who drink in an alcoholic manner do so to experience a mood change to transcend daily events. The resulting sensation of drinking alcohol for the alcoholic provides momentary feelings transformation

and bliss. It is as if the alcoholic ego transforms into a terrible tyrant by placing unrealistic demands upon others in order to sustain rule as the god of a shrinking domain. It is important for pastoral counselors to note not only the shift in focus away from solid spiritual principles and toward selfishness and self-centeredness, (Alcoholics Anonymous, 2001, p. 62), but also the resulting family dynamics which become distorted over time.

May (1988) viewed addiction as a form of idolatry. May emphasized the twofold problem with addiction as attaching desire to the addicting substance and also developing a mental obsession toward the same substance. Although most normal individuals express appreciation for the assistance received from others and at some point later attempt to return to the previous level of self-sufficiency, the alcoholic uses the assistance of family members to ensure the drinking behavior with the purpose of elevating an anesthetized ego. Compounding the issue within the addiction process is the frequently observed phenomenon of the alcoholic's behavior. When reminded of the frequent times in which support has been provided, the alcoholic's response is rarely one of thankfulness, but of hostile anger and vile resentment. The result of reminding the alcoholic of the dependency upon the assistance of others fosters irritation, contempt and rage. Family members display a mixture of stunned surprise, extreme amazement, baffling confusion and emotional devastation at the alcoholic's reaction. The resulting family pattern becomes a re-doubling of the family's attempt to assist the addict until the complaints end. As this newly-set family pattern becomes firmly fixed into place, then all other actions become subservient to drinking. The end result only succeeds in promoting the selfish behaviors of the alcoholic.

Learning and the brain

Recent advances in brain imaging technology have helped educators to understand the relationship between types of learning with specific anatomical structures of the brain. Sprenger (1999) reported that long-term memory involves two structures of the brain's limbic system: the

hippocampus and the amygdala. Specifically, the hippocampus helps in recalling sights and sounds while the amygdala stores the emotional aspects of those events. Sousa (2001) believed that information is more likely to be stored in long-term memory when it makes sense and has meaning. This recommendation is especially important for counselors who work with clients in recovery.

Storytelling and memory

The elaborate sharing of personal stories in AA meetings evokes strong sentiment within the listener and assists in the connecting of story-related images with concepts in a coherent and meaningful fashion. Such a process, inherent within AA meetings, will enable a person to remember with greater clarity. Norden (2007) indicated that activity within the left hippocampus is associated with the process of storytelling and the development of a sense of self. The process of storytelling within AA meeting in which an AA member tells one's story of addiction and recovery is crucial to the development of a recovery identity. Rappaport (1993) viewed the function of storytelling process in AA as establishing a sense of history by providing order and meaning to one's experience. In addition, Sprenger (1999, 2002) remarked that storytelling utilizes multiple "memory lanes" by processing the minutest detail and capturing the entire idea simultaneously. The story format dynamically improves upon the retention of semantic data by combining both the emotional with cognitive aspects while weaving details within the global concept or big picture. The weaving of details is enhanced when the individual becomes an active participant in the learning process. Similarly, Thompson and Thompson (2000) indicated that higher levels of active participation stimulated more areas of the brain. The specific results of this process included improved retention. In essence, the more areas of the brain that are activated, the greater the amount of information is retained.

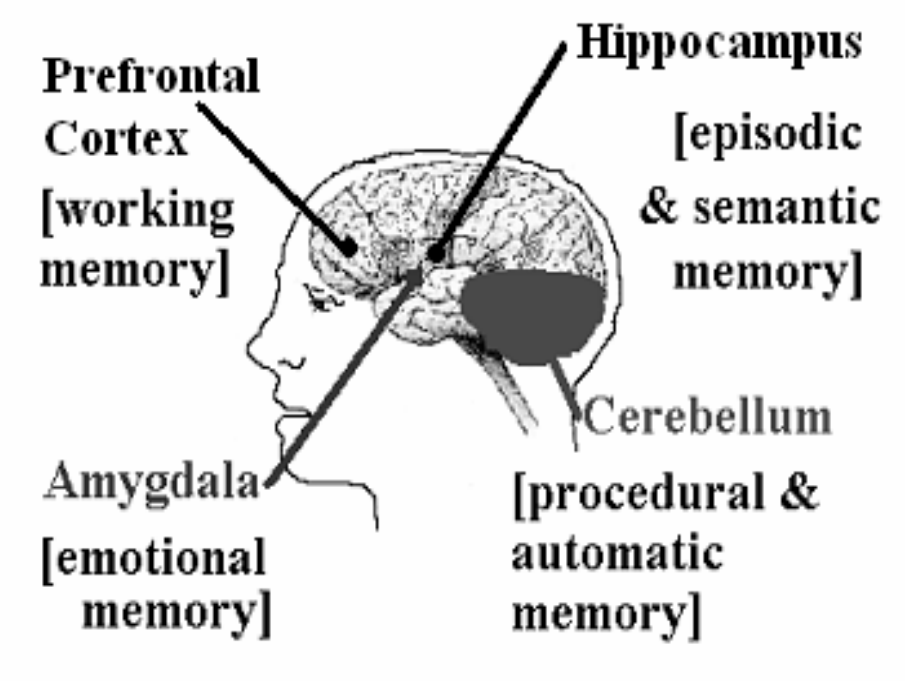
Impaired memories

Excessive ingesting of alcohol damages brain cells, distorts memory and warps perceptions. Prolonged drinking continues to disturb the memory process especially when emotions are involved. Resentments, in the form of mental replays of hurtful events, promote selective recollections which magnify the faults and actions of others. Resentments simultaneously minimize the perceived effect of one's own behavior, thus rationally nullifying the responsibility for harmful behavior during drinking episodes. Various types of memory seem to originate from specific areas of the brain. While the amygdala has been implicated in emotional components of memory, the hippocampus becomes activated with the long-term aspects of both episodic and semantic memories. The prefrontal area becomes engaged in the temporary storage of short-term memory and the manipulation of ideas of the working memory. The cerebellum, which is responsible for fine motor coordination, serves double duty with procedural movement memory and automatic memory that occurs without conscious intent. Figure 1 illustrates areas of the brain and their associated memory functions.

The triune brain in conflict

Figure 2 illustrates the process of conflict with regard to Paul MacLean's concept of the triune brain (Sandoz, 2004). This illustration provides further insight into the process which promotes abusive drinking. At the most primitive level, the reptilian brain produces the fight/flight/fright response. From that point the areas of higher functioning produce resentment, fear and anger. These sentiments fuel the alcoholic's desire to seek relief. At this point it is important to recall Vernon Johnson's feeling chart with regard to learning, seeking and harmful dependency. In time the person develops a love-trust relationship with alcohol that leads to a mental obsession.

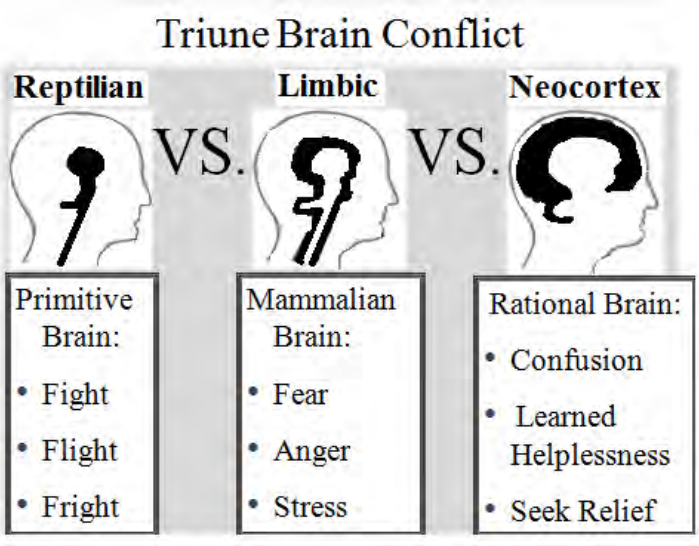
Figure 1 Memory areas of the brain



Eventually the love-trust relationship with alcohol becomes breached and the alcoholic feels betrayed due to the effects of tolerance. As the symptoms of the addiction become more pronounced the mammalian brain experiences fear, anger and an accumulation of stress.

The ultimate impact of the triune brain conflict results in mental confusion and helplessness with a strong desire to find relief as soon as possible.

Figure 2 Paul MacLean's Brain Conflict



Case Study

In the following case study, I (2004) provide details of a person in recovery under the pseudonym of Jackie Brown (JB). In addition to the varied activities associated with attending Big Book studies, JB found the day to day contact with his AA sponsor in early sobriety to be crucial. A "Big Book study" refers to a specific type of AA meeting in which portions of the book, Alcoholics Anonymous, are read aloud and clarified to the newcomer. The frequent ritual of meeting with an AA sponsor (by phone or in person) not only reinforced what JB had learned at the Big Book studies, but also promoted his application of the 12 Step program in his life. The process involved a daily regimen including a mental/emotional realignment of his thought patterns associated with the development of resentment, unresolved anger and the development of fear.

Sponsor contact

The ritual of daily contact with the sponsor helped JB to review the events planned for during the day and to address any issues which would evoke apprehension, fear, worry, or concern and lead to a relapse. This "hands on" guidance of the sponsor helped JB to acknowledge how his thoughts and feelings had become distorted due to his addiction. The sponsor would offer feedback regarding how JB would "go off on his old thinking patterns" and why his former ways of thinking, feeling and behaving would only lead to an eventual relapse along with the creation of more fear, anger and resentment. At this point the sponsor would connect JB's increased emotional discomfort with the intensifying desire for a drink. Through the guidance of his AA sponsor JB began to discern patterns of thoughts, feelings and behaviors, which led to his drinking behavior. The sponsor would remind JB of what information he gained from the Big Book studies by

frequently quoting from, or having JB read pertinent passages of the book, Alcoholics Anonymous. For example, “They are restless, irritable and discontented, unless they can again experience the sense of ease and comfort which comes at once by taking a few drinks” (Alcoholics Anonymous, 2001, pp. xxvi-xxvii).

Daily application of the 12 Step Program

Other helpful recovery-focused actions were examined with the sponsor on a daily basis. These included those personal behaviors, thoughts and emotions deemed helpful in improving sobriety along with a review of those actions that run contrary to recovery. The daily custom involved much instruction and discussion with the sponsor. There was much elaboration as to what actions needed to be taken as well as the rationale behind those actions. As time passed JB began to realize that the spiritual element had become more relevant as he followed the program in the applied manner. As his thinking process began to clear, JB began to examine specific emotions related to various issues of life, in addition to learning "new" and more appropriate ways of responding. As a direct result of the daily sponsor contact JB began to experience a growing sense of self-confidence and self-efficacy. In addition, all of his troubling issues were brought to his sponsor daily in a prayerful context where JB would present them to God, as his higher power, and would offer prayers for each area of concern. In addition, when he felt troubled during the day, there were actions that he took immediately as directed in Alcoholics Anonymous.

Big book tabs as page markers

The duration of the AA daily maintenance routine (including the taking Steps 1, 2 and 3 along with purging of fear, anger, and resentment) lasted about 20 minutes. However, one method utilized by JB to speed up the process of following the directions in the reading of certain

passages from Alcoholics Anonymous included the insertion of page tabs in his Big Book on those pages listed in bold print and underlined. In addition, specific paragraphs referenced on the sheet were highlighted in a vibrant color on those pages of Alcoholics Anonymous for quick and easy detection.

Steps 4 and 5 — Catalyst for the spiritual experience

Steps 4 and 5 assist in the process of resolving the memories associated with fear, anger, and resentment through a written inventory. As seen in Figure 1, the various regions of the brain are differentiated by function: recall of information, procedures, emotions, and eventful episodes of one's life. In this it is important to remind the reader of the function of the hippocampus and the amygdala in long-term memory. Specifically, the hippocampus aids in the recollection of events and the meaning of those events while the amygdala provides the associated emotional aspects. Austin (1998) believed that a specific set of brain activities occurred within the neural network that links the amygdala with other regions during a spiritual experience. The result of such a process promoted the brain's release of the analgesic and euphoric chemicals known as encephalin and the endorphins. This neural event described the process of getting rid of the negative emotional valences of memories stored in those limbic regions. Austin thought that this circuitry process not only amplified the level of neural functioning, but also produced a dynamic shift resulting in the neural unification of various parts of the limbic system with the prefrontal cortex and other regions. The resulting effect was a reduction of selfish drives and motives along with the removal of fear.

