A Sacred Place For Wounded Souls

by

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ABSTRACT

This research study focuses on my role as a spiritual care specialist on the general psychiatric unit at Humber River Hospital. My focus is to create a crisis intervention spiritual care methodology to meet the spiritual care needs of adult survivors of childhood abuse.

Assessing their specific spiritual care needs occurred as a two-fold process. A review of the trauma research revealed six potential obstacles that might prevent them from receiving an effective spiritual care intervention. Afterwards, a review of the spiritual and religious coping research affirms the positive impact for adult survivors who are spiritually receptive and able to access their spiritual resources. All patients in this research study were previously disconnected from their spirituality or place of worship.

Throughout this process there was a concurrent practice of offering spiritual care interventions with adult survivors on the K4E and an integration of Karen Ander Francis’ and Dr. Michael Washburn’s psycho-spiritual models. One year after the actual spiritual care intervention I sent out thirty Questionnaires with nine questions designed to track the spiritual care dynamics of the visit from the onset to its conclusion. The focus of my questionnaire format is two-fold: For the adult survivors to evaluate my spiritual care methodology and to review the outcomes.
The research findings in this study are based on two years of research on the K4E with adult survivors of childhood abuse. From the general research data collection 27 out of 30 adult survivors received new spiritual insight, and reconnected with their spirituality or place of worship within one to three spiritual care interventions. The seven research participants maintained their connection to their spirituality or place of worship one year after the initial spiritual care intervention. Thanks to their willingness to participate I learned valuable lessons which offers a positive contribution to my own spiritual care practice.
ACKNOWLEDGMENTS

Completing a dissertation requires the support of many people and I would like to express my thanks to those who have assisted me in achieving this goal.

First of all, I want to thank the administration at Humber River Hospital who granted me the permission to conduct my research within the hospital setting on K4E. Without their courage and commitment, this project would not have happened. They continued to have confidence and trust that this was a valuable endeavour and throughout all of the struggles it was apparent to me that they offered me unconditional encouragement.

As well, I would like to thank Dr. Paul Posner, for his guidance in moving my research methodology from taped interviews to the Questionnaire format. Most of all, I am eternally grateful for all of the participants in this study who were willing to be honest and open enough to effectively and reflectively answer the Questionnaire.

I wish, too, to acknowledge the help extended to me by my thesis director, Professor David Reed, and faculty advisor, Professor Meg Lavin, and the helpful guidance given me by Professor Joe Schner, Director of the Doctor of Ministry program. Their work with me was characterized by a very helpful blend of challenge and encouragement.

My Ministry Base Group and Collaborative Learning Group too, deserve special recognition for their patience and enthusiasm that they maintained as we searched for the right research question.

In addition, I wish to thank three friends, Maureen Soukoreff, Debbie Selzer and Julie Selzer who journeyed with me at crucial points in the process, always supportive, ready with another resource or kind word of encouragement.

Finally, I would like to thank my family for their constant support over the long period of time it has taken to complete this dissertation. Without their encouragement and cheerful efforts I could not have completed this work.
Dedication

This research project and the development of my new spiritual care practice is dedicated to my beloved mother, Mary Theresa Stevens, who died on October 1, 1999. My mother’s experience of mental illness inspired me to do this research project, as I believe that it is important to leave a legacy of hope and healing in pastoral care for mental health patients everywhere.
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INTRODUCTION

Prayer of St. Francis

Lord, make me an instrument of Thy peace;
where there is hatred, let me sow love;
where there is injury, pardon;
where there is doubt, faith;
where there is despair, hope;
where there is darkness, light;
and where there is sadness, joy.

O Divine Master,
grant that I may not so much seek to be consoled as to console;
to be understood, as to understand;
to be loved, as to love;
for it is in giving that we receive,
it is in pardoning that we are pardoned,
and it is in dying that we are born to Eternal Life.

Amen.¹

The Prayer of St. Francis characterizes my concept of spiritual care par excellence. As a spiritual care specialist the constant challenge is to become an instrument of God’s peace, joy, faith, hope, forgiveness and consolation. As the prayer proclaims, we are instruments of God’s amazing grace and as such, transformation from hatred to love, from injury to pardon, doubt to faith, darkness to light and from sadness to joy is absolutely possible! At the heart of this research project my focus is to create a sacred place for adult survivors who are in the midst of a radical spiritual crisis.

Chapter 1, "A Sacred Encounter," begins with an overview of my earliest spiritual formation, conversion experience, and spiritual care preparation which inform my vocational call and identity as a spiritual care specialist at Humber River Hospital on the K4E

¹ The first translation in English that we know of appeared in 1936 in Living Courageously, a book by Kirby Page (1890-1957), a Disciple of Christ minister, pacifist, social evangelist, writer and editor of The World Tomorrow (New York City).
psychiatric unit. Entry into the DMin program provides a concurrent process of integrating new spiritual insight and relevant spiritual care practices into my spiritual care interventions with adult survivors on the K4E. After writing a spiritual direction essay for one of the DMin core courses, and afterwards, while offering a spiritual care intervention with one of the patients I recognized Francis’ stages of soul loss and soul recovery unfold within the same visit and this is the catalyst for the research question: In this study I want to discover the effects of my method of spiritual care in the life and healing of the mental health patients at Humber River Hospital.

In Chapter 2, “Assessing the Damage and Naming the Need” reviews the trauma research which highlights the six potential obstacles that might prevent adult survivors from receiving an effective spiritual care intervention. By embracing a clear understanding of the obstacles often faced by adult survivors I adapt six key spiritual care strategies to create a sacred place. This section also reviews the spiritual and religious coping research which points to the adult survivors’ spiritual resistance or spiritual receptivity to embrace their spiritual connection.

Chapter 3, “Restless Until We Rest in You,” begins with the concept of emergent spirituality as seen when a person is in a radical spiritual crisis. This section introduces Dr. Michael Washburn’s psycho-spiritual model and the relevant psychological overview which is based on his integration of Freudian and Jungian theories. Washburn’s model provides a three-stage spiritual process which I have incorporated as my internal spiritual care assessment tool for meeting adult survivors during their radical spiritual crisis. The major spiritual focus and relevance in this thesis is meeting adult survivors in the midst of their spiritual crisis at the time of their optimum spiritual receptivity.
Chapter 4, "Research Study," informs my New Spiritual Care Practice which is in keeping with Strauss and Corbin’s grounded theory and "theory after model" as discussed in Chapter 1. In Chapter 4, Part One of the spiritual analysis reviews the general research data collection with the twenty-three patients using a written and visual overview of the thirty patients. At this point it is important to confirm that I do not include any of the 23 patients’ personal information in this thesis. As part of the research validity check a review of the seven participants' spiritual care process provides their evaluation of this spiritual care methodology through their questionnaires answers. Afterwards, I provide a visual overview of the general themes, spiritual care patterns, and spiritual assessments as found within the 30 cases. Analysis Part Two reviews the significant, relevant, and consistent themes, spiritual care patterns, and spiritual assessments as found within the general research data collection and more specifically within the seven cases.

Chapter 5, "Spiritual Resistance and Spiritual Receptivity," reviews the spiritual care difference when meeting with spiritual resistance or spiritual receptivity. Washburn’s model focuses on the possibility of meeting a person during their radical spiritual crisis which according to his model is their time of optimum spiritual receptivity. His model highlights a new spiritual care awareness to recognize parallel stages of regression in the service of transcendence stages one and two which often precedes a person’s spiritual process and entry into the next stage of what Washburn refers to as regeneration in spirit.

Chapter 6, “A Sacred Place for Wounded Souls,” highlights the new spiritual care crisis intervention model which provides a sacred place for adult survivors of childhood abuse.
Chapter 1

A Sacred Encounter

“Seek not abroad, turn back into thyself for in the inner person dwells the truth.”

St. Augustine, *City of God*

1.1 Formation of Vocational Identity

My personal history and spiritual formation, conversion experience, and spiritual care preparation inform my vocational identity and call as a spiritual care specialist on the psychiatric K4E unit at Humber River Hospital.

I was born and raised in a Roman Catholic family and from childhood I remember asking my mother some existential questions about how God calls a person into ministry. She answered by saying that we are to serve the Lord in our ordinary lives and that is what is pleasing to God. This answer did not address the much deeper theological question that stirred within my spirit and my question appeared to be: “Why does God call only some people into ministry and not others?” As time went by, I had two other major theological and existential questions about the meaning of my life. My two major questions were, “Why am I here?” and “Where will I spend eternity?” I became very frustrated as I did not have any answers to these questions. I also wondered how I could know God in a personal way, as I had always felt that God was very distant, remote and impersonal. So, I really struggled with a number of theological questions and longed for a personal encounter with God. I could not seem to grasp onto a living and real faith and I was tired of merely “going through the motions” in church, without a real experience of faith for the rest of the week.

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These unanswered theological questions caused me to run away from the church as I did not feel that I was getting any closer to answering my faith questions. I was actually afraid to let myself think about these questions as I found them profoundly disturbing. I started to live life in my own way, until one day I was hit by a car on November 9, 1972. It was a hit and run accident and I was knocked unconscious. When I came back to consciousness, as I lay on the sidewalk, I heard a voice deep within my heart say: “Mary Ann, I am not pleased with the way you are living.” I answered God in my own heart and said: “I am not pleased with my life either, but I do not know how to be any different.” Somehow, I got up off the pavement and had someone take me to the hospital.

For the next four months, I did not know whether I would live or die. I was afraid, as I still did not have the answers to my major theological questions. I began to say my Roman Catholic prayers, but this time I believed that God was really listening to me. I was so afraid that I would die before I found the answer to my theological questions, but my fear led me to pray more. I was praying almost every waking hour; I always had a prayer in my mind as I struggled to breathe. The accident had left me with a cracked pelvis and severe breathing problems. Prayer was continuous, but day by day, I noticed a deep peace that was indescribable and I questioned, “Why do I feel so much peace now that I am dying?”

Eventually, I had new spiritual insight as I came to know God in a more personal way. I was led back to the cross to understand why Jesus had died on the cross and I knew in that moment that I could safely bring all of my sins to God and be completely forgiven and changed. I now knew where I would spend eternity. Spiritual conversion informed my newfound desire to serve elderly people through a career in geriatric nursing.

My first career was in geriatric nursing where I worked in a nursing home for thirteen
years until one day when I had a serious lifting accident. After spending one year in rehabilitation, a number of physicians and medical specialists informed me that I needed to end my nursing career. Reluctantly, I did this and as I did this I also prayed for God to show me what else I should be doing with my life. I waited and waited on God to show me or to direct my path. One afternoon I felt a little tired and laid down for a nap. As I slept, I had a very vivid dream in which I saw myself sleeping in one of the major hospital on-call rooms. In the dream, I was called to go and be with this elderly man who was very near death. I saw myself reading the bible and praying with him. When I returned to this on-call room, I asked God “What will I do if this man dies? God answered, “This is the time that you will reach the whole family for me.” Next in the dream, God showed me a door with the word chaplaincy office on it and I went into this room and saw myself sitting there with a pile of paper work. I promptly told God that I did not like paper work and He said, “Just do it anyway, what I will do in you and through you is much more important than the paper work.” Then, I woke up from this dream and asked God what he had planned for me.

On Sunday I went to church and Pastor Alan Davey said he would be offering a six week bible study on, “How God Calls Women into Ministry.” For the next six weeks, I continued in bible study and prayer until I felt a spiritual confirmation that God had called me into chaplaincy.

1.2 Personal and Professional Growth

Part of my preliminary spiritual care training took place under the direction of the chaplain at what is now called the University Health Network. Unbeknownst to me, these six years of lay spiritual care training and supervision provided each spiritual care student with the
opportunity to address areas of inner-woundedness as part of the spiritual preparation to become an effective spiritual caregiver. I define inner-woundedness as a person’s distorted beliefs which may have occurred due to a past traumatic event. Over the six year process of weekly spiritual preparation, I received some new spiritual insight, and a new mind-set regarding my past abuse experience. This new spiritual insight caused me to make peace with my father regarding the past verbal abuse. Subsequently, I enjoyed a renewed relationship with my father until he died in 2005.

The goal of this introspective spiritual care process prepares students’ to develop the spiritual care skills of self-awareness and spiritual care sensitivity to offer patient-centered spiritual care. A process of spiritual restoration occurred as each student embraced a new spiritual perception of themselves, others and God. My definition of spiritual restoration is that a person’s previously distorted belief system goes through a process of renewal whereby they embrace a new mind-set or a new world view. This process of spiritual restoration enabled me to move towards some theological studies as I entered into the Master of Divinity degree program.

After three years I graduated with a Master of Divinity degree and directly thereafter, I engaged in a lengthy process of clinical spiritual care studies which include, the basic, advanced, and specialist’s level of requirements as established through the Canadian Association for Spiritual Care. At present I am now classified as a CASC Spiritual Care Specialist. I completed my five -year Peer Review in November 2013. I continue to work as a spiritual care specialist and member of the inter-disciplinary team on the K4E. The following is a brief overview of the specific spiritual care duties on the K4E.
1.3 Humber River Hospital – K4E Psychiatric Unit

Humber River Hospital is comprised of three different hospital sites that is now one hospital. Geographically, the hospital covers a huge catchment area beginning at Jane and Finch, which extends all the way to Jane and Church and then to Keele and Lawrence Avenue. My ministry context is in the psychiatric unit at Humber River Hospital, at the Keele site. Our hospital is recognized as an acute care hospital which means that we are not funded by the government for any long term care. The fundamental objective of an acute care hospital is to effectively treat the patient on a short-term basis and to release them as quickly as possible.

As a spiritual care specialist, I am therefore challenged to meet with the patient in crisis and to establish a spiritual care relationship as quickly as possible. Patients in crisis often turn to the spiritual caregiver in order to find a source of comfort and inner strength to help them.

Although in my role as spiritual care specialist at Humber River Hospital I am in charge of religious and spiritual care for thirteen nursing units at two different sites, in this thesis I will only discuss my role as it relates to the K4E which is the general psychiatric unit. My role on the K4E as part of the inter-disciplinary team is to work with a number of psychiatrists, nurses, social workers, a pharmacist, an art therapist, a recreation therapist and a dietician. During the day my colleague and I provide spiritual care coverage for three different sites, so consequently we co-ordinate a practice of continuity of patient care and follow up. Three on-call Chaplains provide coverage for after hours, holidays, and weekends. Our inter-disciplinary team meets twice a week during clinical rounds to offer professional observations, perceptions and feedback which in turn determines a holistic approach of

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3 The way my colleague and I work is to maintain our own patients, which means that our individual visits will continue with the one who has been involved with that patient. Therefore, we are not duplicating our work and the patient has the benefit of continuity of spiritual care.
treatment for each patient. Each professional gives and receives specific patient referrals, along with an overview and background regarding each patient.

A primary focus of my spiritual care duties on the K4E is offering weekly individual spiritual care interventions with patients who are in a spiritual crisis. Four prominent and common factors of people in a spiritual crisis are these. First, an important initial sign of a radical spiritual crisis is that a person is “disturbed in their spirit”⁴ or in a state of spiritual unrest. Spiritual unrest is an observable lack of spiritual peace which is also symptomatic of a person’s disconnection from their spirituality or place of worship. Second, they have spoken or unspoken existential questions about the meaning and purpose of their life. Those experiencing a spiritual crisis tend to ask spiritual caregivers existential questions: “Is God punishing me?” “What did I do to deserve this?” “Why would God allow this to happen to our family?” “Who and where is God for me now?” Third, there are discernible signs that they are in Washburn’s dark night experience as they feel that their life is meaningless and they have no hope.”⁵ Fourth, they have entered into some, most, or all stages of Francis’ loss soul without soul recovery.⁶

Another primary spiritual care focus is to provide weekly inter-faith Spirituality Groups for patients who are well enough to attend. During the one-hour Spirituality Group I share some inter-faith resources which may include a positive focus on lifestyles, spirituality themes, short stories, or some poetry. The primary objective for conducting the Spirituality Group is to encourage patients to access their inner spiritual resources or core values and to

⁴ Throughout this thesis I use the terminology “disturbed in their spirit” to describe the adult survivor’s spiritual care crisis, distorted belief system or the spiritual unrest that exists within a specific area of their life.

⁵ Chapter 3 gives an overview of Michael Washburn’s psycho-spiritual model.

⁶ Francis’ spiritual care model is discussed more explicitly later in this chapter.
re-focus on something that brings them meaning and hope. One example of the spirituality resources is titled, “My Happiness Bank Account,” which invites the patients’ to remember some positive events or past experiences that bring them meaning, hope, or happiness. Consequently, this group provides a venue for patients to voice their opinions and personal experiences or to request their own personal spiritual care intervention. Often one of the patients will request a spiritual care intervention directly after this group concludes. On the K4E we have some signage which alerts and invites patients to make their own referrals for spiritual care and this initiative works very well.

Crisis intervention is another major focus of my spiritual care on the K4E as at times traumatic events involving suicide have occurred. In such cases my colleague and I debrief with the patients and the K4E staff. Debriefing occurs within the larger community setting as we listen, empathize and invite people to share their grief. Afterwards, we offer individual support with patients or staff members as they may require more time and attention. As patients and staff come to terms with this traumatic event, we re-evaluate the preventative measures of safety and strive for a higher level of accountability on the unit. Staff accountability includes communication with the nursing staff whenever a patient presents as suicidal because this activates a process of close patient observation which occurs every fifteen minutes. Following the hospital policies and procedures is an essential part of accountability for members of the inter-disciplinary team. Spiritual care documentation provides the major communication with the inter-disciplinary team.

At times ethical-religious dilemmas arise and part of my role as a spiritual care specialist is to make a spiritual care assessment of the patient who is engaged in a prolonged fast due to their religious beliefs. Part of the spiritual care assessment is to evaluate the
underlying motivation for their religious observation to fast. Often they have misinterpreted their sacred text and after some clarification the patient discontinues their religious fast. In other ethical-religious dilemmas it is imperative to contact the patient’s own faith representative, as in the case of the Jehovah Witnesses’ patient who requires a blood transfusion. Arranging a consult with the Jehovah Witnesses’ faith representative and placing an emergency phone call to their twenty-four hour bloodless hotline usually resolves the crisis. Consequently, it is my spiritual care practice to contact the appropriate inter-faith representatives, which includes a rabbi, imam, pandit, Buddhist monk, priest, minister, or Jehovah Witnesses’ representative in order to offer religious specific guidance to the person in crisis.

Because my spiritual care role is interspersed across two different sites, it was helpful for me to develop some spiritual care assessment tools to determine my response time. Therefore, two spiritual care assessment tools include the Three Levels of Spiritual Care and Three Levels of Listening.

1.4 Spiritual Care Assessment Tools and Research Question

Three levels of spiritual care is my own spiritual care assessment tool that I developed as an assessment process to determine the urgency of my response time to meet a patient’s spiritual care need. In this thesis, my focus is on the Level Three Spiritual Care intervention.

1.4.1 Three Levels of Spiritual Care

1.4.1.1 Level One Spiritual Care

Level One spiritual care interventions represent my spiritual care assessment of a patient’s non-urgent spiritual care need. Therefore, it is possible to schedule some time with them to
more specifically meet their spiritual care needs. Patients in the Level One category may have some specific spiritual or religious questions that will require some spiritual direction. During my interaction with a patient at this level, they will receive some spiritual clarification and affirmation of their beliefs and practices as well as encouragement and prayer as this meets their spiritual care needs. Spirituality resources or religious reading material might meet the spiritual care needs of people in all three levels.

1.4.1.2 Level Two Spiritual Care

Level Two spiritual care interventions represent my spiritual care assessment of a patient who has a specific spiritual care issue that concerns them. When meeting with patients discerned with Level Two spiritual care needs the spiritual caregiver knows that this patient has named a specific spiritual care need and that they are emotionally in touch with what “disturbs their spirit.” For example, a patient's spiritual concern might be focused on how to approach a troubled relationship. They are looking for spiritual direction from their sacred text or they want to know what their church teaches about forgiveness. Level Two spiritual care needs do cause patients some moderate spiritual care concern, but these patients are not in a radical spiritual crisis. Therefore the spiritual caregiver could meet with them later the same day or the following day and these patients would still not be in a state of radical spiritual crisis.