For a person in recovery the process of the spiritual experience unfolds in the following sequence of events: Initially, the process for one addicted to alcohol begins with the acknowledgement that the production of resentful mental images habitually stimulate limbic

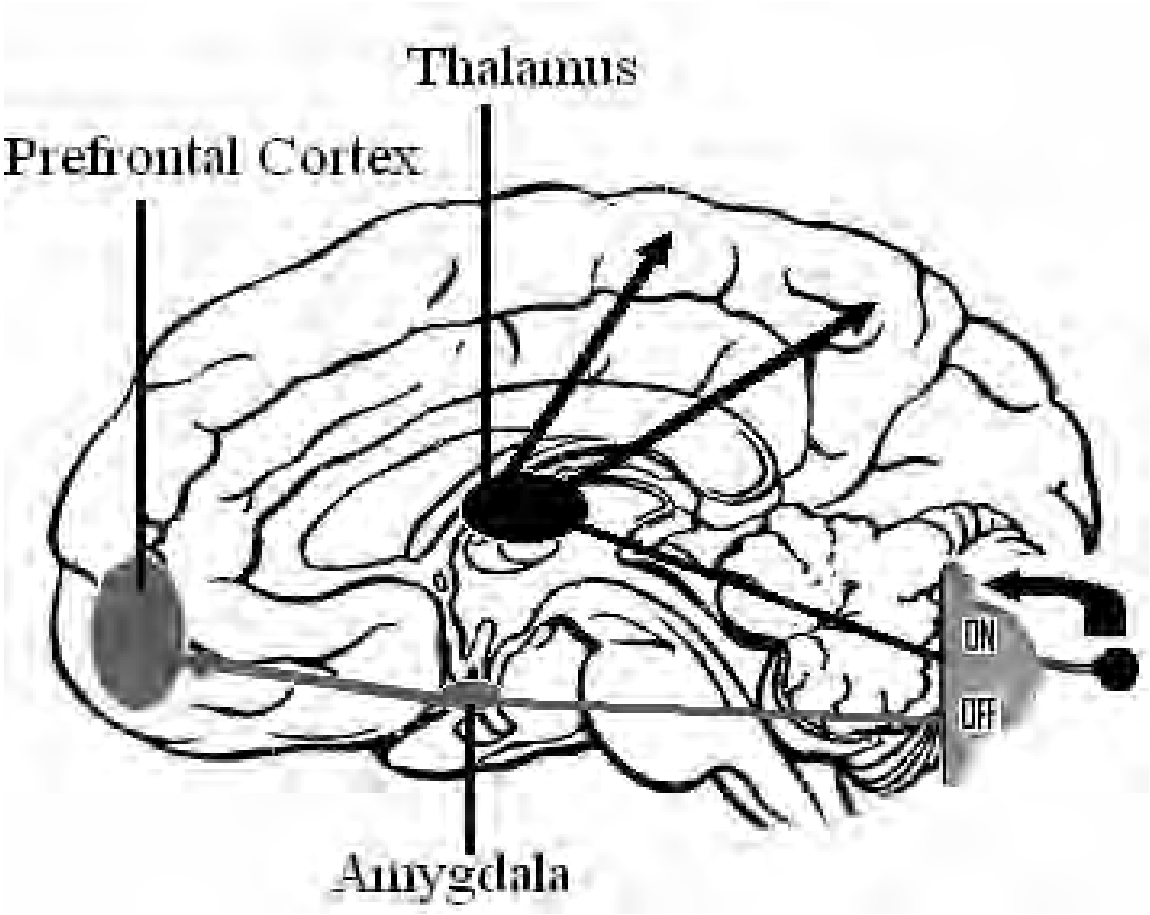
regions reinforcing fight/flight/fright response. This neural 'Fear Link' between amygdala and the orbitomedial frontal cortex is continually activated and the resulting agitation is so profound that it drives the person to seek relief in the form of drinking alcohol. However, once the individual completes the 4th and 5th Steps (a process of not only writing down the information, but also verbally sharing the patterns of behavior with another person), then the negative emotional pattern stops. This process breaks up of links of the aversive chain of neural events within the limbic system which prompt resentment, push anger, and produce fear.

If the 4th Step Inventory is performed correctly, then the person completing it will realize that much of these troubles are of one's own making. Insights include how the mind has deceived one into believing one's own lies and motives which justify misdeeds and taking action resulting in harm to others. The person in recovery understands that all of one's actions were based upon selfishness, a self-centeredness which compelled one to live for the thrill of the moment and cast away moral principles of proper action. The 4th Step Inventory helps the person to not only correct false memories, but also to connect the areas of memory together. In doing so one acknowledges a sense of simultaneous loss and gain. The loss involves a willingness to let go of selfish drives and motives. This loss occurs simultaneously with a loss of fear. Norden (2007) specified four brain regions in unlearning one's fear response. These areas include the amygdala (emotions), the hippocampus (learning and memory), the prefrontal area (will and decision making), and the reticular formation (involving alertness and selective attention).

The gain that occurs within the spiritual experience involves the opening of a neural pathway which allows for the reception of input in a new way. The activation of this neural circuit produces a novel pattern of interaction among specific areas of the brain resulting in an endorphin cascade (Austin, 1998). The effect includes a psychic change in which there is a transformation of the old automatic behavioral responses that were previously connected to the

mental obsession to drink. Figure 3 offers a hypothetical graphic rendition of the spiritual experience: The thalamocortical master switch connects the thalamus with other brain circuitry. This process integrates posterior regions of the associative cortex and the amygdala with the orbitomedial frontal cortex (Austin, 1998).

Figure 3 Neural Connections during a Spiritual Experience



Examining the 4th step inventory

The 4th Step involves a written inventory of fear, resentment, anger and harm done to others. The process includes the accessing of long-term memories, which activate the amygdala, the hippocampus and the working memory of the prefrontal cortex. The resulting four-column chart (as described on page 65 of *Alcoholics Anonymous*) examines (1) who, (2) performed

what behavior, (3) which hurt/affected the alcoholic. However, the fourth column (described on page 66 of *Alcoholics Anonymous*) is often glossed over or omitted as it is not located on the same page as the description. However, completing the fourth column is essential as it verifies how the alcoholic was responsible due to initiating actions based upon selfishness and one's defects of character. As a result of completing the 4th Step written inventory, the AA member forgives self, others and begins to seek reparations for those harmed.

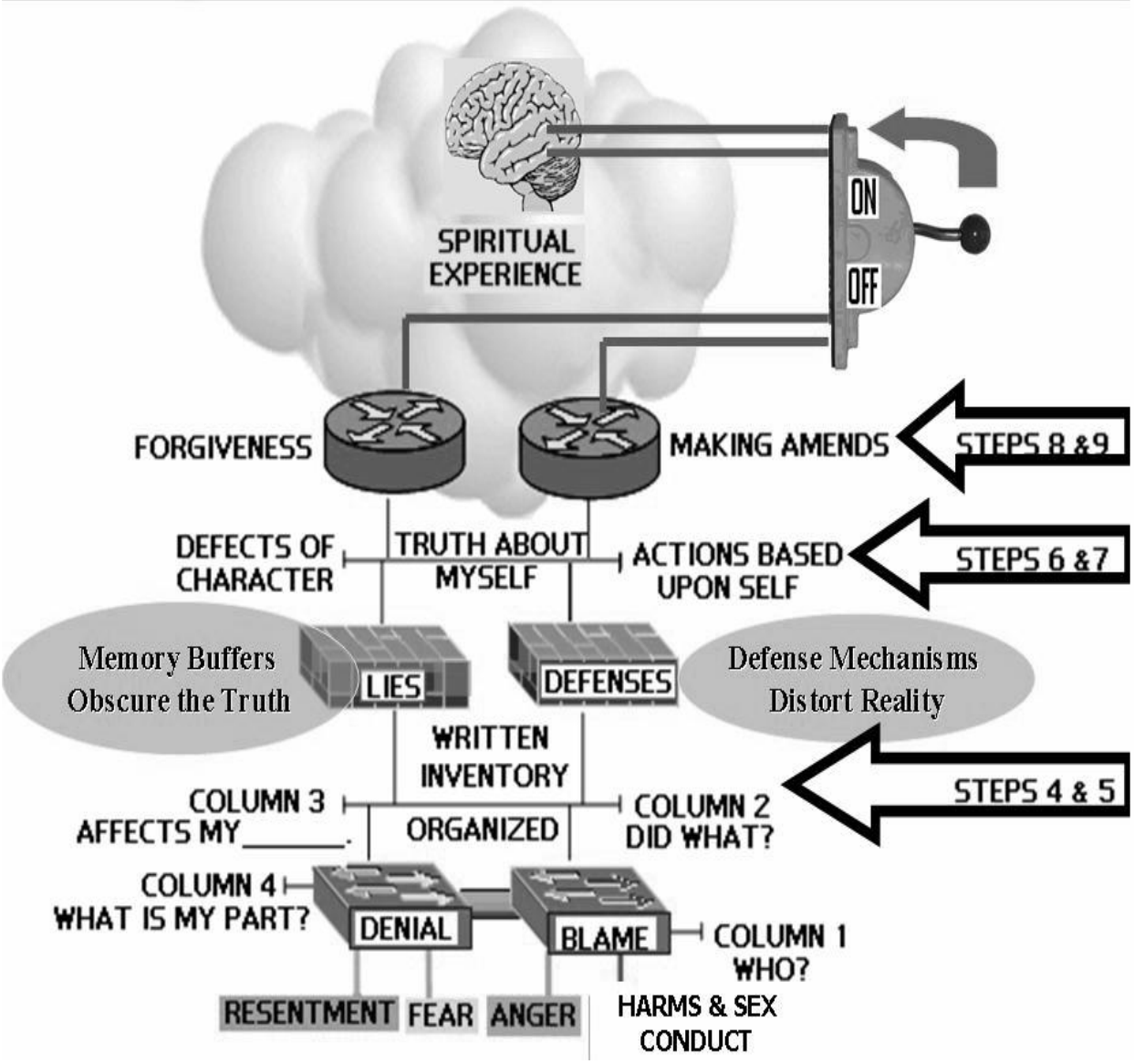
4th step connects memories with a written inventory

Figure 4 illustrates the detailed path of 12 Step program which culminates with a spiritual experience/spiritual awakening. One of the reasons that the 4th Step inventory is written is because memory is fallible. The detailed aspects of resentments are examined. The source of one's anger is explored along with one's fears and how one has harmed others. The inventory process logs events in specific categories, such as resentment, anger, fear and harm done to others (including sexual behavior) and the resulting patterns are scrutinized. As these items are written down and tallied, the ego defense "denial" cannot distort or erase what is entered.

Similarly, once the person has accepted responsibility for what is written, blame is no longer shifted onto someone else. By the time the written portion has been completed, the painstaking process reveals in an organized format the truth which is delineated from the deceitful lies and distorted defenses of the ego. Upon further examination one begins to unearth patterns of behavior prompted by one's defects of character as evidenced by the entries of column four. Insights arise and patterns emerge regarding one's thoughts, feelings, and behavioral habits. The insights provide a profound understanding of the automatic processes involved in obscuring the truth with false memories and the fabrication of "lies" to avoid responsibility or escape punishment. Realizations emerge regarding the warping of one's

perceptions, based upon the immediate satisfaction of the instincts.

Figure 4 The 12 Step Program and the spiritual experience



In Steps 4 and 5 one discovers the truth about oneself and shares that information with another person. Specifically, one is able to see clearly what defects of character (personal shortcomings) have led one to act upon selfish motives at the expense of others. Steps 6 and 7 include prayers for willingness to remove of one's defects of character, Steps 8 and 9 include seeking the

forgiveness of self and others, along with the making of amends. During this phase of recovery the AA Promises (found on pages 83 and 84 in Alcoholics Anonymous) begin to be fulfilled along with the culmination of a spiritual experience or awakening.

Throughout the 4th Step process, the AA member continues to activate more areas of the brain as well as to stimulate the connecting neural pathways. In essence, the dynamics include an activation of those areas which previously had become dormant due to effects of prolonged heavy drinking. There appears to be some evidence of a pattern regarding the activation of the spiritual experience as one completes the process of the 4th and 5th Step. AA co-founder Bill W. reported having a second spiritual experience after he completed Step 5 with Fr. Dowling (Alcoholics Anonymous, 1984, pp. 241-243). As I indicated in my earlier study (Sandoz, 1999), all participants who claimed to have a spiritual experience/awakening had completed Step 5.

Prior to occurrence of spiritual experience, Alcoholics Anonymous declares that the alcoholic is "without defense against the first drink" (p. 24). One of the reasons for this is clarified in the same text: "We are unable, at certain times, to bring into our consciousness with sufficient force the memory of the suffering and humiliation of even a week or a month ago", (p.24). However, after attaining the spiritual experience, the person in recovery not only remembers the painful consequences of drinking, but also would "recoil from it as from a hot flame" (p. 84). Such a process implies that a neural connection has been made and that the memory process has been repaired.

Working with other alcoholics in recovery and the spiritual experience

AA co-founder Bill W. indicated that "experience shows us that nothing will so much insure immunity from drinking as intensive work with other alcoholics" (Alcoholics Anonymous, 1976, p. 89). This same idea was repeated several times and through various events within the life of

Bill W. who felt "amazingly lifted up" (p.15) whenever he reached out to another for help. Furthermore, Bill W. specified that "when all other measures failed, work with another alcoholic would save the day" (p. 15).

Re-charging the spiritual experience

Regarding the recovery process for the case study, JB reported that while helping other alcoholics to recovery he often felt a physical sensation that closely resembled the physiological and emotional aspects of his spiritual experience. Such descriptions of the sensation included intense joy that was emotionally uplifting and satisfying. JB described the process as a recharging of his spiritual experience. In interviewing others in recovery who claimed to have had a spiritual event, comparable reports have been told to the author of this article.

Similar anecdotes have been reported to the author by mental health, addiction and pastoral counselors who have counseled individuals in recovery. In addition, the author has found such reports to include the emotional experience of exhilaration to be commonly associated with helping others in various aspects of recovery. In giving to others the recovery that one has received, there is return of the thrilling sensation associated with the spiritual experience along with a profound sense of gratitude. This observation of this phenomenon requires closer analysis and demands further study. It is my belief that the sensation associated with the recharging of the spiritual experience is related to the medial prefrontal cortex which contains "mirror neurons" that link bodily sensations with the brain stem, limbic and cortical regions (Ratey, 2008).

The AA model and the effect of the spiritual experience

In the section entitled "The Doctor's Opinion" in the Alcoholics Anonymous text , Dr. Silkworth describes his concept of alcoholism as being two-fold in nature, affecting both the mind

and the body of the alcoholic. He referred to this as a physical allergy and a mental obsession. Pastoral counselors should be aware that the direct effect of the spiritual experience is upon the mental obsession that alcohol had upon the individual (Sandoz, 2004). After having a spiritual awakening/experience, alcohol loses its potent power to convince the alcoholic that drinking alcohol can occur safely without consequences. However, the alcoholic has a daily reprieve that is contingent upon the maintenance of one's spiritual condition (Alcoholics Anonymous, p. 85). As such, the power of the spiritual experience manifests itself in the mind of the alcoholic and not in the body. Specifically, there is nothing that one can do about the physical allergy. Figure 5 illustrates the spiritual experience as the result of the Twelve Step program— the process which nullifies the mental obsession aspect of alcoholism.

Figure 5. The Effect of the Spiritual Experience

Summary

In this article the reader was taken along the path of defining alcoholism from the perspective of Alcoholics Anonymous as well as the psychiatric view. In addition, various etiologies of the disease were discussed including learning, biological aspect and in response to stress. However, most of the article provided detailed information the spiritual aspects related to recovery for the pastoral counselor. Specifically, the information contained in this article provided information regarding the impact of alcoholism upon the brain and how the 12 Steps of the AA program and daily sponsorship combine to evoke a spiritual experience that produces a psychic change sufficient to recover.

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Reexamining the Brain, Addiction and Neuro-Spirituality

Jeff Sandoz, Ph.D.[1]

Abstract

This article represents a compilation of neurological data and present day theories about brain function in addiction and the spiritual experience in recovery. This article can be viewed as an amalgamation of working hypotheses until technology catches up with theory. With the improvement of resolution from neuro-imaging devices future investigators may be able to confirm or correct some of the ideas offered in this article.

Keywords Brain, addiction, neuro-spirituality

Introduction

Recent advances in brain imaging technology have provided new information that is especially important for professionals in the addiction field. During the past decade, there have been numerous findings based upon technological advances in brain imagery regarding the spiritual experience (Austin, 2006; Beauregard & O'Leary, 2007). In light of neurological evidence, connections are being made between the functioning of neural structures and the process of addiction as well. Whitten (2008) suggested that changes in the neural functioning are due to the effect that drugs have upon brain structures. Recent neurological findings have influenced some in the field to view addiction as a brain disease (Leshner, 2008). As such, these research findings have prompted the author to revisit and reexamine the phenomenon of the spiritual experience in recovery, especially with regard to neural substrates. Hopefully, the reader will find that this

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additional information will not only provide an update of my initial findings (Sandoz, 1999), but will also bridge the gap between the processes involved the daily maintenance of Twelve Step program of recovery with the subsequent neurological events and behavioral changes.

This article builds upon the information offered as a basic primer of brain anatomy and functioning in addition to the degree to which the brain is affected by alcohol addiction (Sandoz, 2004). In addition, this article utilizes the ideas with regard to learning to live soberly through sponsorship (Sandoz, 2004). Also, this article will elaborate on the specific types of functioning of various areas of the brain (i.e., especially the prefrontal cortex and the limbic system) as related to the process of recovery. Finally, this article provides information related to the neural substrates that are associated with the spiritual experience, especially with regard to the impact of AA's influence upon various brain structures.

Addiction and brain imaging

Addiction involves a loss of perspective which renders the person incapable of determining exactly how much is enough. The internal gauge is broken. In time one's perception becomes warped. The ongoing betrayal by alcohol leaves the person heartbroken that the liquid which once promised empowerment now guarantees only disappointment and pain.

How much neural damage occurs after years of abusive drinking? The correct answer is "It depends!" The truth, in fact, is that it does depend upon numerous factors based largely upon genetics, the environment, the frequency, intensity and duration of drinking along with nutrition and metabolism. However, a brain imaging picture can offer a more concise and precise response to that question. Taken together, Figures 1 and 2 offer a simulated comparison of a normal drinker's brain with a problematic drinker's brain after years of heavy abuse.

In actual SPECT scan images the dark areas resemble physical holes. However, in reality, the darker regions are indicative of functional holes. Specifically, the shady areas lack proper

circulation due to the toxic nature of alcohol. In essence, these blackened portions remain in a somewhat dormant state until reactivated by refraining from the ingestion of alcohol and other addicted substances for an extended period of time. In addition, these inactive areas can be triggered to reawaken by specific activities used to enhance memory and learning in recovery regarding the case study of Jackie Brown (Sandoz, 1999).

Figure 1

Simulated Image of a Normal Brain

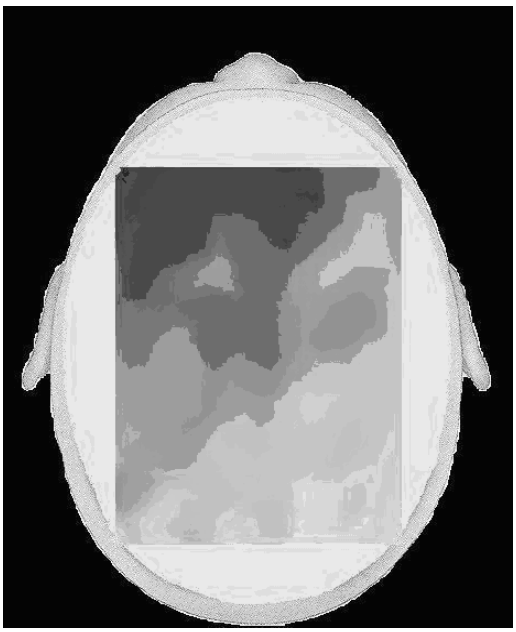
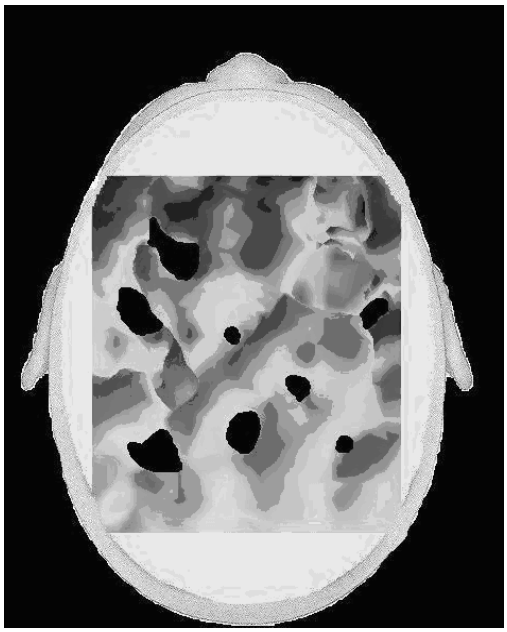


Figure 2

Simulated Image of an Abnormal Brain



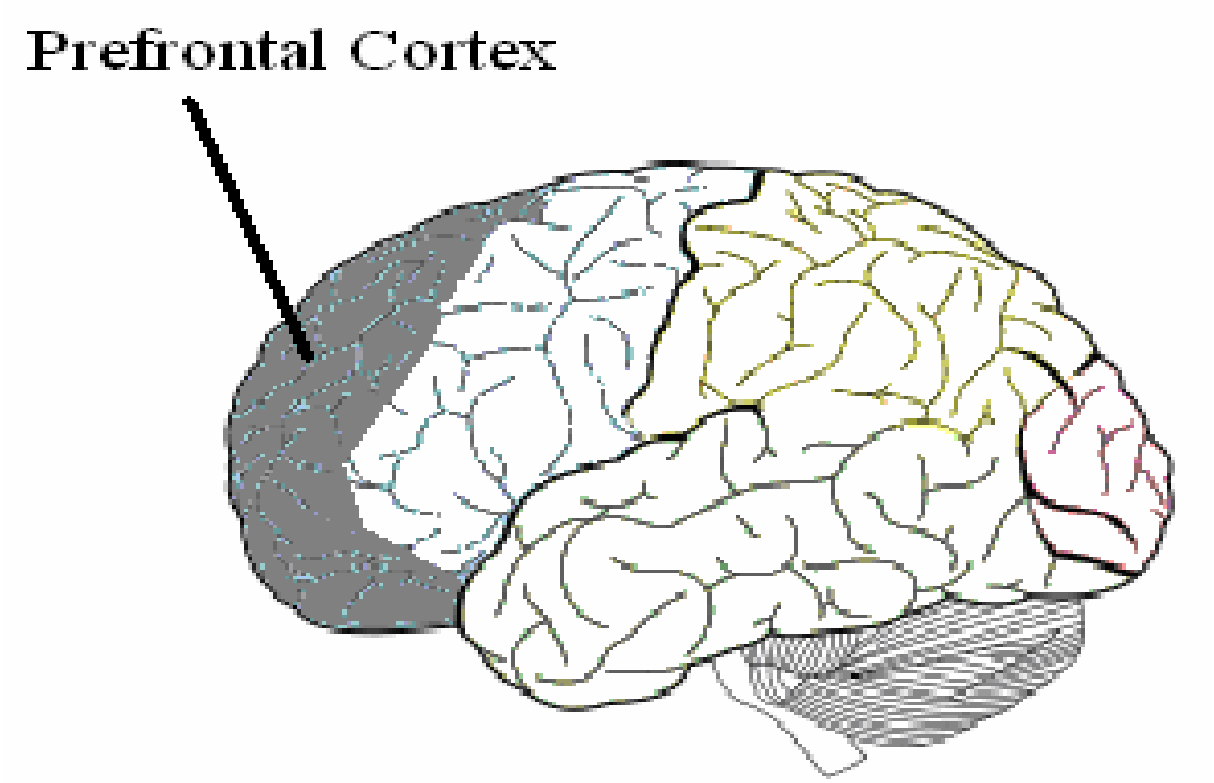
The Prefrontal Cortex

My assumption is that most readers of this article have not undergone extensive study of brain anatomy. Therefore, it is necessary to provide abundant graphic representation along with technical language for the novice who desires to learn more about brain functioning along with the implications of addiction.

The examination of the region of the brain known as the prefrontal cortex has received much attention in recent years. In order to enable the reader to understand the functioning of this brain structure, it is necessary initially to describe the region anatomically and then to examine the research findings regarding functionality. The prefrontal cortex is found in the anterior region

of the frontal lobes of the human brain. This region sits above the eye-sockets and extends in the front of one's head slightly above and to the rear of the location of the forehead. Figure 3 provides an illustration of the position of the prefrontal cortex.

Figure 3 Location of the Prefrontal Cortex



Functional aspects of the prefrontal cortex

In general, the prefrontal cortex of the human brain has been associated with planning, complex cognitive processes and behavior. In addition, this region not only monitors social behavior, but also prompts one to curb and correct actions that are deemed to be inappropriate. To a large extent this structure is involved with the development of the will, personal values and goals. Specifically, this area has been implicated in the decision making process. The skills involved in the decision making practice include aligning, coordinating and organizing thoughts, feelings and behavior. Perhaps the neurological term "executive function" is most apt in

describing this command center of the brain. However, within the alcoholic, functioning of prefrontal cortex is severely compromised. In fact, Hyman, (2007) suggested that addicted individuals have substantial impairments in cognitive control of behavior. Alcoholic behaviors leave the impression that one's moral compass has been disengaged. In extreme cases it seems that the basic survival mechanisms have been usurped by the desire for the addicting substance. Newberg and d'Aquili (2000) refer to the ability of certain brain structures to block the input into other structures as deafferentation (p.258). As such, it appears that the executive function center of this area of the brain has been commandeered by the pleasurable effects of drugs and alcohol. In fact, as the result of addiction, the dopaminergic reward pathway has been hijacked by the activation of the brain's pleasure centers. This begs the question, if the executive function of the prefrontal cortex has been compromised, then how is one to recover?

The frontal lobe region plays a very important role in encoding and retrieving memories. There are specific areas of the left frontal lobe that become quite active during encoding of memories. However the same regions within the right frontal lobe become more active during the retrieval of memories. Specifically, the right anterior prefrontal cortex becomes activated in the attempt to retrieve a previously experienced episode of one's life. Interestingly enough, there is evidence that this region becomes increasing active whenever the person is successful in retrieval the information. This process takes on immense importance as the person actively retrieves memories in a systematic format such as the 4th Step inventory.

Regions of the prefrontal cortex

Austin (2006, p. 104) identified the four regions of the left frontal areas that become activated in the process of retrieving memories as the left polar cortex, the left mid ventrolateral cortex, the left mid dorsolateral cortex and the dorsal anterior cingulate. Furthermore, Austin provided a description regarding the functioning of specific areas of the prefrontal cortex.

- Dorsolateral- selects, manipulates, and monitors incoming data working memory (p.159)

- Orbitofrontal – assigns emotional value to incoming messages (p.159)
- Medial frontal – function of introspection, accesses emotionally valenced material
- Anterior frontal polar cortex – evaluates of memories, activated in making moral decisions
- Ventromedial prefrontal cortex – emotional monitoring and processing (p.196)
- Dorsomedial prefrontal cortex – monitors one's mental state of self-related thoughts and emotions, takes an active role in planning
- Anterior cingulate responds to both physical and emotional pain (p.83).

Ciaramelli et al. (2007) reported finding deficits in moral judgment within individuals following damage to ventromedial prefrontal cortex. In an animal study, Wilson et al. (2007) found that damage to ventrolateral prefrontal cortex impaired spatial memory, particularly regarding object-in-place scene memory. Figures 4 and 5 provide information regarding the location and functions of the prefrontal cortex.

Additional regions in this vicinity of the brain include the anterior and ventral areas of the cingulate cortex, the anterior prefrontal cortex and the medial prefrontal cortex. These areas are best viewed in a medial cross section of the brain. In some animal studies the medial prefrontal cortex provides regulatory input to the amygdala.

Figure 6 displays information regarding the location and function of additional sections of the prefrontal cortex. Specifically, the medial prefrontal cortex participates in the decision making process by communicating the degree of attractiveness as related to predicted outcomes (Morgan et al., 1993; Bechara et al., 1999; O'Doherty et al., 2001; Milad et al., 2002).