As a spiritual care specialist, I prayerfully listen to them as they explicitly share their spiritual concerns. In Level Two spiritual care interventions, the patient receives an emotional release as they express their feelings and major concerns in the present context.
They also receive a measure of spiritual comfort and peace as they address whatever “disturbs their spirit” or disturbs their sense of peace.

1.4.1.3 Level Three Spiritual Care

Level Three spiritual care interventions represent my new spiritual care assessment of adult survivors who are in a radical spiritual crisis. I incorporate a concurrent process of spiritual care assessments by integrating Francis’ and Washburn’s psycho-spiritual models. A more explicit introduction and integration is found later in this chapter under 1.5. Chapter 3 provides an introduction and overview of Washburn’s three stage assessment process which usually only takes place within the Level Three spiritual care intervention. A total integration of this process is found in Chapter 4.

1.4.2 Three Levels of Spiritual Listening

Three Levels of Spiritual Listening is my own spiritual care assessment tool which is based on the wisdom of Freud’s Theory of Personality which has three levels of awareness: “conscious –awareness, preconscious, which is retrievable information and the unconscious, in which a person has no immediate access or insight to discern what is happening within them.”

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7 A diagram of Freud’s Theory of Personality is found in appendix F.

1.4.2.1 Level One Spiritual Listening

Level One spiritual listening is a conscious–awareness and from this perspective a patient is talking about their present concerns regarding their faith and current circumstances. I listen to what is being said and what they think, feel and believe about their faith and current circumstances.

1.4.2.2 Level Two Spiritual Listening

Level Two spiritual listening is the preconscious stage, which is defined as retrievable information which the patient remembers and relates to within their current circumstances. Level Two spiritual listening is defined as listening to what is not being said. For example, as I listen to their story I might discern re-occurring themes or memories that they have shared and perhaps what they are not saying to me is: Why are the same themes re-occurring? Why does this memory still disturb me? In these cases within the Level One and Two Spiritual Care Listening it is my practice to ask some open-ended questions. Freud’s theory seems to offer theoretical support to my spiritual care practice of asking open-ended questions. Freud recommends, “Establishing rapport with the patient, to stay with the patients’ imagoes⁹ and for therapists’ to turn our own unconsciousness like a receptive organ towards the transmitting unconscious of the patient in order to establish open-ended questions.”¹⁰ Unlike the Level One and Two Spiritual Care Listening I do not ask any open-ended questions as these patients are in a radical spiritual crisis and therefore it is my spiritual care practice to follow their lead.

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⁹ The term *imago* is a Latin word meaning a person’s conception, idea or impression.

1.4.2.3 Level Three Spiritual Listening

Level Three spiritual listening is defined as the unconscious, in which a person has no immediate access or insight to discern what is happening within them. Due to the fact that unconscious memories might re-surface within the patient’s memories during the spiritual care intervention I then listen to what cannot be said. What cannot be said refers to this patient’s core values which have been buried underneath many layers of experiences for perhaps decades. As the patient re-visits these memories often they need to grieve certain losses or express what they were unable to express during the original traumatic event. After they receive their emotional release they at times experience some new spiritual insight or perhaps they are now able to name what it is that they still believe. Conducting a spiritual care research project requires a process of finding the precise research question.

1.4.3 Research Question

My responsibility as a spiritual care specialist is to make an assessment of adult survivors’ past and present trauma, spiritual distress, spiritual pain, suffering, grief and loss, and respond appropriately.\textsuperscript{11} This leads me to my research question: \textbf{In this study I want to discover the effects of my method of spiritual care in the life and healing of the mental health patients at Humber River Hospital.}

I am referring to developing a new spiritual care methodology with accompanying spiritual care assessment tools from an evidenced-based perspective. Before entering into my

DMin degree studies, my standard spiritual care methodology was not specifically designed for adult survivors of childhood abuse. A major focus in this research project is a review of the trauma research in the light of the spiritual and religious coping research as the foundational concept for building my spiritual care methodology to meet the specific needs of adult survivors of childhood abuse. This process is reviewed in Chapter 2.

A unique and concurrent process of new spiritual care practices was introduced and constantly integrated into my spiritual care practice which made the learning a relevant experience. The major catalyst unfolded during my spiritual care intervention with an adult survivor that I refer to as Jim and his experience of spiritual transformation. During this spiritual care intervention with Jim, I found Francis’ ten stage model of soul loss and soul recovery to be helpful in understanding his situation and spiritual needs better. After my spiritual care intervention with Jim I permanently incorporated Francis’ external spiritual care assessment tool as part of my new spiritual care methodology.

1.5 New Spiritual Care Awareness: The Catalyst for this Project

A radical change in my thinking and understanding of spiritual care occurred one evening as I followed up on a spiritual care referral on the K4E. Actually, I did try to have a spiritual care intervention with the patient for whom I had the referral, but she was unavailable for my spiritual care intervention. However, Jim, a patient with whom I was well acquainted from previous hospital admissions, wanted to meet with me. Unbeknownst to me, my encounter with Jim was a catalyst leading me to a new perception and understanding of the depths of inner-woundedness within a person’s soul. Inner-woundedness within the soul is unique to

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12 Before entering into my doctoral studies, I incorporated a model of spiritual care that was not designed specifically for adult survivors of childhood abuse. A copy is found in appendix A.
each person, but in this case my ministry to Jim provided me with a new perception of listening to Francis’ stages of soul loss and recovery.

Jim is an intelligent young man who was diagnosed with bipolar disorder. Bipolar disorder includes intermittent alternative episodes of mania and high energy, and also times of depression which often drains the patient’s energy and greatly debilitates the patient’s quality of life. He has been receiving psychiatric treatment for many years due to his bipolar disorder and this admission to the K4E is due to another very serious suicide attempt. When I saw Jim in the corridor, he appeared to be in need of someone to listen to him. It was obvious to me that Jim wanted to talk to me. For the first time in his life, he shared an enormous secret of early childhood abuse. In listening to him, he was experiencing a spiritual crisis and he was not able to find any peace in his soul or any meaning and purpose for his life.

Jim’s trauma happened within the context of his family which includes his mother, father and sister. The extent of the trauma includes emotional, mental and sexual abuse. In the safety of the spiritual care setting, Jim felt free to unburden his pain and shed his tears. He had carried his trauma inside for almost thirty years. Jim continued to share his traumatic experience for two hours after which he experienced an emotional release and some new spiritual insight. For the purpose of this thesis, I am guided by the following definition of spirituality by David Benner:

Spirituality is the response to a deep and mysterious human yearning for self-transcendence and surrender. This yearning results from having been created in such a fashion that we are incomplete when we are self-encapsulated. As important as relationships with other people are, we need something more than involvement with others; something within us yearns for surrender to the service of some person or cause bigger than ourselves. When we experience this self-transcendent surrender, we suddenly realize that we have found our place. It may be that we never before recognized that our restlessness was our search for our
place. However, when we find it we immediately know that this is where we belong. Again spirituality is our response to these longings.\textsuperscript{13}

Jim immediately expressed his new found spirituality and felt moved to write daily prayers to God. Because this spiritual care encounter was a new learning experience for me, I asked Jim if he would write down the negative beliefs and values that he held about himself as a result of his early trauma. He agreed that this would be helpful and over the course of the next few weeks, he came up with four or five of what I call maladaptive core beliefs.

Eventually, Jim revised his destructive maladaptive core beliefs. He altered his beliefs so that they are a more positive statement of hope. The quality of Jim’s life continues to improve and he is now able to use his leadership skills to enhance the lives of other mental health patients. The other benefit of this spiritual care intervention is that Jim began to embrace a new spiritual dimension within his life as he now also attends church. Even without mentioning God explicitly, Jim’s new mind-set allowed him to celebrate his new-found spirituality. By getting in touch with and revising his core maladaptive beliefs, Jim became freer to experience God more as an unconditional loving presence.

Now, in listening to Jim the stages of Francis’ soul loss with soul recovery unfolded as I listened to him. Consequently, Francis’ model is now integrated into my spiritual care practice as the external spiritual care assessment tool. The following is an overview of Francis’ ten stages of soul loss and soul recovery.

\textsuperscript{13} David Benner, \textit{Psychotherapy and the Spiritual Quest: Exploring the Links Between Psychological and Spiritual Health} (Grand Rapids, MI: Baker Book House, 1988), 104.
1.6 Spiritual Care Assessment: Karen Ander Francis Spiritual Care Model

Karen Ander Francis is a spiritual care director and practitioner with over ten years of specialized experience with adult survivors of childhood abuse. The following is an overview of each of Francis’ ten stages of her spiritual care model.

Francis’ Stage One is deprivation, in which a survivor expresses their deprivation with the following themes, words, and feelings. “I am not loved, nurtured, protected or respected by my parents. Love is conditional, limited and deprivation of basic needs is just the way life is.”\(^{14}\) On the K4E, I often hear and discern concrete examples of Francis’ description of deprivation.

Stage Two of Francis’ soul loss is the stage of abuse. She states: “In abusive families physical and emotional deprivation often escalates into verbal, physical, emotional and sexual abuse.”\(^{15}\) I often make a spiritual care assessment of a number of distinctive abuses within the same case as described by Francis and some examples are found in Chapter 4.

Stage Three of Francis’ soul loss is a disconnection. Francis writes that, “it is here that the child starts believing the lies and begins to fold in on the truth of who they are.”\(^{16}\) In my experience adult survivors use explicit examples to describe their self-hatred or alienation from God.

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\(^{15}\) Ibid.

\(^{16}\) Ibid.
Stage Four of Francis’ soul loss is loss of meaning, or as one adult survivor describes it, “a hole in the soul.”\footnote{Ibid.} My response to Francis’ Stage Four is to listen carefully to the adult survivors’ multiple losses that are inherent in each memory that they share.