Figure 4 Lateral Regions of the Prefrontal Cortex

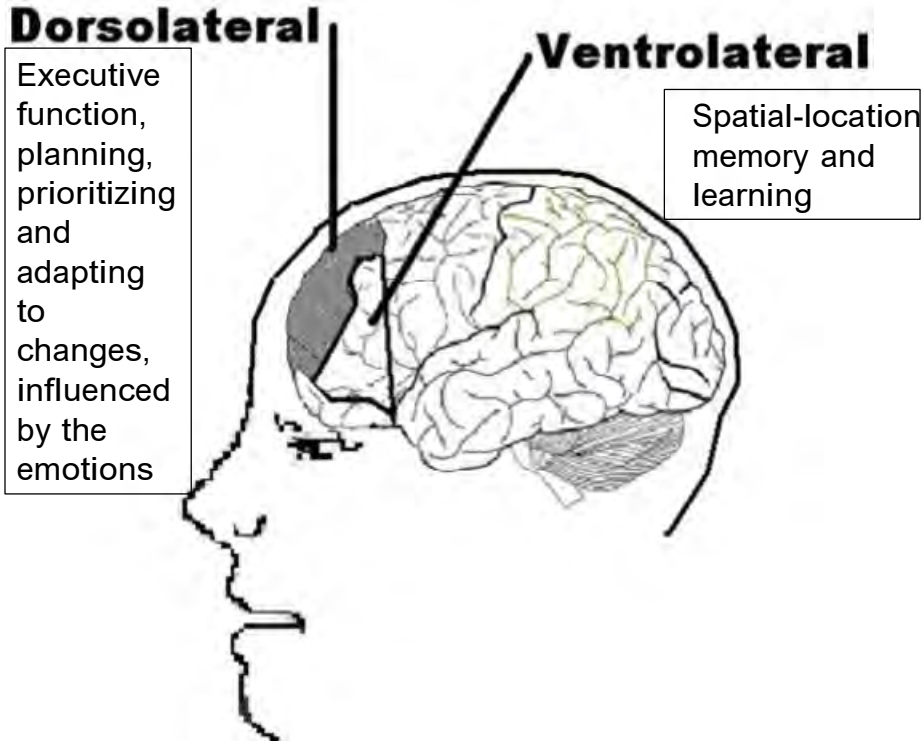


Figure 5 Ventral (Underside) Regions of the Prefrontal Cortex

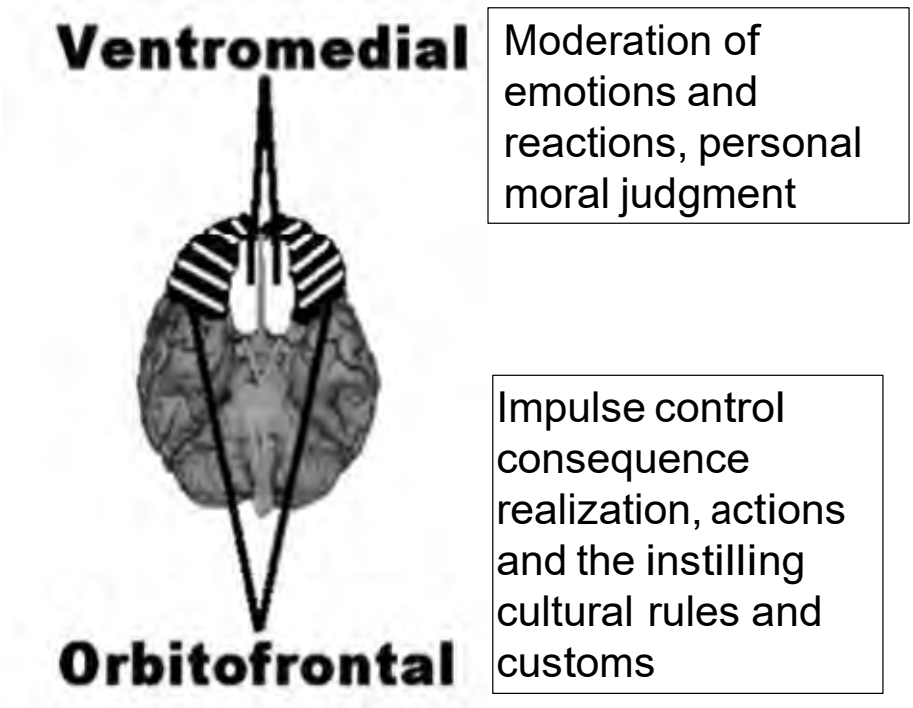
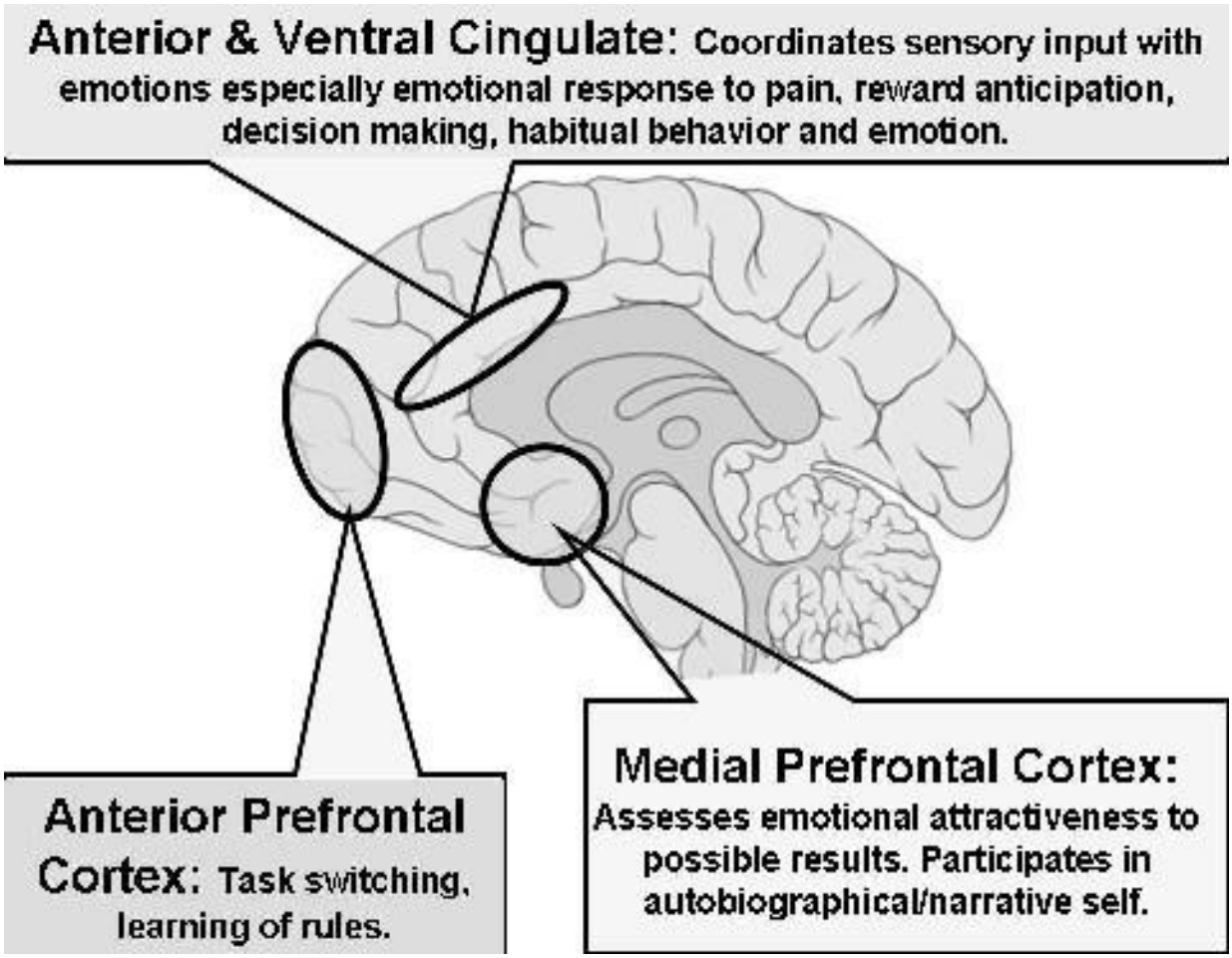


Figure 6 Medial (Cross Section) of the Prefrontal Cortex



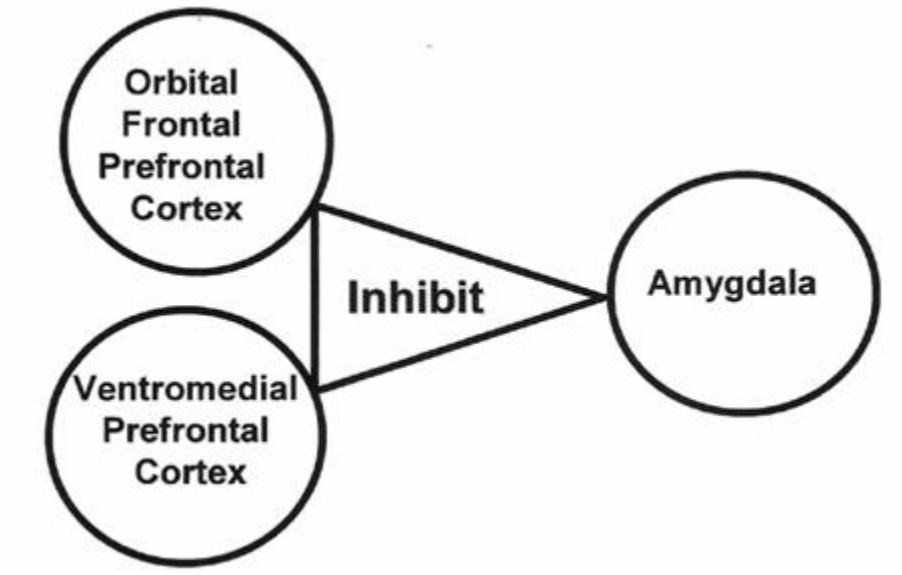
Limbic system and prefrontal cortex neural links

Brain pathways consist of interconnected neurons through which neural signals can be transmitted from one region of the brain to another. The system of neurocircuitry allows for multiple levels of communication among different brain regions. As such, the limbic system provides a variety of integrative functions in the areas of learning, memory, and emotion by connecting neural pathways to the executive function of the prefrontal cortex. Although many neuroscientists are prone to separate the functions of the prefrontal regions with the limbic

system, Norden (2007) includes aspects of the executive function within the limbic system. It is important to mention that the prefrontal cortex has numerous neural interconnections with both the limbic system and a region of the brainstem known as the Reticular Activating System (RAS). The RAS portion of the brainstem is responsible for alertness.

Carlson (2007) reported that the ventromedial prefrontal cortex shows signs of reciprocal connectivity within the limbic system, including projections to the cingulate cortex, temporal cortex, hippocampus, hypothalamus and the amygdala. Furthermore, Carlson indicated that the ventral prefrontal cortex (comprised of both the orbitofrontal and ventromedial prefrontal cortex) has direct inhibitory connections with the amygdala. Figure 7 illustrates the process of the neural inhibition of the amygdala by two regions of the prefrontal cortex.

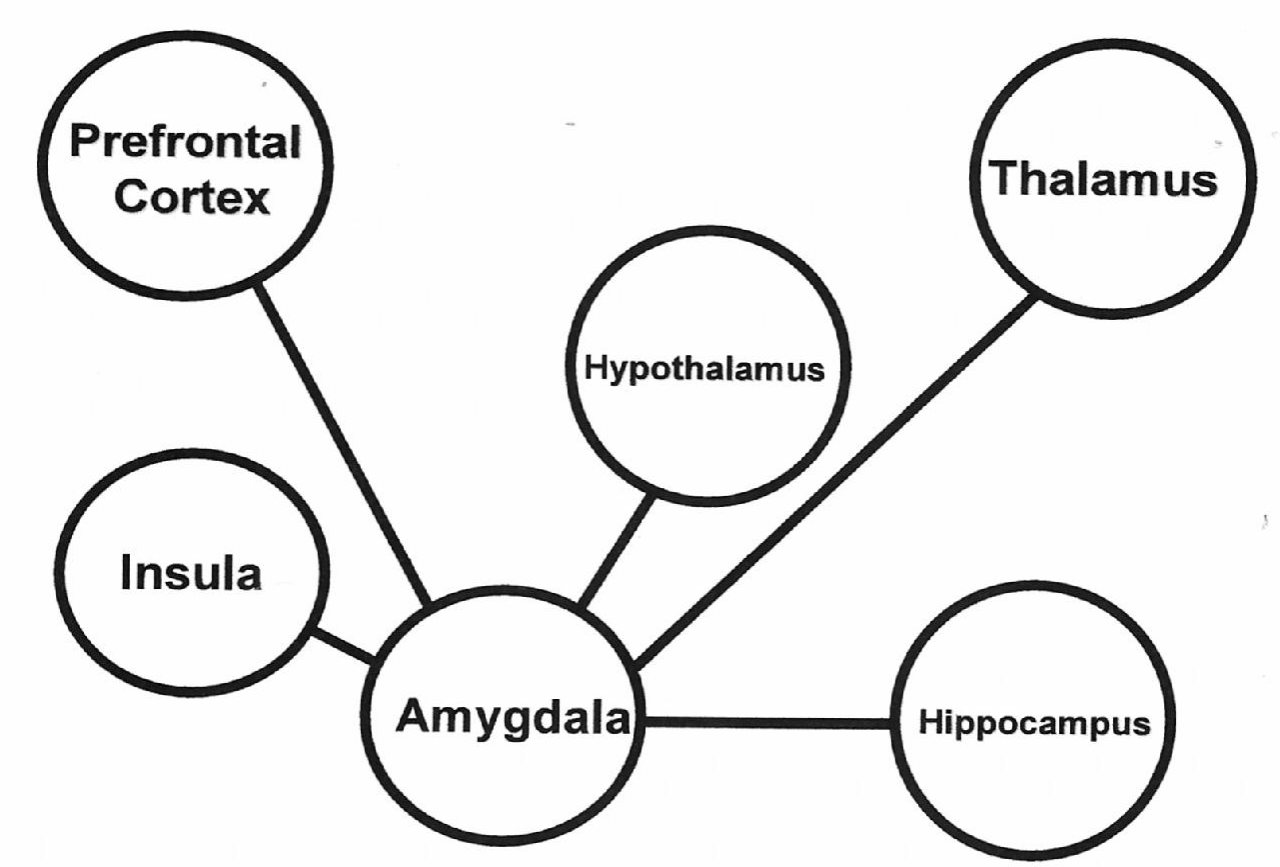
Figure 7 Inhibition of the Amygdala



Norden (2007) reported that the amygdala was involved in emotional processing, specifically fear. However, regions of the prefrontal cortex have been implicated in the unlearning of a fear response. Such a connection implies a high degree of neural communication between those structures regarding cognitive assessment and emotional processing. In addition, the limbic structure known as the amygdala is a rather complex arrangement involving five interconnected, yet functionally distinct regions which play a key role with regard to the processing emotions

related to sensory information. Also, these connections are extensive, linking to such widespread areas as the prefrontal cortex, thalamus, insula, hippocampus and hypothalamus. Many of these links are reciprocal in nature. Figure 8 illustrates the neural links of the amygdala.

Figure 8 Neural Links of the Amygdala



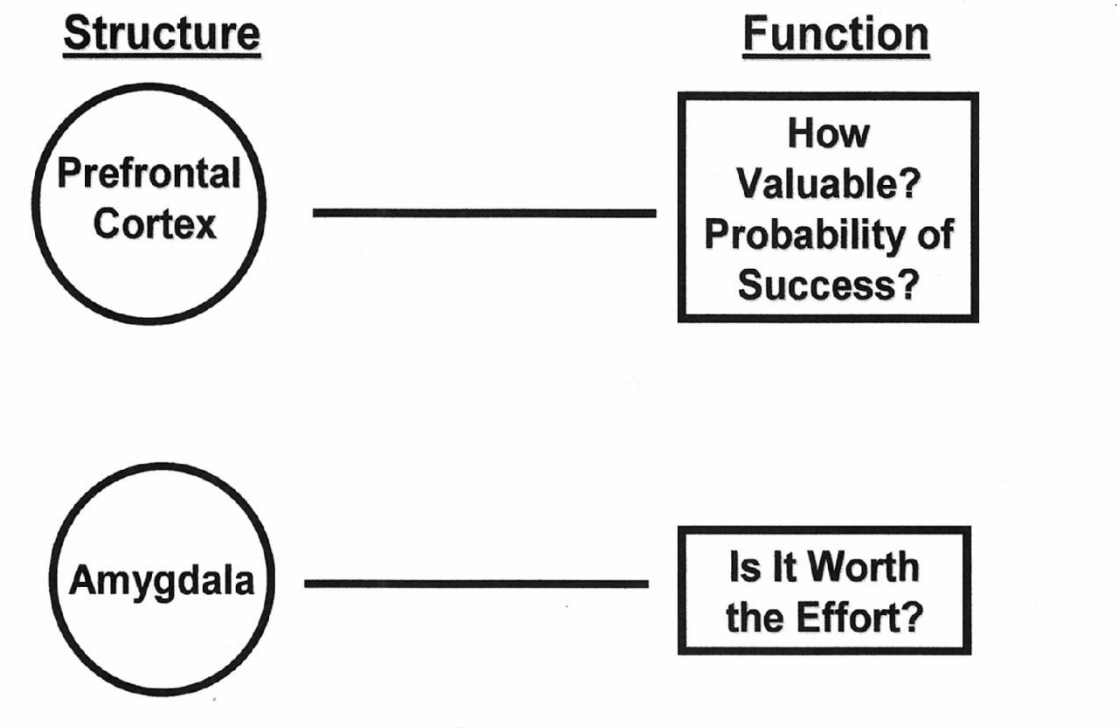
Another region with important neural links with the amygdala is called the insula. While the anterior portion of the insula receives a neural projection from the basal region of the ventral medial nucleus of the thalamus and a particularly large input from the central nucleus of the amygdala, the anterior insula also projects a neural tract to the amygdala. Such a process provides the neural circuitry for a feedback loop.

One of the best-known neural connections is referred to as the Papez circuit, which connects the hippocampus with mammillary bodies of the hypothalamus and continues with portions of the anterior nuclei of the thalamus and onto the cingulate gyrus. In essence, this neural circuit

creates a feedback loop which integrates the various aspects of emotion with memory. The limbic system contains multiple complex circuits which feedback upon themselves dealing with learning memory and emotion.

As such, Izquierdo et al. (2004) concluded that the orbital prefrontal cortex was critical for responding appropriately to changes in either reward value or contingency. However, the amygdala was critical only for responding appropriately to changes in reward value. In simple terms, the prefrontal cortex assesses the value and probability of an action, while the amygdala contributes the emotional element if the proposed action is actually worth the effort. Figure 9 compares the function of the orbital prefrontal cortex with the amygdala.

Figure 9 Functional Comparison of Brain Structures



Dopaminergic pathways

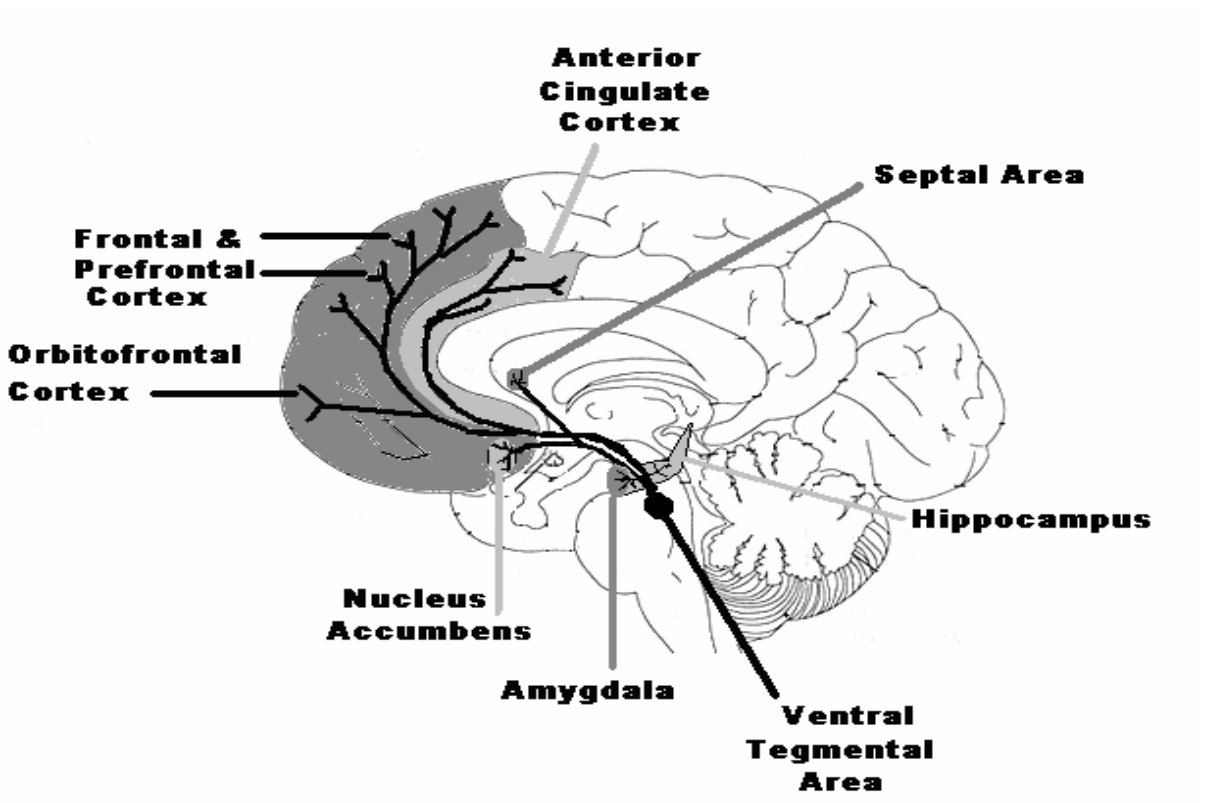
Addictive drugs affect levels of neurotransmitters in the brain. Although the nigrostriatal and the tuberoinfundibular neural circuits are two important pathways in the brain that utilize dopamine,

perhaps it is the mesolimbic/mesocortical neural pathway that provides the greatest promise in the understanding of the addiction and recovery processes (Blum et al., 2000). In fact, regions connected by means of these neural circuits, have been called the endogenous reward system. The first medial neural pathway is the mesolimbic system which extends from the ventral tegmental area and projects to the nucleus accumbens, the amygdala, the hippocampus and the septal area. Another neural pathway in the mesocortical system extends from the ventral tegmental area to the orbitofrontal area and branches off above to higher regions of the frontal and prefrontal cortex and the anterior cingulate gyrus. The neurotransmitter dopamine from the ventral tegmental area activates the nucleus accumbens in relaying messages between the limbic system and the prefrontal cortex. While the outer shell of the nucleus accumbens projects to the hypothalamus and the amygdala and the tegmentum of the midbrain. The amygdala activates the midbrain which in turn provides more dopamine for the nucleus accumbens. However, the prefrontal cortex can block the process (Austin, 2006, p. 80). It is important to note that both the nucleus accumbens and the septal region are reward centers. The mesolimbic and mesocortical neural pathways and the structures that are connected in this neural circuitry are areas of intensive research by neurophysiologists. One of the main reasons of this interest is due to the susceptibility of this region of the brain to addictive substances. The mesolimbic and mesocortical neural branches are illustrated in Figure 10.

Learning and the addiction process

Johnson (1973) described three phases of addiction which included learning, seeking and harmful dependency. In the learning phase, the person realizes that the consumption of alcohol is pleasurable. Specifically, as the person begins to relax the stress is relieved. The individual experiences immediate gratification with very little effort. During this learning phase one experiences pleasure via the nucleus accumbens. In time, one may develop a love-trust relationship with alcohol.

Figure 10 Mesolimbic and mesocortical neural branches.



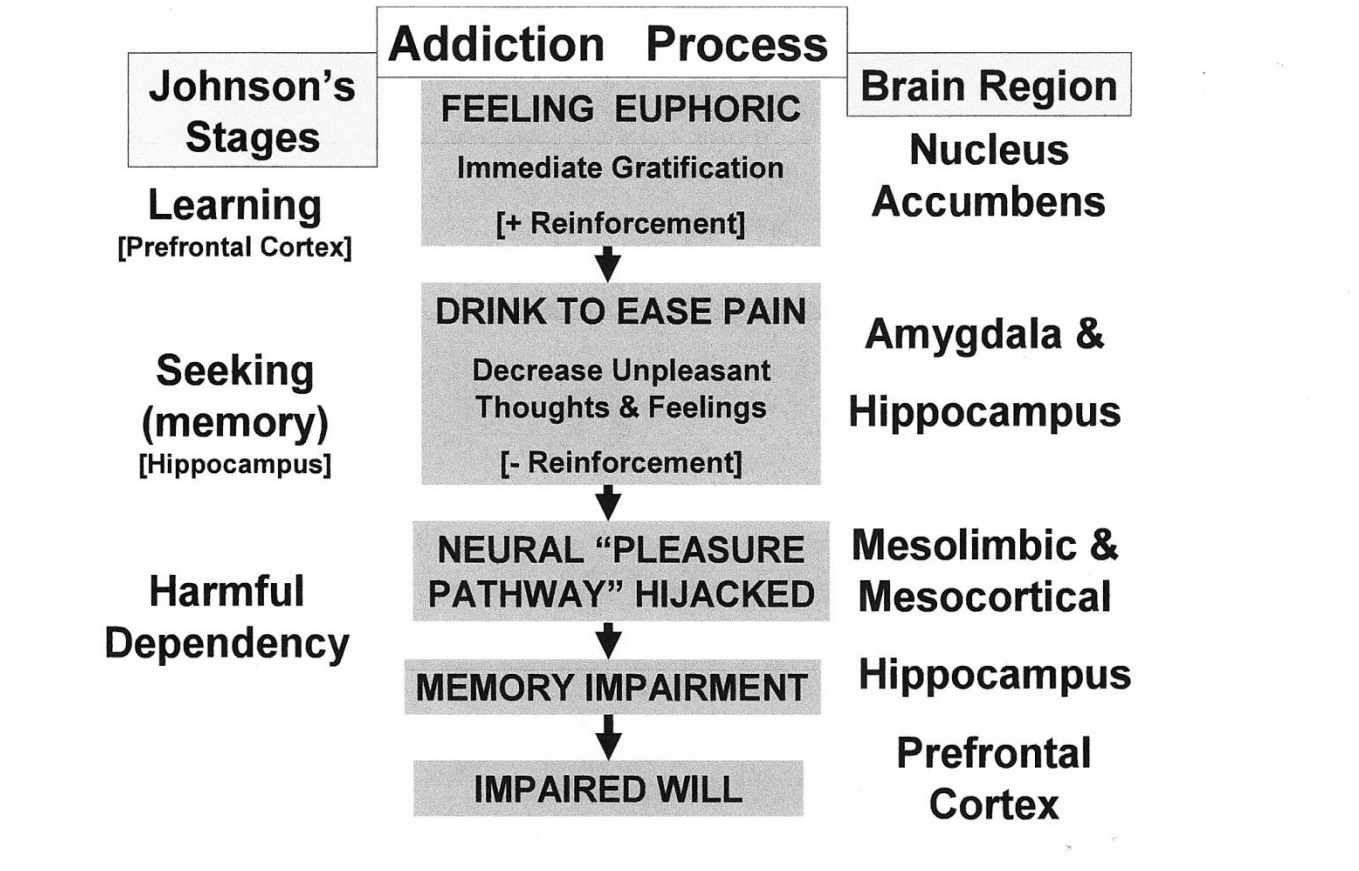
Actively seeking relief

In stage two of Johnson's view of addiction, already the person has recognized that drinking is a pleasurable experience. At this point, in psychological terms, alcohol consumption is regarded as positive reinforcement. As such, the memory of drinking as a pleasurable event becomes firmly established within the mind and the person frequents the opportunity to consume alcohol. However, whenever the individual is experiencing stress or some other unpleasant sensation, then alcohol consumption is actively sought in order to decrease or to cease the bothersome thoughts and feelings.

At this stage of the addiction process, alcohol consumption provides negative reinforcement as it helps one to minimize an unpleasant situation or a disagreeable emotional state. Some counselors in the field of addiction view the process up to this point as being alcohol abuse, since once the stress has been removed the person no longer finds it necessary to drink.

However, to progress beyond this point is considered by most to be a sign of alcohol addiction. The addiction progression and Johnson's ideas are illustrated in Figure 11.