Stage Five of Francis’ soul loss is loss of identity. She describes their condition: “They hate themselves with a passion and they do not believe that they have a right to exist.”\footnote{Ibid.} One adult survivor expressed Francis’ Stage Five—loss of identity with the following words, “I learned to give people what they wanted even at the expense of my own soul.”\footnote{Ibid.} Whenever a spiritual care assessment includes all five stages of soul loss, I am alerted to consider that, in Francis’ analysis this person is experiencing a state of soul loss without soul recovery. Soul loss without soul recovery usually indicates that this patient is in a state of spiritual desolation, spiritual disconnection, and is unable to access their own inner spiritual resources.

Francis’ soul recovery includes Stages Six to Ten: the longing for connection, remembering, emotional catharsis, authenticity and empowerment, and meaning and mission. Stage Six of Francis’ soul recovery is longing for connection: “Longing is the soul’s wake up call to seek healing and surrender for the longing to leave the destructive path and begin to tread the path that will take them home to their true self and God.”\footnote{Ibid, 50.} Listening and assessing Francis’ Stage Six is an absolute joy as the patient names and expresses their own longing for this spiritual connection.
Francis’ Stage Seven is remembering: “Each new memory is accompanied by a companion emotion and pain that has been locked away in the body/mind for years in order to retrieve forgotten pieces of their soul.”

In my own spiritual care practice Francis’ Stage Seven is also discerned as a time when the patient begins to re-visit past memories in the present tense.

Francis’ Stage Eight is emotional catharsis. Francis writes that, “the truth emerges from emotional cleansing as the survivor acknowledges and embraces their history and during this stage 'lost' pieces of the image of God are remembered.”

In my spiritual care intervention, Francis’ Stage Eight is clearly defined as the patient begins to grieve their losses with an emotional release which often leads the person to receive some new spiritual insight.

Francis Stage Nine, authenticity and empowerment, confirms the adult survivor’s spiritual transition as they “find the voice of their true self, the voice that knows that they are not born to be victims.”

In my spiritual care practice, Francis’ Stage Nine relates to the adult survivor’s new spiritual insight of their past abuse and at this stage the survivor often reconnects with their spirituality or place of worship.

Francis’ Stage Ten is meaning and mission: “Once a survivor has achieved consistent stability grounded in authenticity and remembered identity, there is a point at which the quest for meaning begins in earnest.”

Francis’ Stage Ten relates to the patient’s new spiritual

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21 Ibid.
22 Ibid.
23 Ibid, 51.
24 Ibid, 53.
insight as witnessed during the spiritual care intervention and evidenced within the research questionnaires as a one-year follow up, which is recorded in Chapter 4.

Francis’ model offers some significant spiritual care insight. As a result, I have integrated her model as my own spiritual care assessment tool for recognizing the external spiritual care dynamics of soul loss without soul recovery or soul loss with soul recovery. Patients who are in a state of spiritual crisis might present with some, most, or all stages of Francis’ soul loss. My own personal spiritual care practice is to continue in on-going prayer for patients who are discerned with soul loss without soul recovery.

At times, the spiritual assessment is that a person has transitioned from soul loss into soul recovery within the same visit. When this occurs, my spiritual care assessment is often to recognize some, most, or all stages of soul recovery. A major indication that soul recovery has taken place is evidenced as the adult survivor communicates some new spiritual insight or a new perception of their past trauma and a reconnection back to their spiritual source. Spiritual care research with adult survivors is an important focus and choosing the most effective research methodology was my next challenge.

1.7 Research Methodology

As with other aspects of this research project, it was a challenge to find the research question, and identify the most useful theoretical base and research methodology. After reading through John W. Cresswell’s book, *Qualitative Inquiry and Research Design*, and by contrasting and comparing other research methodologies I incorporated Strauss and Corbin’s Grounded Theory. Strauss and Corbin write: “This is accomplished primarily through

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25 Francis’ stages of soul loss and soul recovery is incorporated into my spiritual care methodology as the external spiritual assessment tool.
collecting interview data, making multiple visits into the field (theoretical sampling) attempting to develop and inter-relate categories (constant comparison) of information, and writing a substantive or context-specific theory.”

Incorporating Strauss and Corbin’s theory proved to be a challenging endeavour as the K4E psychiatric unit does not have a specific database for mental health patients with a history of childhood abuse. Therefore, it was a two-year process to define the cases that fit my research criteria and to establish a database for this research project. Afterwards, this research project was officially approved by the Ethics Research Committees at Humber River Hospital and the University of Toronto.

The integration of Strauss and Corbin’s theory into this research project is to be understood as a two-part process involving at least one to three spiritual care interventions with each of the 30 patients. Therefore, incorporating a grounded theory translates into a substantial amount of time listening to the adult survivors’ personal experience of childhood trauma through a spiritual care intervention. I documented concise clinical notes of each spiritual care intervention. I also kept field notes of the evolving theory as per the consistent themes and spiritual care patterns that I observed and noted in each case. An individual spiritual care analysis was completed for each of the 30 cases.

Initially, I coded the general research data collection according to the abuse that each represented, and at times more than one type of abuse was coded for the same case. The process of coding took place after reading and analyzing my own patient care notes, field notes, and analysis for each case in order to record the common themes and discernible

spiritual care patterns. This process continued until all of the themes and patterns were noted. I kept notes of the evolving theory, which is where I came to understand that my evolving spiritual care practice was also taking on a discernible pattern. The coding process took place until there were no new themes that emerged from the data. In the grounded theory this process is known as the saturation point which means that the coding process is complete.

Major ethical concerns that I encountered along the way related to the fact that I had chosen to focus my research on a vulnerable population, those who have a mental illness and a history of childhood abuse. Obviously, I did not want to offend or harm the very ones that I have been able to help, so I consulted with Dr. Paul Posner who is part of our psychiatric team and he offered some wise counsel. My initial research plan was to conduct taped one-hour interviews with patients who were willing to take part in this research project. But as time went by I had second thoughts about this methodology because of the ethical issues. After my consultation with Dr. Posner it was clear to me that I needed to change my research methodology to a questionnaire format, as this was the most ethical solution. Because this research took two years to come to the saturation point, some of the adult survivors received their questionnaire two years later and some only one year later. Approximately ten questionnaires were returned back to the hospital because the former patients had changed their place of residence.

Anonymity was the other major ethical issue. The way I chose to address this issue was to disguise the person's name. My focus changed to empower the participants to share their own experience of my spiritual care through a nine-question questionnaire. Therefore, the participants had control as to whether they wanted to participate in the research study or not.

27 I received permission from the Ethics Committee to use my own patient care notes.
not. If they did not want to participate they could discard the questionnaire. Even if they chose to answer only some of the questions, they could still participate. Consequently, my intention was to honour their feedback in order to evaluate my new spiritual care methodology.

Renewed clarity occurred as I realized my intention for establishing this research was three-fold in nature. First, it means sharing developments in spiritual care through my research. Second, the grounded theory is an ‘evolving’ process which allowed for an ongoing integration of new spiritual care theories and practices. A patient’s evaluation of the spiritual care methodology occurred as they answered the nine questions involved in the questionnaires. Finally, the grounded theory provides the process and development of a comprehensive theory-after spiritual care practice. After resolving the two major ethical dilemmas, it was time to name the limitations to this study.

1.8 Limitations of the Study

The first limitation in this research study is that I do not have the specific knowledge of other therapeutic interventions or the names of the prescribed medications that the patients were taking. During the time of my spiritual care intervention, each patient involved in my research study was an inpatient on the K4E. Each patient received psychiatrist treatment and appropriate medication and other holistic interventions.

The second limitation is that, from a spiritual care perspective, there is a lack of spiritual care models specifically designed for crisis intervention with adult survivors of childhood abuse. As I reviewed the spiritual care literature, I found only one spiritual care model for adult survivors of childhood abuse. Therefore I found it necessary to review and
incorporate the spiritual care practices from the few existing spiritual care practitioners who focus their spiritual care practice with adult survivors of childhood abuse.

The third limitation involves the fact that adult survivors are difficult to engage in a research project due to their residual aftermath of childhood abuse. Particularly in the case of this thesis, information gathered was minimal due in part to the use of the written questionnaire, a form which did not elicit trust in the absence of face to face contact. According to the trauma research some major obstacles that might prevent them from engaging in any research project are these that follow: Abuse often leaves a negative image of God, a negative self-concept, rejection sensitivity, lack of trust, denial of God’s existence and a loss of identity which according to Francis’ “is a disconnection from themselves, others and God.” After naming the limitations of this research study, it was necessary to find some effective ways to analyse the research data.

1.9 Data Analysis: Symbolic Interactionism, Holistic and Cross Case Analysis

Analyzing the research data is an important step in establishing the new spiritual care learning with regards to the consistent spiritual care themes and discernible spiritual care patterns across the thirty cases. Therefore, I incorporate three inter-related methods to capture the rich spiritual care learning across the cases. Symbolic Interactionism, Holistic, and Cross-Case Analyses provides an integrated way to record the discernible spiritual care patterns and efficacy of the new spiritual care methodology according the research data and questionnaires.

Herbert Blumer’s theory of symbolic interactionism rests on three premises: “first, human beings interact with other people in their environment in order to find meaning and

28 Francis, 47.
purpose in their relationships. Secondly, human beings derive meaning through shared language, social interaction, and their spirituality. Thirdly, meaning is established and modified through the power of human thought towards an interpretative process. Symbolic Interactionism requires that the researcher actively enter the worlds of people being studied in order to see the situation from their unique perspective, observing what the patient takes into account and observing how they interpret what is taken into account.”

Incorporating symbolic interactionism as an interpretative process underscores the adult survivors’ experience of my spiritual care intervention from the onset until the conclusion. The holistic analysis underscores the integrated spiritual care strategies which are to be evaluated by the participants in this research study.