Figure 11 Addiction Process, Johnson's Stages and Brain Areas Implicated



Harmful dependency

In Johnson's final stage, harmful dependency, the process of alcohol consumption goes completely awry. In the case of harmful dependency the dopaminergic "pleasure pathway" becomes hijacked and various areas of the brain become commandeered such as the hippocampus (memory), and the prefrontal cortex (executive center). It is important to note the progression of the addiction process in Figure 11. Specifically, as the addiction gains ground the control of the neural pathway is lost, followed by memory and finally the person's will is impaired. Another important area with regard to the addiction process is the amygdala, which will be discussed in a later section.

The brain held hostage

Imagine the recursive, persistent pattern of a resentful thought which evokes anger. When such thoughts and emotions are joined together the hippocampus and amygdala have become activated and work in tandem. Perhaps the repetitive nature of this event taps into the same regions which are activated in obsessive compulsive disorder; namely the thalamus, orbitofrontal cortex and the caudate nucleus. The obsessive nature of these recurring thoughts are prone to highly agitate the individual in a seemly never-ending scenario of reverberating signals that are bounced back and forth between the orbitofrontal cortex and the thalamus. The person responds to the ever-increasing level of anxiety by drinking alcohol in an attempt to relieve this state of apprehension. However, while drinking one may loosen inhibitions, neglect certain social

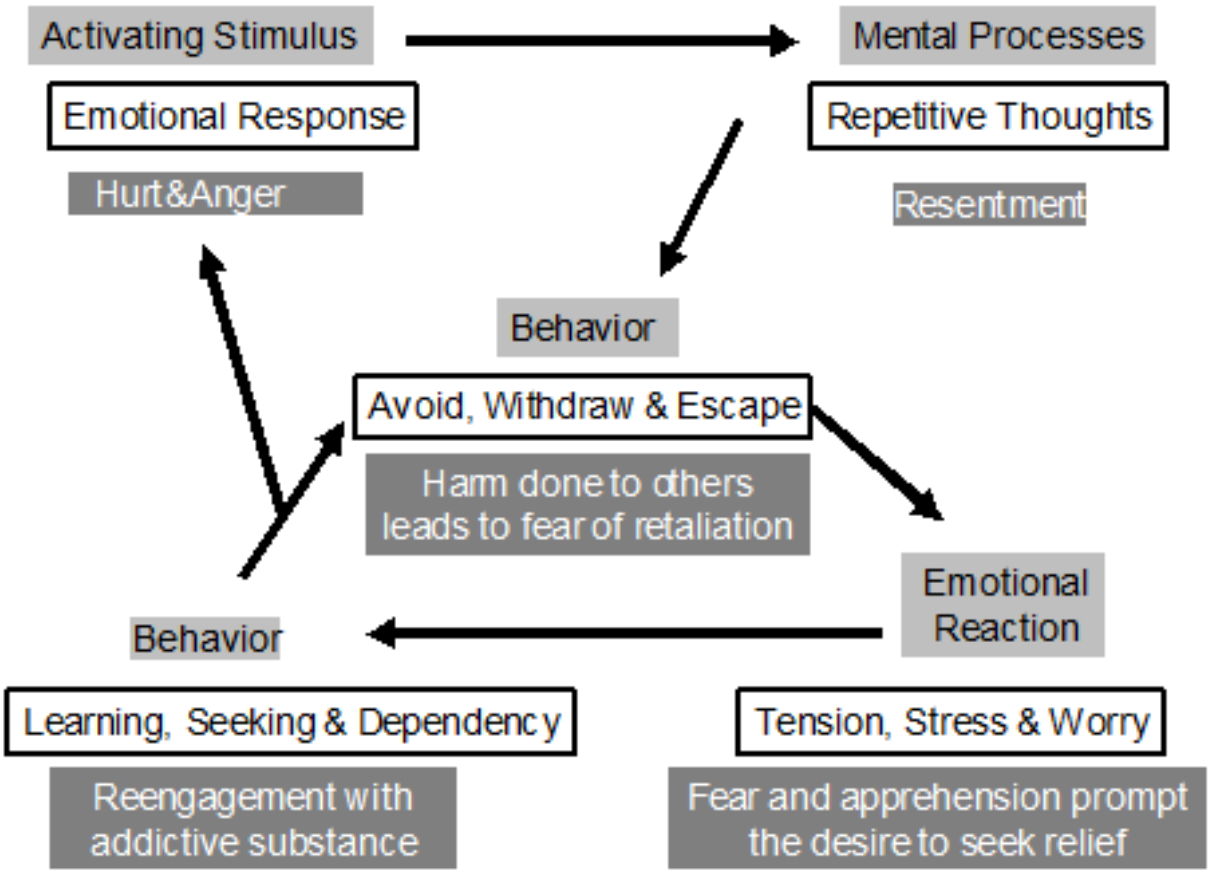
amenities and behave in an offensive way to others. Such actions instill fear that the offended party may retaliate. Ongoing thoughts of fear and worry produce a high level of stress and tension which prompt the person to seek relief again in the form of consuming alcohol.

Figure 12 presents a view of the mental and emotional processes involved in addiction. In this diagram, the person has taken offense by some event or an accumulation of unpleasant dealings with others (listed as the activating stimulus) and feels either hurt and/or angry. Mental replays of such repetitive hurting events become resentments. Next, the person may resort to behaviors by which one would be able to avoid an unpleasant situation, withdraw from an unsettling environment or escape from others.

At times, the person's avoidance, withdrawal or escape behaviors may offend others and promote additional tension, stress and worry. Fear and apprehension may reach a fever pitch. In an attempt to find relief the person reengages with the addictive substance. The process runs full circle as one either persists in the practice avoidance behaviors and/or the person continues to obsess over a series of events which prompt more hurt and anger. At this point the cycle repeats itself, but in a

faster pace as the symptoms of the addiction deepen.

Figure 12 Mental and Emotional Processes Involved in Addiction



The amygdaloid influence

Austin indicated that the internal thought processes shape the response of the amygdala (2006, p.93). This is especially true regarding the process of replaying resentful thoughts. However, in reexamining one's feelings Austin noted a decrease in the level of functioning of both the amygdala and the medial orbitofrontal cortex. Such a process is believed to occur in the completion of a 4th Step inventory. The amygdala plays a specific role regarding the level of a person's attention as related to reinforcement. In addition, the amygdala has been implicated in

emotional memory. In active alcoholics the sentiments of anger, resentment and fear influence mental activities and behavior. The self-induced emotional stress leads one to seek relief through drinking. In examining the mesolimbic neural pathway it would appear that the activation of upsetting emotions would resonate within the amygdala and prompt more drinking.

The effect of alcohol consumption not only quiets the amygdala, but also targets the reward center of the nucleus accumbens. The process involves the rapid onset of the experience of pleasure which calms the emotional influence of the amygdala, but only momentarily. The pacification of the amygdala is short-lived as the emotional issues are merely masked. However, when anger resurfaces the habitual response to seek relief by drinking becomes firmly established.

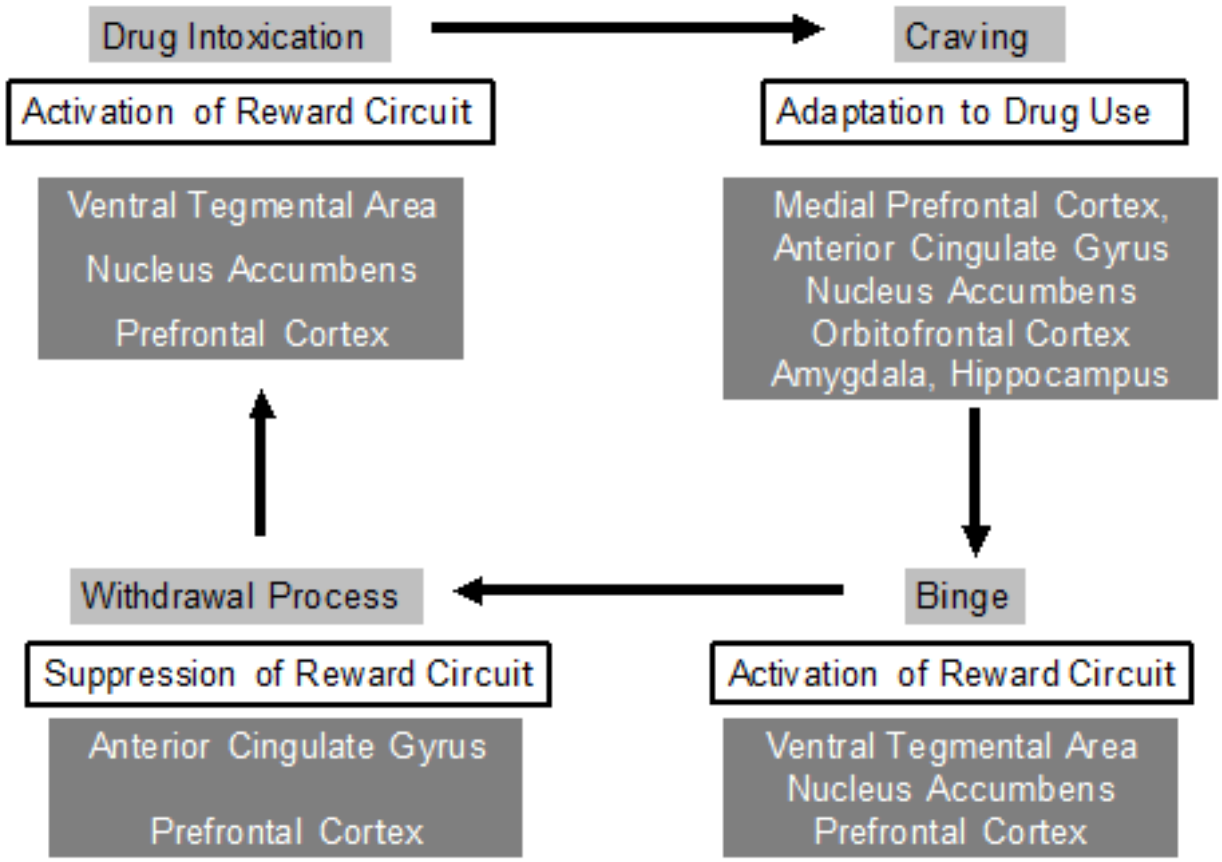
The neuroanatomical substrates for the merging of memory involve the amygdala and the hippocampus. However, the activation of the thalamo-orbitofrontal circuit in addition to the anterior cingulate could result in the psycho-physical sensation known as craving. Similarly, functional imaging studies have also implicated the insula in drug craving. Blakeslee (2007) indicated that the insula cortex "lights up" in brain scans when individuals crave drugs.

Craving

The term "craving" is quite prevalent in addiction literature. However, there is a distinction in the use of this term. In current literature craving is used most frequently to describe the intense mental and emotion anticipation which leads to the use of an addictive substance. However, in Alcoholics Anonymous, the author of "The Doctor's Opinion" offers clarification of craving in a different sense. Dr. William Silkworth declares that all types of alcoholics "have one symptom in common: they cannot start drinking without developing the phenomenon of craving" (1976, p. xxviii).

Silkworth attributed this type of craving to the physical allergy. This is different from the type of craving that exists prior to the ingestion of alcohol. Silkworth viewed alcoholism as a two-fold disease with a physical allergy and a mental obsession. At the time of this writing there is nothing medical science can do about the physical allergy, but the Twelve Step program is effective in curbing the effects of the mental obsession. Figure 13 illustrates the addiction cycle with associated actions and implicated brain structures involved with drug intoxication, craving, binge behaviors and withdrawal.

Figure 13 Addiction Cycle and Brain Structures



The influence of AA upon the prefrontal cortex

AA co-founder Bill Wilson commented that the will of the alcoholic was "amazingly weakened" with regard to alcohol (Alcoholics Anonymous, 1976, p.7). The prefrontal

region of the brain is considered to be the area implicated with regard to the human will. The reactivation of the executive function comes into play as one weighs out the consequences of possible future actions and begins to wrestle with conflicting thoughts and emotions. This functioning of the human will (or volition) becomes increasingly important in recovery, especially when conversing with one's sponsor on a daily basis. The sponsor not only explains the principles of behavior that are embedded within the Twelve Step program, but also helps the newcomer in the daily practice of those same principles.

Instruction in the practical application of these steps is crucial in early sobriety especially in the process of planning one's day and examining under close scrutiny one's personal feelings and thoughts. In essence, the sponsor assists in the retraining of this prefrontal region of brain by helping the person to align one's thoughts, feelings and behaviors by orienting and organizing one's life in relation to the Twelve Step program. By engaging within this regimen on a daily basis the person in recovery gains a sense of discipline by internalizing the tenets of the AA program.

In accordance with Step Three, the AA member turns his or her will over to the care of God. The will is cleansed of emotional residue in Steps Four and Five through the development of a moral inventory and the sharing of those findings with another. Steps Six and Seven involve a readiness to have God remove one's defects of character and a plea for God to do so. Having made a list of those whom one has harmed in Steps Four and Eight the AA member makes direct amends to those who have been offended or harmed by one's actions.

At this time the AA member has internalized many of the principles of the 12 Step program. By the time one has completed Step Nine, it is implied in Alcoholics Anonymous (p. 85) that the person's will has been rectified and returned. However, the dependency changes, and in order to remain free of the compulsion to drink one must "choose to carry the vision of God's will into all of our activities" (Alcoholics Anonymous, 1976, p.85). As long as one continues this on a daily basis, the compulsion to drink (i.e., the mental obsession) leaves and the person accepts

a dependency on God.

Figure 14 illustrates aspects of the recovery cycle, including the influence associated with sponsorship, participation in AA meetings and the daily application of the principles inherent within the Twelve Step program. For the purpose of simplification, the AA influence appears to have a direct supportive impact upon the various regions of the prefrontal cortex.

For example:

(1) The daily contact with the sponsor helps the person to schedule and plan the day, adapt to potential changes within one's agenda and prioritize the activities for the next twenty-four hours.