The questionnaire design provides the former patients’ an opportunity to answer the nine questions based on how they were feeling before this spiritual care intervention, and to ask how they felt and what they experienced throughout the spiritual care intervention. Another important focus was to ask the question: “Did you experience any new emotional or spiritual awareness? If so, explain.” Major turning points were recorded by the participants as they remembered how they came into the visit, how they felt during the visit and if they received any new emotional or spiritual insight. I invited them to make suggestions on how to improve the evolving spiritual care practice. The symbolic interactionism theory helped me to design the research questions in such a way as to gently invite former patients into a process of theological reflection. This methodology proved to be effective.

Along with the symbolic interactionism theory, I incorporate a holistic and cross-case

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analyses to indicate the consistent spiritual care patterns as found across the 30 case trajectory. A holistic analysis “includes a detailed description, theme analysis of each case.” Theme analysis takes into consideration the common themes as found in the general research data collection within the thirty cases. An overview of the seven cases including the patients’ evaluation of the spiritual care methodology as found in their questionnaire answers is found in Chapter 4.

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30 Ibid, 250.
Summary

Chapter one provides an overview of my vocational identity, spiritual care development, and vocational call into chaplaincy. My spiritual care encounter with Jim and his positive outcome provides the impetus for this research project and establishes Francis’ ten-stage model as the external spiritual care assessment tool. My research question is: In this study I want to discover the effects of my method of spiritual care in the life and healing of the mental health patients at Humber River Hospital. I conclude with a review of Strauss and Corbin’s Grounded Theory and the three-part analysis used to interpret the research.
Chapter 2  
Assessing the Damage and Naming the Need

Children Learn What They Live

If children live with criticism, they learn to condemn.  
If children live with hostility, they learn to fight.  
If children live with fear, they learn to be apprehensive.  
If children live with pity, they learn to feel sorry for themselves.  
If children live with ridicule, they learn to feel shy.  
If children live with jealousy, they learn to feel envy.  
If children live with shame, they learn to feel guilty.  
If children live with encouragement, they learn confidence.  
If children live with tolerance, they learn patience.  
If children live with praise, they learn appreciation.  
If children live with acceptance, they learn to love.  
If children live with approval, they learn to like themselves.  
If children live with recognition, they learn it is good to have a goal.  
If children live with sharing, they learn generosity.  
If children live with honesty, they learn truthfulness.  
If children live with fairness, they learn justice.  
If children live with kindness and consideration, they learn respect.  
If children live with security, they learn to have faith in themselves and in those about them.  
If children live with friendliness, they learn the world is a nice place in which to live.

Dorothy Law Nolte, 1972

Part of implementing best practice into my spiritual care methodology is to review the trauma research for potential spiritual care obstacles that are unique to the aftermath of adult survivors of childhood abuse. Assessing the Damage and Naming the Need begins with an introduction of Ana Maria Rizzuto’s research and her integration of the object relations theory to review the co-relationship between childhood abuse and the adult survivor’s image of God. I then review some relevant trauma research to ascertain the adult survivors’ potential obstacles that might prevent them from receiving a spiritual care intervention. Afterwards, I review and integrate spiritual care antidotes to create a sacred place for adult

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survivors. Section two reviews the spiritual and religious coping research with a focus on the adult survivors’ spiritual resistance or spiritual receptivity and connection with their spiritual source.

2.1 Assessing the Damage and Potential Obstacles to Spiritual Care

In this section, I review the trauma research with adult survivors of childhood abuse in order to focus on the residual aftermath from their past childhood abuse. Afterwards, I name the six potential spiritual care obstacles that might prevent the adult survivor from receiving an effective spiritual care intervention.

2.1.1 Adult survivors often have a negative image of God

Assessing the damage that often resides within adult survivors according to the trauma research provides a new understanding of potential spiritual care obstacles. According to the trauma research, adult survivors often have a negative image of God. Ana Maria Rizzuto, researcher and author of *The Birth of the Living God*, integrates the object relations theory to illustrate the inherent connection between a child’s earliest relationship with their primary caregivers and their later perception of God. Her use of the object relations theory affirms “a child’s earliest interactions and relationships with their parents or primary caregivers and this process is generally complete by the age of six years.”\(^{31}\)

At times a child’s earliest relationships are predominately positive and healthy, so what happens to a person’s belief system if the abuse occurs during the adolescent years? According to this research project, when abuse occurs during the adolescent years the

adolescent’s core belief system often incurs a few serious consequences which may include spiritual or religious confusion, a negative self-concept or spiritual disconnection which leads them into a state of spiritual crisis. Spiritual crisis may cause a person to question everything that they used to believe and now they no longer know what is true or what they should believe. Some case studies in Chapter 4 provide examples of the distorted belief system where abuse occurred after the age of six years old. A person’s first role models are very important as these relationships with a parent, relative, teacher, or friend, help to inform a child’s earliest belief system and self-concept. Depending upon whether or not these relationships were positive or negative determines their feelings and beliefs concerning themselves, others, and God.

The following example highlights a case study from Rizzuto’s research as she records her analysis of a research participant named Bernadine Fischer. She has always had a dysfunctional relationship with her mother. Now, as an adult Bernadine lives in a constant state of unresolved anger and turmoil because she still feels a strong sense of parental rejection by her mother. Parental rejection means that Bernadine has never felt loved or accepted by her mother. Due to her feelings of intense rejection, she strives to become the perfect daughter, which is not an attainable goal.

Consequently, Bernadine’s earliest relationship with her mother continues to inform her current image of God as her enemy. She draws an image of a sun in a light yellow color with the following explanation that it is “a bright, warm, clean feeling.” Bernadine’s image of God is a "struggle with a demanding, harsh God that she would like to get rid of if she was not convinced of his existence and power.”

This unhealthy cycle affects her spirituality and

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32 Ibid, 150, 161.
her image of God. Rizutto’s findings are confirmed within the trauma research which affirms that survivors of past childhood abuse often have a negative concept of God.

A qualitative research study conducted by Imbens and Jonkers confirms that childhood abuse often has a negative impact on a person’s image of God, and that, “many childhood abuse survivors’ reported having a negative image of God as being cruel, uncaring and punishing in the light of their abuse history.”

Hall’s research study focuses on the spirituality of those who were abused in which he finds that “childhood abuse survivors’ were less likely to feel loved and accepted by God. They did not have a sense of trust in God and were less likely to be involved in organized religion. This sense of disconnection from a higher power may reflect the survivors’ sense of shame and guilt.”

Granqvist’s research reviews parental influences on a person’s image of God and concludes that, “a person’s relationship with God and how this corresponds or reflects their relationship with their parental figure.”

Questionnaire data containing retrospective measures of perceived attachment to parents, socialization-based religiosity, sudden religious conversion, and characteristics of religious change were collected from 156 students. “Results supported the revised correspondence hypothesis in that security of attachment was positively linked to socialization-based religiosity and to gradual religious changes that were associated with

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early onset and life themes indicating adoption of religious standards, whereas compensatory themes were uncharacteristic.”

L.A. Kirkpatrick and P. Shaver’s research clarifies the importance of the attachment theory as they affirm that “we come to understand that an individual’s experience of a personal relationship with God functions in a similar way to a child-parent relationship and can be considered an attachment.”

From a positive perspective “those who experience a secure attachment with God tend to perceive God as more loving, less controlling and less distant than those with an insecure attachment.”

This study concludes that “participants with a secure attachment to God, perceived God as more loving, less controlling and less distant than those with insecure attachment. They scored highest on level of commitment to religion and reported less anxiety, depression, physical illness and greater life satisfaction. Those with an avoidant attachment to God were most inclined towards agnosticism whilst individuals with an anxious /ambivalent attachment to God reported the highest incidence of speaking in tongues as well as the greatest proportion of atheists and individuals describing themselves as anti-religious. Therefore, this study lends support to the compensation hypothesis in relation to parental attachment (the idea that later relationships can compensate for earlier deficit) and also supports the idea that relationships with God can be considered attachments by nature.”

36 Ibid.


38 Ibid.

39 Ibid.
Ganje-Fling and McCarthy’s research continues to focus on parental influences that impact a person’s image of God. Their research finds that, “if a child has a negative or abusive relationship with their parental figures they might also experience the same negative relationship with God.”40 Lemoncelli and Carey’s research continues with a similar study and finds that, “God would be viewed as punishing, wrathful, distant and conditional while the self would be seen as unworthy of love, guilty of wrong-doing, and deserving of punishment.”41

2.1.2 Development of a Negative Self-Concept

Before entering DMin studies, many questions challenged my conscious awareness with regard to the process and development of a child’s negative self-concept. Where does this process begin? How is the negative self-concept reinforced and held in place without any verbal expression for many years? As previously discussed in Rizzuto’s case study, adult survivors’ image of God often evolves from their troubled earliest relationships with their primary caregivers. In this section, I review Tulk’s research with adult survivors to understand how a child’s original beliefs are reinforced and contribute to the development of their negative self-concept.

Childhood development, including the development of a negative self-concept happens deeply within the inner recesses of the child’s soul. Children’s closest relationships


with their primary caregivers or parents influence a child’s earliest belief system. Verbal and non-verbal communication with their primary caregivers or parents are then interpreted and unconsciously stored within a child’s memory. This complex formulation and interpretation by the child contributes to the rudimentary development of their self-concept.

Tulk meets with adult survivors of childhood abuse and through her research she has gained tremendous insight into the process which she calls inner child healing. Tulk writes that “inner child healing impacts the patterns that are formed as a result of emotional and spiritual trauma.” Her research focuses on a process of allowing adult survivors the opportunity to share their memories of past abuse with a focus on moving forward with a new spiritual concept. “By re-visiting memories a person comes to realize that their own faulty judgments are at the root of all dis-ease, and this effects healing.” Tulk defines her theoretical perspective as, “the cognitive process of moving beyond the personality into the transpersonal self.” The process developed by Tulk invites people to explore areas that impede their spirituality and healing so that they will learn to love themselves. Tulk’s research on inner healing adds a foundational insight into childhood trauma in order to understand the progressive cycle of inner-woundedness which is reinforced over time.

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42 Fiona Tulk, “Children and the Inner Child” (Tasmania: Transpersonal Lifestreams, 1998-2003): 2. Tulk’s concept of inner child healing requires the adult survivor of abuse to re-visit their memories and find their own voice in order to be liberated from the many layers of false beliefs. Some of the layers are apparent, but most are not made explicit until the adult survivor re-visits their memories to discern how and what they were conditioned to believe as children.

43 Ibid.

Tulk writes:

Behaviour patterns may not necessarily come from a single incident which defines the wound that a child carries. A series of unrelated traumas can overlay one another in such a way that cripples the adult until the patterns of all related childhood incidents are accessed. 45

She continues to emphasize that “we were all born innocent” to be who we are, “but as time goes by our parents, teachers and peers influence our self-concept to the extent that we forget who we are.”46 If or when a person tries to incorporate everyone else’s values and principles into their life in order to find acceptance, they might compromise their own beliefs, values, and principles in order to fit in with the crowd. The following poem entitled “The Child” was written and published by one of the patients’ at Humber River Hospital.

The Child

The child is an individual
whose growth is gradual.
Some see the child-property
and want to control its identity.
Don’t they know control will
make him lose his identity?
Don’t they know loss of identity
will make him a candidate for psychiatry
at great cost to society?47

Tulk believes that our own faulty self-judgment is at the root of our loss of identity. 48

According to Tulk, an adult survivor’s loss of identity reflects their self-judgment against


46 Tulk, “The Truth of Who I Am,” (Tasmania: Transpersonal Lifestreams, 1998-2003): 1. Tulk’s use of the phase “born innocent” alludes to the fact that a baby does not initially have a self-concept. A person’s self concept is developed, reinforced and influenced by both positive and negative relationships.

themselves as they believe that they are not adequately living up to the expectations that other people have set for them. Therefore an adult survivor’s self-judgment and their perceived inability to please other people create an on-going cycle of rejection sensitivity.

2.1.3 Rejection Sensitivity

Rejection Sensitivity is defined as part of the aftermath of childhood abuse and is lived out in the lives of many adult survivors as a fearful and anticipated expectation of being rejected by other people. For many adult survivors the prospect of another rejection prevents them from seeking out some spiritual care support. Therefore, in this section I review some research on rejection sensitivity.

Researchers affirm that rejection sensitivity is one aspect in the aftermath of childhood abuse that still impacts adult survivors. Geraldine Downey conducted research with adult survivors on the subject of rejection sensitivity. Downey writes that, “rejection sensitivity is to anxiously expect, readily perceive and to overreact to rejection.” 49 All adult survivors involved in this research study exhibited a negative self-concept, a deep sense of self-rejection, and a high expectation of rejection sensitivity. Along with rejection sensitivity adult survivors have a difficult time to let down their defensive guard as they do not know who they can trust.

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48 Tulk’s understanding of loss of identity refers to the abuse survivor who is trying to please everyone else until they forfeit their own free will and authentic self.

2.1.4 Lack of Trust

One of the major obstacles that prevent adult survivors of childhood abuse from seeking a spiritual care intervention is their lack of trust. Because the majority of adult survivors were abused by authority figures or people who they thought that they could trust they are reluctant to share or disclose their sacred story with another perceived authority figure. Authority figures might represent the survivors’ unspoken fear of this “power over relationship.”

Due to the violation that they suffered as children there is still a high level of fear and confusion within them and they might not know who to trust. Therefore, they find it easier to remain silent than to expose their vulnerability to anyone. Lack of trust within the lives of adult survivors is a predominant obstacle which prevents them from seeking help. Jenna Bateman, Corrine Henderson, and Louise O’Brien wrote in an Australian Journal for the Advancement of Mental Health:

Some of the survival mechanisms utilized to advantage in childhood can prove counterproductive in adult life. These include the fierce independence with lack of acknowledgement of the need of help, and a reluctance both to ask for and accept help. Issues around trust, especially from those perceived to be in authority, can limit both contact and engagement with the people who can potentially provide the most effective help.

Research studies reveal that adult survivors' lack of trust is at times a legitimate fear of disclosure and re-traumatization. The following trauma research accentuates some negative outcomes to adult survivors’ disclosure. Trauma research studies affirm that rape survivors have experienced a re-traumatization after disclosure with informal support.

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50 A “power over relationship” represents a relationship where the authority figure disregards the adult survivor’s sacred story as part of the healing process.

providers or from the professional medical or legal representatives. These studies affirm that re-traumatization occurs primarily due to the negative reactions that they receive from support providers. According to Courtney E. Ahrens, rape survivors’ disclosure leads to a process of re-traumatization which causes them to be silenced once again. He writes: “Three routes to silence were identified: 1) negative reactions from professionals led survivors to question whether future disclosures would be effective; 2) negative reactions from friends and family reinforced feelings of self-blame; and 3) negative reactions from either source reinforced uncertainty about whether their experiences qualified as rape.” An exploration of further research on re-traumatization confirms Ahren’s research.

Davis, Brickman, and Baker, 1991 conducted some research on supportive and unsupportive responses to rape victims and they found that, “Negative social reactions from informal support providers encompass both overtly negative reactions such as blaming or doubting victims.” Campbell, Wasco, Ahrens, Sefl and Barnes research study confirms that, “anywhere from one quarter to three quarters of survivors receive negative reactions from at least one member of their informal support network.” Filipas and Ullman found that, “rape victims frequently report receiving negative or unhelpful reactions from legal and medical personnel.” Every time an adult survivor experiences re-traumatization due to disclosure of


their past abuse, they usually enter into the unhealthy practice of silence and self-suspension. Many adult survivors become despondent and suicidal.

Reviewing the high ratio of suicide attempts according to the research statistics sheds some light on the importance of providing a sacred place in the spiritual care setting. Reviewing this research is relevant to this thesis because a number of the patients on the K4E were actually suicidal and some examples are found in Chapter 4.

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Other studies confirm her statistics. "People with mental health disorders such as those who are diagnosed with mood disorders are at high risk of suicide."57 "Studies indicate that more than 90 per cent of suicide victims have a diagnosable psychiatric illness."58 "Suicide is the most common death for people with schizophrenia."59 "Major depression and

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57 Ibid, 14.


bipolar disorder account for 15 to 25 per cent of all deaths by suicide in patients with severe mood disorders.\footnote{60}

Due to these statistics and my direct experience with patients in this category, part of the added safety strategy calls for inviting adult survivors of childhood abuse to receive crisis support as they require it. Knowing the facts and high suicide risk of patients in this category is valuable information as the interdisciplinary team works together to put preventative structures into place.

2.1.5 Denial of God’s Existence

Adult survivors with a history of physical and emotional abuse may well question or deny the existence of God and they may also believe that there is no meaningful order to the universe. This spiritual care insight keeps me alert to the magnitude of their spiritual care crisis and reinforces my endeavour to appropriately advocate for their safety needs.

A body of research exists to underscore the detrimental and long term impact of childhood incidences of physical and emotional abuse. Wilson and Moran conducted research which measures the impact of childhood experiences of physical and emotional abuse as related to their religiosity and spirituality. Their research study shows that, "those who have experienced physical or emotional abuse in childhood will turn away from God or deny the existence of a divine creator."\footnote{61} Herman’s research and Janoff-Bulman and Thomas’s studies indicate that “infliction of horrible deeds on one’s body or mind may


undermine or violate beliefs that there is a meaningful order to the universe.” Every form of religious or spiritual abuse is a violation against a person’s human rights.

**Spiritual trauma experienced due to religious abuse**

The following is my own definition of spiritual trauma which occurs due to religious abuse. Spiritual trauma due to religious abuse drastically violates, alters, distorts or obliterates a person’s religious symbolism and spiritual connection with the divine. Four participants in this research study experienced spiritual trauma due to religious abuse; therefore, I will share a brief overview in this section, but a more explicit overview is found in Chapter 4.

Case 3 Bess was raised in a Jewish household which also included religious educational training within the synagogue. After her parents shared their traumatic memories of the Holocaust, Bess’s Jewish faith entered into a state of spiritual confusion as the teachings from the Torah clashed with the harsh realities of the Holocaust. As a result she came to believe that her parents and all Jewish people were abandoned by Yahweh.

Case 4 Cassandra was raised in a Jewish household with weekly worship in the synagogue and she accepted this lifestyle and found a measure of peace. Years later she was sexually abused by her father on Yom Kippur and afterward he forced her to go and worship in the synagogue. Spiritual confusion and spiritual disconnection occurred as a direct result of this sexual and religious violation.

Case 5 Jerry was religiously abused when he was in a state of distress and his priest was unavailable to help him. As a result he and his family were spiritually and religiously disconnected from the divine and the church for many years.

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Case 7 Ted was raised in a Roman Catholic home and his family lived a sacramental lifestyle. At the age of 12 years old he was coerced into a satanic ritualistic abuse ceremony by a cult leader which resulted in his living twelve years with the distorted spiritual perception and belief that because he had ‘sold his soul’ to the devil there was no way back to faith for him. The spiritual and religious coping research affirms the profound spiritual impact that survivors often experience after religious abuse.

Reviewing the spiritual and religious coping research relates specifically to adult survivors of religious abuse. This body of research illustrates and articulates a graphic picture of their unspeakable sense of violation, spiritual confusion and catastrophic disconnection from their once loved and cherished religious symbols, church and community of faith or other symbolic representations of the transcendent. In essence, their previous religious symbols of faith which brought a measure of peace in the past now represent disillusionment and hopelessness. As a spiritual care specialist, recognition of this potential obstacle provides a new level of spiritual care awareness to more effectively provide the spiritual care needs of adult survivors of religious abuse.

Religious abuse is amongst the most insidious violations that can happen in childhood and the aftermath of religious abuse leaves the adult survivor at the point where they feel absolutely alienated from the source of their spiritual comfort. In Chapter 4 there is an overview of four participants in my research study who have experienced religious abuse.