(2) With the sponsor and within AA meetings one learns to moderate personal behavior and in following the principles of the steps one considers which behaviors are best. This process, repeated time and again, promotes the development of moral judgment.

(3) Through interactions with others in meetings and through service, there is the opportunity to gain vicarious learning experiences in the understanding of behavioral consequences of one's actions and in moderating future behaviors.

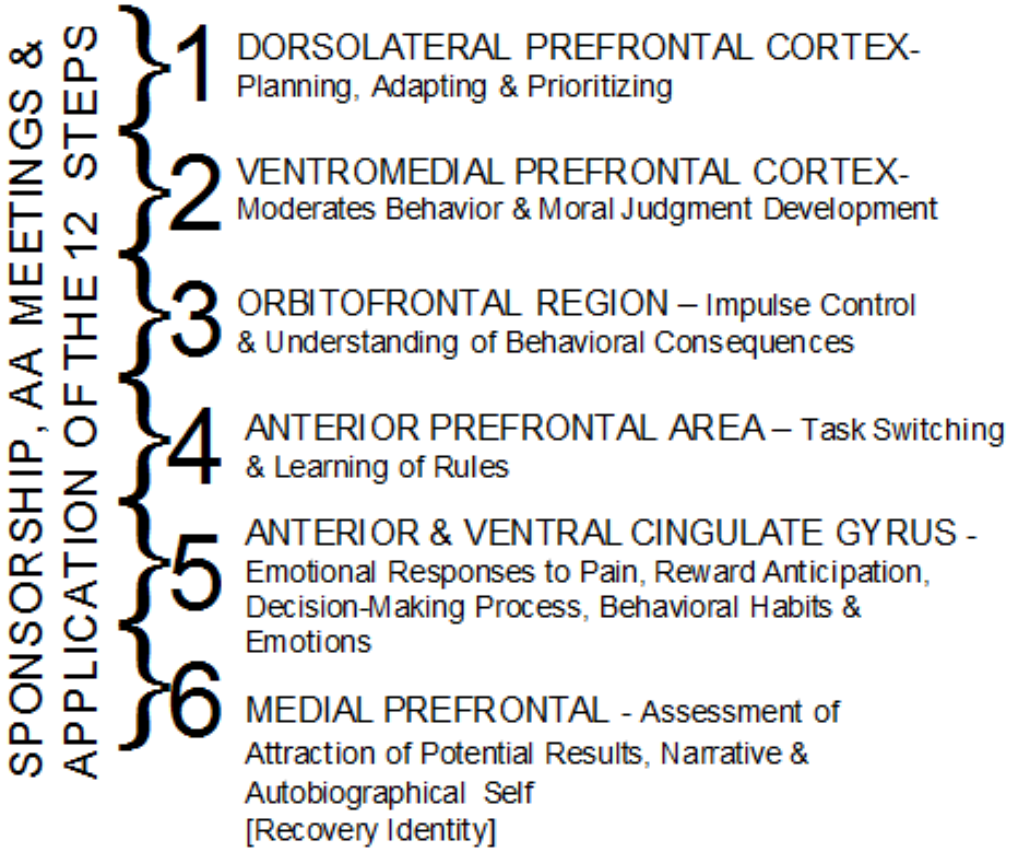
(4) AA members gain knowledge of more appropriate ways of acting in response to numerous demands that are faced each day. In the planning and prioritization of activities they learn to foresee difficult areas or trying times during the day. In response to such events they continue to discover novel techniques or methods to solve or circumvent problems.

(5) The manner of handling pain also changes. Alternative and more productive actions are taken instead of getting on the mental treadmill with worries and concerns. The person is prompted to seek other options rather than to dwell upon pesky thoughts, indulge in unpleasant feelings and act in ways which previously led to drinking.

(6) The sense of a personal identity is changing as drinking is no longer considered to be an option. A recovery identity is solidified each day as one implements action based upon

AA principles.

Figure 14 AA Influence and the Prefrontal Cortex



During the addiction process the executive function was hijacked and the person lost control over drinking. After the establishment of a firm foundation of understanding the AA principles, the prefrontal cortex assumes control of the executive function and the power of the human will is regained. It is essential that the influence of AA must have an impact upon the six regions of the prefrontal cortex of the recovering alcoholic.

Mesolimbic/Mesocortical pathways: Feedback loop in addiction & recovery

Consider the individual in recovery who practices the principles of the Twelve Step program in all of his or her activities. A life lived upon the solid principles of the AA program is radically different as one is able to remove the persistent feelings of anger, fear and resentment through the completion of Step Four. As a result of daily maintenance, the previous habit of emotional agitation decreases rather dramatically. As such, the results of Step Four not only curtail

present resentments, but also prevent future sentiments of anger and fear from developing. Such a change offers credence to the proper reactivation of the mesocortical connection of the prefrontal areas.

In essence, the process results in a less active amygdala, but a more active frontal cortex. This hypothesis is not without precedent in other brain related disorders. For example, Norden (2007) reported that the process of recovery from such conditions as post traumatic stress disorder and obsessive compulsive disorder involve a simultaneous action: decreasing the level of activation of the amygdala while increasing the level of activation in the pre-frontal cortex.

The neurons within these mesolimbic and mesocortical feedback systems are so incredibly intermingled that a feedback circuit within one will also activate the other. Addiction has disturbed the normal functioning of these neural pathways. Neural recovery from the addiction of alcohol begins with the feedback looping of the mesolimbic and mesocortical circuits.

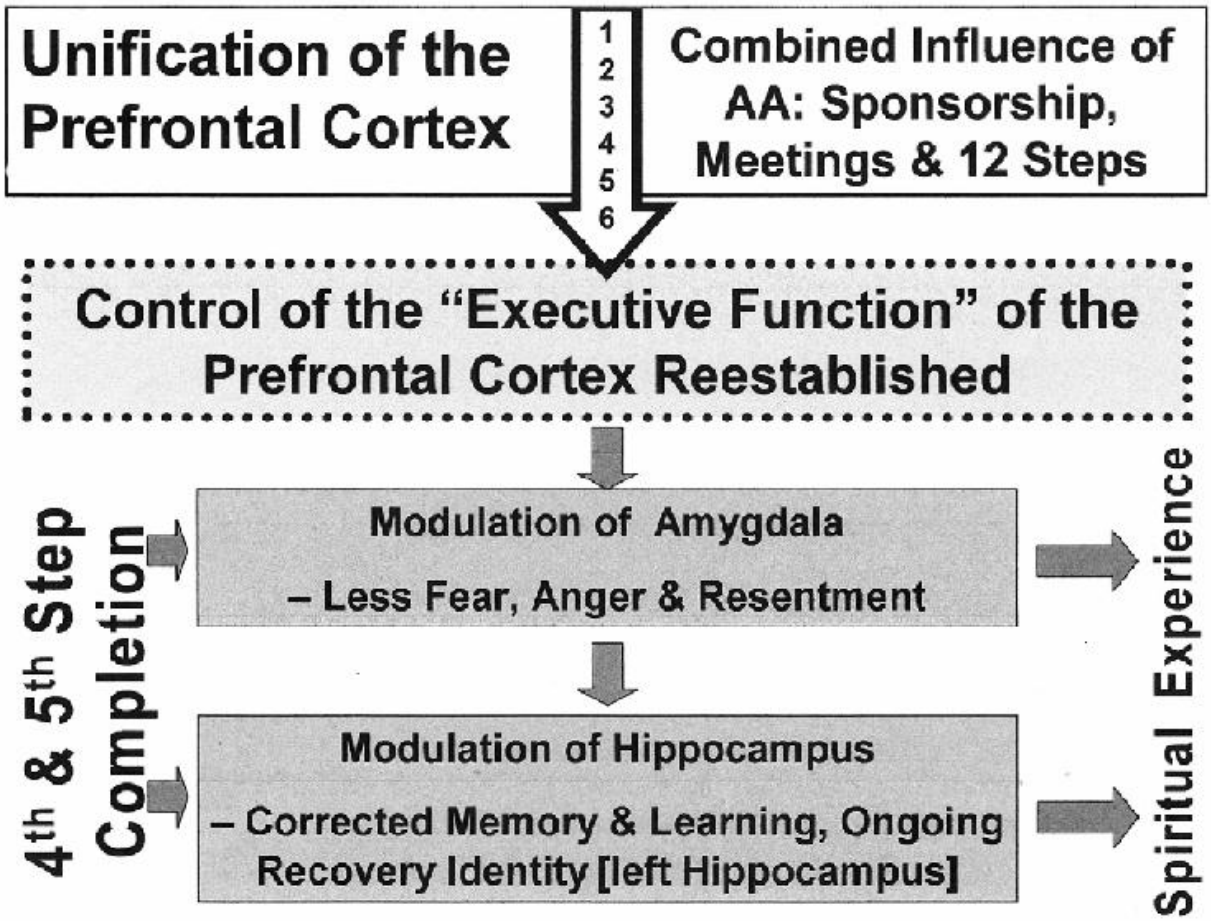
It is my belief that the mesolimbic and mesocortical systems return to normal functioning in conjunction with the other neurological events associated with the spiritual experience. I believe that an observable manifestation of this neural feedback loop can be seen in the emotional change of the AA members as moods become more positive, anger dissipates and irritability disappears.

In addition, as persons in recovery become more closely associated with the recovery processes through sponsorship and the associated daily maintenance practices, their focus in no longer upon drinking, but upon the new goals of serenity, sobriety and service. The ritualistic process of daily interaction with the sponsor regulates positive affective expression. Furthermore, the acid test for recovery is not just an absence of drinking, but the emotional display of an overwhelming sense of gratitude paired with the active service of helping others within the fellowship of AA.

Once the executive function has been returned to the prefrontal cortex and the mesolimbic and mesocortical circuits are operative, the combined force is sufficient to regulate

the amygdala, which, in turn modulates the hippocampus. As Figure 14 illustrated, the combination of the six regions of the prefrontal cortex exerting control over the executive function, Figure 15 displays the influence of the Fourth and Fifth Step upon getting rid of the emotions of fear, anger and resentment which are related to the functioning of areas of the limbic system, notably the amygdala and hippocampus.

Figure 15 Prefrontal Cortex Influence upon the Amygdala & Hippocampus



Relapse vs. Relapse prevention

Robert Claytor (1996) believed that a person recovering from an addiction must have a spiritual experience of some sort to produce the transformation necessary for permanent and satisfying sobriety. In plain terms, what change must occur in the processing for the person to recover? I believe that the explanation can be explained in a comparison of two simple diagrams. The first will display brain processes prior to a spiritual experience/awakening and the second will be after the event.

Figure 16 illustrates the interaction between various brain structures prior to the exposure to the Twelve Step program and the spiritual experience. Within this diagram the areas of the amygdala and the hippocampus become activated with the brewing of resentments. As a result the person experiences agitation and the region of the prefrontal cortex prompts the person to

find relief in the form of consuming alcohol.