Some research literature affirms that religious and spiritual abuse may occur simultaneously with other types of abuse. Research conducted by a number of researchers focuses on the spiritual harm that a person sustains as a result of any form of abuse or
neglect. It concludes that mistreatment of any kind damages a child's capacity to give and receive love, participate meaningfully in community, and thrive in life. Other research reviews the negative impact of religious abuse instigated by a clergy person or religious authority figure. Outcomes from Crompton, Gartner and Matchan’s research affirms the following: whenever childhood abuse occurs with a religious authority, "it is thought to have specific meaning for its young victims since children are often encouraged to trust and relate to religious leaders as special persons who are a direct living representative of the divine.”

Ragsdale echoes these conclusions regarding clergy religious abuse, “A priest represents an icon of the transcendent, and hence the survivor suffers spiritual consequences beyond the damage caused by similar cases of abuse not involving a clergy.” Bishop Geoff Robinson emphasizes the spiritual trauma that happens as a result of clergy abuse:

The power that has been abused is a spiritual power that allows a person to enter deeply into the secret lives of others. The link between the minister and God can be impossible to break and it can easily seem as though God is the abuser. The abuse shatters the power of the symbols of that belief e.g., the picture of a priest holding a host aloft becomes a mockery. The search for perfect love within that system of belief can become impossible.

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The rupture of their relationship with God is a deep spiritual loss which leads to anxiety, depression and hopelessness. Countless adult survivors of religious abuse experience a sense of desolation and spiritual disconnection from the comfort, security and hope of their faith, due to the long-term impact of clergy abuse. Other types of abuse including sexual abuse impact a high degree of spiritual trauma.

**Spiritual trauma due to sexual abuse**

As a spiritual care specialist it is imperative to understand the aftermath of adult survivors of sexual abuse. In the words of P.L. Ryan, “Some adult survivors of sexual abuse may experience negative changes to their spirituality which range from questioning their faith to denouncing religion altogether.” It is important to be cognizant of the belief distortion that exists within some survivors of sexual abuse as they have come to believe that they are not loved or accepted by God. Many sexual abuse survivors still blame themselves for these incidences in spite of the fact they are the victims of the violent crimes. Understanding this major distortion within their belief system as part of the aftermath of their abuse prepares me to listen for this spiritual distortion as found in the context of their story. Spiritual distortion within the adult survivors’ belief system might become a major obstacle which prevents them from receiving a spiritual care intervention.

Sexual abuse is a human violation that cuts a person to the very core of their being and some survivors would say that this violation “murdered their soul.” Negative coping occurs when adult survivors struggle with a disconnection from their faith, religion or spirituality. Pargament and his colleagues’ research points to the fact that, “a loss of faith or

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spiritual disconnection causes survivors to question the existence and benevolence of God.”

According to Flaherty, “it appears that childhood sexual assault can have a negative impact on a survivor’s sense of spirituality. Abused women are less likely to feel loved and accepted by God and less likely to have a sense of trust in God, or to be involved in an organized religion. This feeling of disconnection from a higher power and others may reflect the survivor’s sense of guilt and shame that accompanies the abuse.”

Spiritual disconnection is often associated with adult survivors’ loss of identity.

2.1.6 Loss of Identity

Prolonged abuse or trauma often results in spiritual trauma which causes the adult survivor to feel a loss of identity. As already discussed in Chapter 1, Francis’ “first five stages of soul loss include deprivation, abuse, disconnection, loss of meaning and loss of identity.”

According to her, a culmination of all five stages is equal to what she refers to as soul murder. Dr. Judith Herman is an experienced psychiatrist who works extensively with abuse survivors. The following statement depicts Herman’s clinical observation of a patient’s evolutionary process towards their loss of identity:

Herman writes,

People subjected to prolonged, repeated trauma develop an insidious, progressive form of post-traumatic stress disorder that invades and erodes the personality. While the victim of a single acute trauma may feel after the event that she is “not herself”,

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70 Francis, 47.
the victim of chronic abuse may feel herself to be changed irrevocably, or she may lose the sense that she has any self at all. \textsuperscript{71}

Herman’s poignant statement offers an explicit description of an adult survivor’s loss of identity. She contrasts and compares the impact of an isolated act of abuse as opposed to a long term experience of chronic abuse. After enduring many years of chronic abuse a person begins to feel that “they have completely lost their sense of self.”\textsuperscript{72} In over ten years of experience as a spiritual care specialist on the K4E, people in this category have told me that they no longer know who they are and many of them no longer care. As Herman writes, “these people are in a state of post-traumatic stress disorder or suffering from an eroded personality.” Adult survivors who are experiencing the aftermath of past abuse require a uniquely supportive environment or a sacred place for their wounded souls to receive some spiritual healing.

2.2 Naming their Spiritual Care Needs and Creating a Sacred Place

After determining the six potential obstacles that might prevent adult survivors from receiving an effective spiritual care intervention, in this section I review six spiritual care strategies to create a sacred place within the spiritual care setting to meet their specific spiritual care needs.

2.2.1 Developing an Authentic Spiritual Care Relationship

In this section, I share my strategic spiritual care plan to create a sacred place for adult survivors of childhood abuse. Ultimately, my spiritual care focus accommodates adult

\textsuperscript{71} Herman, *Trauma and Recovery*, 86.

\textsuperscript{72} Ibid, 86.
survivors’ spiritual care needs with a focus on building an authentic relationship of trust. Because adult survivors have major difficulties related to their fear of rejection and their inability to trust others, it is expedient for me to engage in an authentic rapport of unconditional acceptance in a prayerful environment from the onset of the visit until its conclusion. The hallmark of an environment of unconditional acceptance takes place in a non-judgmental environment.

2.2.2 Unconditional Acceptance within a Non-Judgmental Environment

Creating a sacred place in a non-judgmental environment for adult survivors who have experienced past sexual or religious abuse is an absolutely essential spiritual care practice. According to spiritual and religious coping research, some adult survivors believe that if God does exist, God certainly does not love or accept them as they are. Therefore, creating a sacred place in a non-judgmental environment communicates unconditional acceptance of them.

Adult survivors’ pervasive fear of rejection causes them to transfer their sensitivity rejection to the divine as well. Perhaps they hope that God does not actually exist, for if God does exist they might feel that they are not only rejected but also judged by God. An adult survivor’s fear of rejection and judgment by God holds the adult survivor in a vicious cycle of spiritual disconnection. In my experience most adult survivors do not feel that they are loved or lovable according to themselves, other people, or God. In order to accommodate their perceived sensitivity rejection which translates into a fear of judgment and rejection I establish a non-judgmental environment in which my body language, my eye-contact and emotional affect reflects an atmosphere of unconditional acceptance. My rationale is that if
they experience an atmosphere of unconditional acceptance without any hint of judgment, then maybe they will unwittingly experience something uniquely different, if only for a couple of hours. Creating a sacred environment for adult survivors inspires faith to envision that if the survivor is spiritually receptive perhaps they will be able to receive some new spiritual care insight. Unconditional acceptance and empathy as opposed to over-identification or counter-transference creates a positive environment where patients have the potential to receive some new spiritual insight.

2.2.3 Empathy as Opposed to Over-identification or Counter-transference

Spirituality and trauma research informs my spiritual care methodology to integrate spiritual care practices to meet the unique spiritual care needs of adult survivors. The following is a definition of empathy as understood from the educational CASC guidelines: “Empathy is not so much a technique as a practice of sensitivity and intimacy--meeting the other in his or her inner world. For such empathic identification to be therapeutic, however, we need to acknowledge its boundaries. The theologian H. Richard Niebuhr spells this out when he characterizes love as reverence:”

1. it keeps its distance even as it draws near
2. it does not seek to absorb the other in the self or want to be absorbed by it
3. it rejoices in the otherness of the other

This overview from Niebuhr accentuates my own working definition of empathy.

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73 CASC/ACSS National, The following overview is from the CASC manual found in the section Curriculum for Basic SPE Chapter V under the heading Person-Centered Caring, 4.
Empathy, spiritual listening and unconditional acceptance are effective characteristics for building an authentic relationship of trust with adult survivors of childhood abuse. Building a relationship of trust with adult survivors takes into consideration what the trauma research highlights as obstacles that might prevent them from receiving an effective spiritual care intervention. Creating a sacred place for adult survivors consists of maintaining a non-judgmental spiritual care atmosphere of unconditional acceptance. Because some adult survivors have experienced long-term or chronic abuse they might experience what Francis refers to as a loss of identity which she defines as “a person’s disconnection from self, others and God.” Adult survivors in my practice who are assessed with a loss of identity often speak with the following words, “I do not know who I am and I no longer care.” Some adult survivors in this category have experienced several very serious suicide attempts. As I prayerfully listen and empathize with those who are experiencing a loss of identity, many themes of disconnection are evident in their story. Careful and prayerful listening while incorporating Francis’ and Washburn’s spiritual care assessment tools enables me to make spiritual care assessments of the major disconnections from family, friends and also the vital disconnection from their spirituality or place of worship.

The role of empathy is a key factor in establishing a relationship of trust with a patient who is assessed with a loss of identity and a spiritual disconnection. Creating a sacred place for adult survivors translates to providing an atmosphere of unconditional acceptance and empathy in order to make them feel welcomed, accepted, respected, listened to and valued within the context of the spiritual care relationship. Unconditional acceptance and a spiritual care stance of empathy provide an atmosphere where the adult survivor is able to re-

74 Francis, “The Soul’s Journey through Abuse,” 47.
focus, and be more comfortable and receptive to share the memories that “disturb their
spirit.” Patients are often ready to share their soul secrets because they experience the gift of
unconditional acceptance and empathy within the spiritual care relationship. Bohart and
Greenberg write the following about the spiritual care virtue of empathy:

    First, empathy includes the making of deep and sustained contact with another.
    Second, empathic exploration includes deep sustained immersing of oneself in the
    experience of the other. Third, empathic exploration includes a resonant grasping of
    the ‘edges’ or implicit aspects of a client’s experience to help create new meaning.75

    According to the trauma research adult survivors often sustain some residual
aftermath due to their past abuse which includes the following spiritual care challenges: a
negative image of God, a negative self-concept, rejection sensitivity, lack of trust and fear of
disclosure and re-traumatization, a denial of God existence and loss of identity as some of the
potential roadblocks that might prevent them from receiving an effective spiritual care
intervention. Therefore, I purposefully integrate the spiritual care practice of empathetic
listening so that adult survivors feel empowered to share their story as I engage in a non-
directive spiritual care model in order to establish a relationship of trust.