Figure 16 Brain Processes Leading to a Relapse

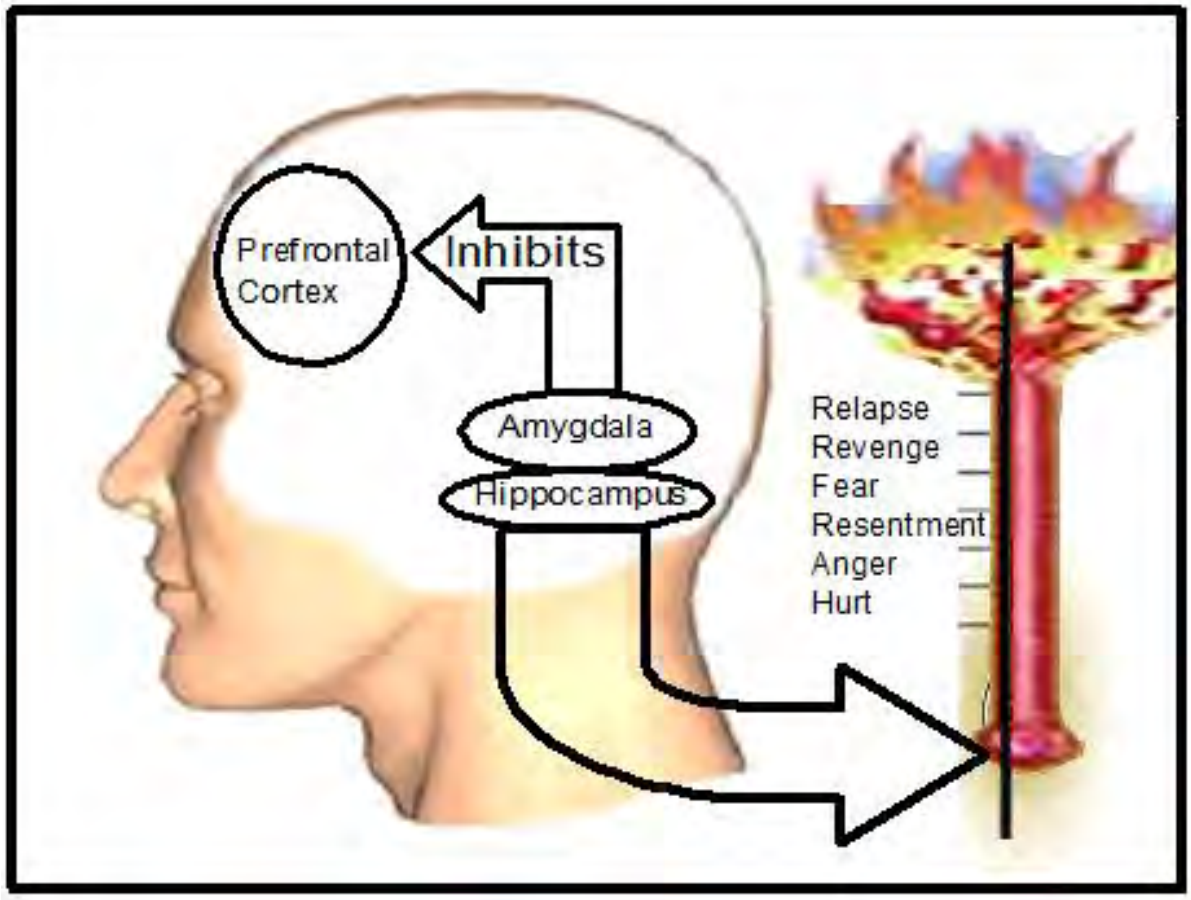
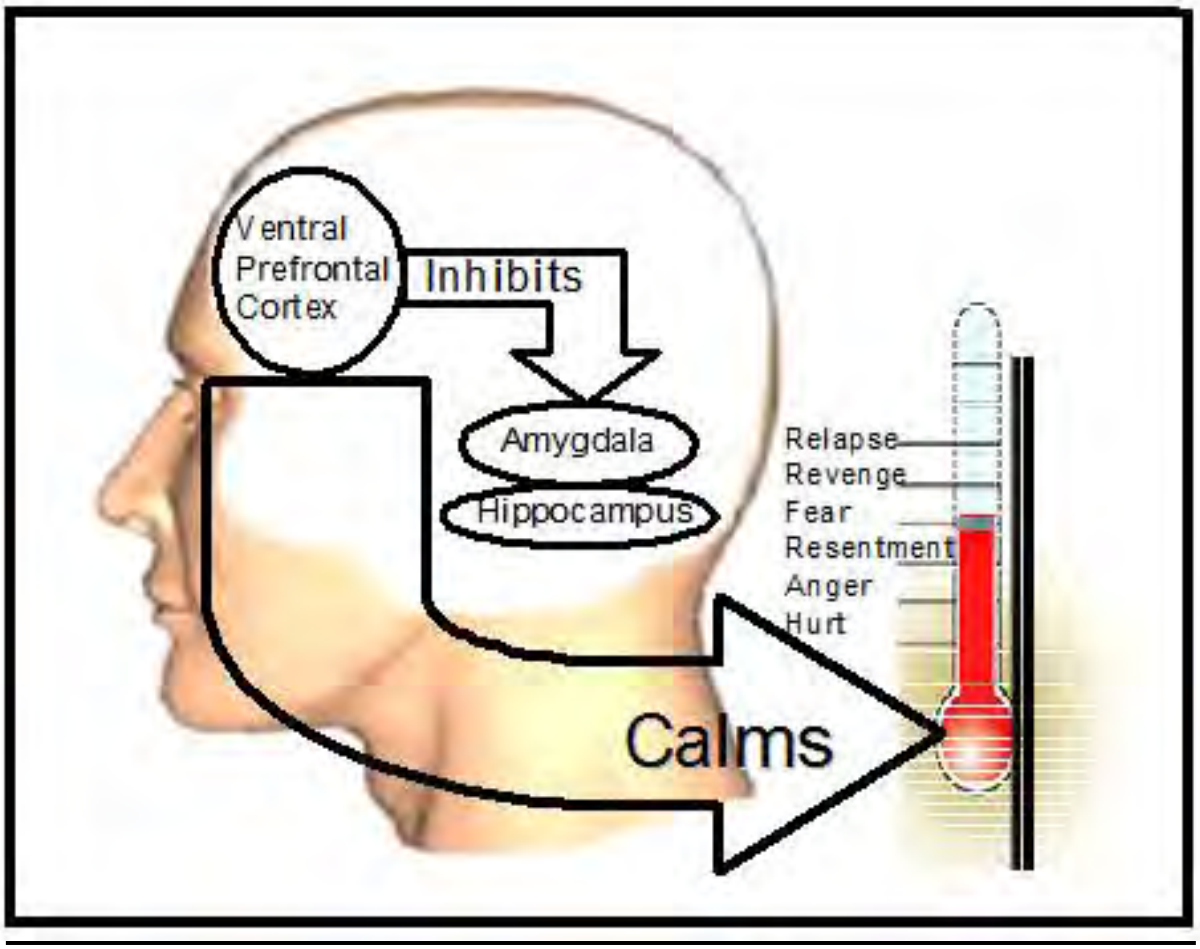


Figure 17 displays the process between various brain structures after the tenets of the Twelve Step program have been integrated into one's life and the person claims to have had a spiritual experience/awakening. Within this diagram the areas of the ventromedial region of the prefrontal cortex prompt the person to find relief in the form of the daily maintenance program, which in turn quells the amygdala and the hippocampus from becoming activated with resentments. As a result the person experiences a greater sense of serenity through practicing the steps and reciting certain prayers to combat resentment, anger and fear. As anxiety and frustration subside, the person calms down and does not succumb to a relapse.

Figure 17 Brain Processes Preventing a Relapse



Spiritual Experience in research

Beauregard and O'Leary (2007) suggested that mystical states are complex events that are mediated by several brain regions that are related to the following processes: perception, cognition, emotion and self-consciousness (p. 272). The following structures of the brain were implicated: left inferior parietal lobule, visual cortex, right medial orbitofrontal cortex, right

middle temporal cortex, left and right superior parietal lobule, left brainstem, left insula, left and right anterior cingulate cortex, and right medial prefrontal cortex. Beauregard and O'Leary concluded that the psycho-spiritual transformation following the mystical experience often will include changes in behaviors, thoughts, and core beliefs one has about oneself and the world (p. 291).

While Beauregard and O'Leary (2007) commented that there was no "God switch," they did indicate that spiritual experiences leave signatures in various regions of the brain. Needless to say, it will be left to future research in neuroscience to chart with greater certitude the labyrinth of neural pathways and structures associated with this conversion process. In any event it is my hope that the information in this article will guide the reader to a deeper understanding of the addiction/recovery process and an appreciation for the spiritual experience which promotes long term sobriety.

The spiritual experience in AA

The spiritual experience in the AA program of recovery involves a ceremonial ritual of not only learning the Twelve Steps, but also an individual practice of applying these principles throughout one's life. The effects of this spiritual experience are manifold. Initially, one may feel a sense of unity with God or, in the AA vernacular, a conscious contact with one's Higher Power. However, the process does not stop at that point. In fact, the experience grows to include a special bond with other members of the AA fellowship. The group rituals involve sponsorship (in which the tenets of the program are shared), group meetings (during which members offer their stories), mutual support (in the helping of others in need) and the acknowledgement of a dependency upon God.

Brain operators and the spiritual experience

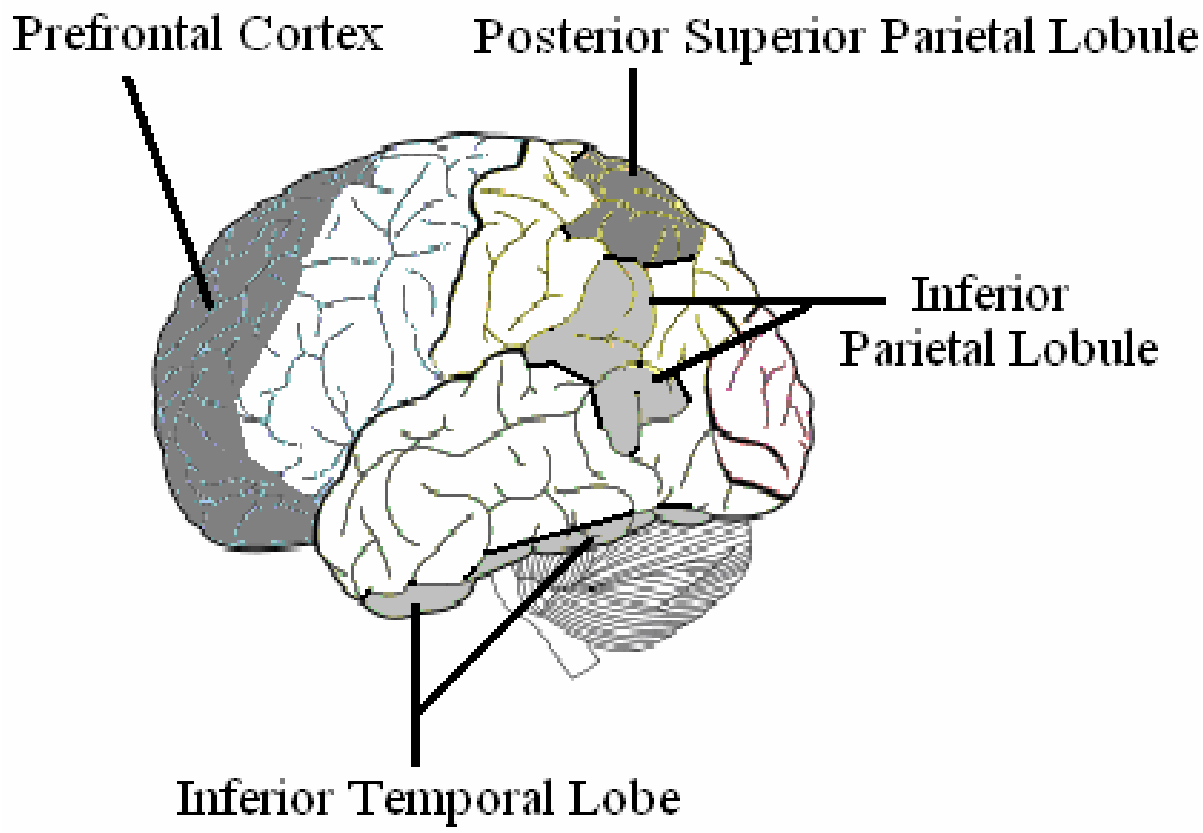
Newberg and d'Aquili (2000) reviewed the research on brain function as an attempt to develop a neuropsychological model of spiritual experiences. Regions of the cerebral cortex and the limbic system have been implicated as having major roles in the spiritual experience. While Newberg and d'Aquili indicated that the thalamus is one of the major relays between numerous brain structures, the hippocampus can block some of the attempts to pass on neural information by the thalamus (p. 257). However, the amygdala can enhance the transfer of information among brain regions. The process of inhibiting neural transmission and controlling emotional responses is crucial to the generation of a spiritual experience. Furthermore, Newberg and d'Aquili report evidence that the transmission of neural information can be totally or partially blocked by the prefrontal cortex through the hippocampus.

Brain activation and the spiritual experience

Newberg and d'Aquili highlighted four regions of the association cortex implicated in the spiritual experience which are illustrated in Figure 18. These areas include:

1) The posterior superior parietal lobule, which plays a role in attention responses,
2) The inferior temporal lobe, which has strong neural connections with the medial temporal lobe (accessing long-term memories), the limbic system (involving emotions), and the dorsal visual stream (processing object location),
3) The inferior parietal lobule, which integrates sensory input and processing, and
4) The prefrontal cortex whose functions were previously mentioned.

Figure 18 Brain Regions Implicated with the Spiritual Experience



Newberg and d'Aquili (2000) refer to cognitive operators as the process by which the brain not only interprets sensory input and thoughts, but also enables one to order reality from the chaos of sensory input and detect cause and effect relationships. Newberg and d'Aquili believe that the brain areas implicated with these processes include the inferior parietal lobule in the left hemisphere and the anterior convexity of the frontal lobes in the left hemisphere and their reciprocal neural interconnections (p. 254).

The holistic operator involving the right posterior superior parietal lobe allows for the brain to perceive reality as a whole. Newberg and d'Aquili believe that the brain areas implicated with these processes include the parietal lobe in the non-dominant hemisphere (specifically the posterior superior parietal lobule along with the adjacent regions). The holistic operator is

activated during a spiritual experience. Also, the activation of the brain's limbic system is associated with spiritual experience (d'Aquili & Newberg, 1993).

Possible determinants of the sudden and slow conversion

Newberg and d'Aquili indicated that the spiritual experience is more intensely felt emotionally if the holistic operator functions more strongly than the cognitive operators (analytical functions) of the left hemisphere. If this hypothesis can be verified then it could shed light upon the two types of conversion experiences in AA known as "sudden" (spiritual experience) and "slow" (spiritual awakening). Austin (2006, p. 105) mentioned a neural pathway in the limbic system that connects the anterior nucleus accumbens with the cingulate gyrus and the orbitofrontal cortex which reverberates and merges the limbic and cortical networks. Perhaps this area warrants closer examination as future research may shed light upon the type of experience that one may have, sudden or slow.

As mentioned previously, two structures within the limbic system are the hippocampus and the amygdala. These two structures interact with regard to attention and emotionally linked images (Newberg and d'Aquili, 2000). Furthermore, these researchers indicated that the hippocampus can block neural information to several brain structures through another limbic structure called the thalamus. While the amygdala increases input to areas of the brain, the hippocampus decreases or blocks neural input. Similarly, Newberg and d'Aquili indicated that another limbic structure, the hypothalamus, also has a dampening effect on emotional extremes. However, these researchers reported that the prefrontal cortex area is activated during meditative states. The neural activity involved in the spiritual experience may involve another neural circuitry process which provides a feedback loop.

Another neural feedback loop

Newberg and d'Aquili include the following scenario of neural interactions associated with the spiritual experience. The right inferior temporal lobe sends a neural message to the right hippocampus which in turn activates the right amygdala and continues onto the hypothalamus and finally the prefrontal cortex. In addition, there are a few other regions including the left prefrontal cortex blocking input to the posterior superior parietal lobe.

Concluding remarks

In commenting on the information in this article there are a few points that I would like to make abundantly clear.

1) In the process of succumbing to alcohol addiction the normal functioning of the brain becomes impaired.
2) In the process of recovering from alcohol addiction the normal functioning of the brain is restored and repaired.
3) The point of recovery is NOT simply to have a spiritual experience and rest upon one's laurels, nor is it to glorify the brief, transitory moment of ignition. The crucial points are not only to maintain the ongoing personal transformation, but also to possess the willingness to be of service to those who still suffer from the addiction.
4) Whether one believes that the brain alone is the source of the neurological change associated with the spiritual experience, or believes that the brain perceives a spiritual reality is totally irrelevant. The point is simply this: The phenomenon reported as a spiritual experience has changed and continues to change the lives of those condemned to the hell of addiction. And while scientific technology may not be able to capture the lightning of this experience in a bottle, the results of this process have convinced many that this process is a supernatural one and a gift of God.

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