    An incorporation of the spiritual care practices of unconditional acceptance, empathy
and prayerful spiritual care assessment are essential factors for building trust with adult
survivors, particularly those who have a loss of identity. Joan D. Koss-Chiono writes the
following about the role of empathy within the context of the spiritual care and healing
relationships: “Empathy in the healing relationship creates an inter-subjective space where
individuals enter into a kind of extreme relationship where differences are melded into one

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75 A.C. Bohart and L.S. Greenberg, *Empathy reconsidered: New directions in psychotherapy*
field of feeling and experience, a phenomenon I label radical empathy.”

Linehan, speaking of empathy, describes how once an intense emotional response starts, “a vicious cycle is often set up where the emotion sets off memories, images, thoughts and influences perceptions,” which is a parallel response by adult survivors on the K4E.

The spiritual care practice of empathy is not to be confused with the detrimental practice of over-identification or counter-transference which is defined by the American Psychiatric Association as the "unique psychological situation in which the client actually represents an individual from the therapist's past." The primary type of countertransference that is relevant to this discussion is subjective countertransference because it is the potential obstacle that prevents effective spiritual care. Subjective countertransference is defined by Winnicott “as the type of countertransference that encompasses both responses to material that is troubling to the therapist and the characteristic responses of the therapist to the client.” This definition of “subjective countertransference can be expressed in either a positive or negative way, but both definitions stem from a therapist’s distorted perceptions within the interactive relationship.”

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countertransference have been conducted by Gelso and Hayes, Glickauf-Hughes, Kahn, Masterson, and Pipes and Davenport. They draw upon examples of therapists who have their own unresolved anger.

Literature and research conducted on countertransference in the therapeutic setting highlights the potential danger of therapists including spiritual care specialists who fail to develop and maintain a reflective self-awareness and collegial support. Potential dangers of countertransference might occur when a spiritual care specialist fails to be diligently self-aware and proactive about putting safety structures into place to prevent countertransference. As a spiritual care specialist, I have put the following preventive structures into place to heighten my own self-awareness to prevent countertransference. My colleague and I debrief difficult cases with each other. We are active members with other spiritual care specialists within our catchment area. Self-care strategies include being an active member of SWIFT Self Help Group for the last fourteen years. The Canadian Association for Spiritual Care (CASC) Manual outlines the spiritual care competencies for spiritual care specialists in Chapter 5 Section I under the heading: Code of Ethics for Spiritual Care Professionals. Spiritual care specialists are professionally responsible to operate within the CASC code of


ethics to ensure that patients, their families and the staff receive professional and accountable spiritual care.

2.2.4 Non-Directive Spiritual Care and Prayer

A major component of the CASC spiritual care training program endorses a non-directive model of spiritual care which is based on the three characteristics of congruence, acceptance and empathy which are the inherent practices found in a Rogerian approach to spiritual care. The following three points are taken directly from the CASC basic unit level of spiritual care education, and it outlines the non-directive spiritual care characteristics to be honed by spiritual caregivers.

1. "In congruence the caregiver is present as a real person, rather than the pseudo-presence of one hiding in the role of the professional or expert. The helping relationship is not a clinical one of scientific detachment but a real one of genuine, personal presence. The counsellor is co-present, both to himself or herself, and thus can draw from the fullness of the counselling relationship." 86

2."In acceptance the counsellor prepares a place of positive regard and belief in the other. The core task of religion may well be located in the symbols and rituals representing the sacred place of acceptance. It is the universal human need, and the essence of love, to meet in mutual confirmation. In the context of a person-centered counselling relationship,

there is the analogy of the transcendent place offering full attention and unconditional acceptance. The caregiver provides a presence that symbolises an enduring place.\(^{87}\)

3. "In empathy the counsellor is attuned to the inner world of feelings, thoughts and yearnings of the client. It is entering the other’s perceptual world, seeking to understand what it is like to be in that place. Through this empathic entry, the client’s world is enlarged and transformed into a world where the client can be at home. Rogers defined empathy as a potent therapeutic force and compared it to a birthing process of securing a place of belonging: it releases, it confirms, it brings even the most frightened client into the human race. If a person can be understood, he or she belongs.\(^{88}\)

Non-directive spiritual care as outlined from the CASC manual is part of my current and on-going spiritual care practice. Non-directive spiritual care means that as a spiritual care specialist my position is not to engage in therapy. Non-directive spiritual care is specific to a Level Three spiritual care intervention which means that I do not give guidance to the adult survivor, I do not tell them where to focus or what they should or should not believe, I do not tell them what, when, or how to grieve. My spiritual care incorporates a spiritual care practice of prayer and holy listening which creates a sacred place whereby the adult survivor feels safe to re-visit their memories. Holy listening is a dual listening to the adult survivor and to the inner wisdom of spiritual direction that prompts me what to say and how to say it.

Disarming the spiritual care power imbalance is a key component of non-directive spiritual care. Non-directive spiritual care recognizes that adult survivors have a lack of trust

\(^{87}\) Ibid. Although the CASC Manual includes the ethic of positive regard under a non-directive spiritual care model, it refers more precisely to a “non-judgmental” approach. I include it here because it is one of the three characteristics of the Rogerian approach presented in the CASC Manual.

\(^{88}\) Ibid.
and a fear of rejection and therefore, a non-directive spiritual care methodology is my conscious choice to purposefully and deliberately disarm the perceived power imbalance. Adult survivors quickly understand that as a spiritual care specialist my role is not to manipulate or control the spiritual care intervention. By purposefully relinquishing the power imbalance adult survivors come to believe that as their spiritual companion my role is not to tell them what is wrong with them and how they need to change. Perhaps, this is what they are expecting from the spiritual care intervention and they are pleasantly surprised and delighted that as their spiritual companion they are free to lead me to where they need to go.

Prayerfully honing these specialized spiritual care skills imparts a sense of safety and empowerment within the adult survivor as they come to understand that as their spiritual companion I am following their lead and not my own agenda. Empowering the adult survivor takes place as they lead me to the memories that they need to re-visit. As a spiritual care specialist my role is to engage and enter into the world of the adult survivor as they extend their personal trust to welcome me on their journey. Spiritual companionship with the adult survivor is a journey into the center of their soul, a place where memories that are shared encapsulate spiritual values, themes, beliefs and an underlying spiritual violation that has been buried for decades. Non-directive spiritual care is a radically different approach as I take into consideration the specific spiritual care needs that are representative of adult survivors of childhood abuse.

From this radically different spiritual care approach, when the patient is in a spiritual crisis, they have my undivided attention. Level Three spiritual care listening focuses on maintaining a spiritual care alignment with the patient as they invite me, as their spiritual companion to re-visit their long-forgotten memories. Spiritual care alignment with the
spiritually receptive patient often brings a new dimension of spiritual insight as they experience affirmation and validation of their trauma.\(^8^9\) Ultimately, this positive relationship helps to build a patient’s self-esteem and as a result they tend to embrace a better quality of life. Naturally the question is raised, what is the reason for this predictability in this non-directive approach to spiritual care when it serves only a catalytic function? Rogers writes:

Within the client resides a constructive force whose strength and uniformity have been either entirely unrecognized or grossly underestimated. It is the clear-cut and disciplined reliance by the therapist upon those forces within the client, which seems to account for the orderliness of the therapeutic process, and its consistency from one client to the next.\(^9^0\)

Integrating a non-directive approach to spiritual care means that my focus is to prayerfully and empathetically listen to a patient’s past trauma during the spiritual care intervention. W.U. Synder writes the following statement to confirm that when the spiritual caregiver follows the patient’s lead in a non-directive approach to spiritual care that new spiritual insight transpires within the adult survivor:

We have known for centuries that catharsis and emotional release were helpful. Many new methods have been and are being developed to bring about release, but the principle is not new. Likewise we have realized that revised action patterns, new ways of behaving, may come about as a result of insight.\(^9^1\)

Non-directive spiritual care and prayer is an antidote to the adult survivor’s rejection-sensitivity as this spiritual care practice helps to maintain a sacred place throughout the entire spiritual care intervention. New spiritual care awareness is that if the patient

\(^8^9\) My use of the term spiritual care alignment refers to the non-directive spiritual care which follows the patient’s lead as they re-visit their traumatic events.


perceives any hint that communicates impatience or judgment as they shed their tears, then they will re-coil and no longer share at the same level. Attentiveness and spiritual sensitivity to the patient’s needs are essential components that often lead to a measure of new spiritual insight.

2.2.5 Theophostic Prayer Ministry

Part of my DMin studies inspired me to take a Theophostic Training Course in Chesapeake, Virginia with Dr. Smith and to study under his valuable spiritual care teachings. Dr. Ed Smith is a Christian minister, counsellor and the founder of (TPM) Theophostic prayer ministry. Smith integrates a process of prayer as the patient re-visits their traumatic memories which contain their distorted belief system or lie-based thinking. The meaning of the word “theophostic” comes from the Greek words “theos,” which means God, and “phos” which means light. These two words describe God’s illumination in a previously darkened area of one’s mind and thoughts. Smith came to believe that traumatic events that happen in a person’s life tend to leave them with a distorted belief system, which is lie-based thinking. In order to be a candidate for Theophostic prayer ministry, the person must be spiritually receptive to re-visit any memory that holds their distorted or lie-based thinking.

Smith’s methodology is to pray aloud with the person and then wait for the person to access the memory that they need to re-visit. Prayerful spiritual care sensitivity enables the spiritual caregiver to listen, empathize and hear the patient’s emotional and spiritual trauma, which validates their experience. After the traumatic experience has been shared, Smith will ask if there are any other memories that the person is thinking of, and he listens to the

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memories. He continues to pray aloud that God will give this person His own perspective on this event, and he waits. Sometimes the person will start to smile and say that they understand or perceive their trauma in a completely different way. Smith then asks them to look through all the memories that they have shared and when they feel at peace about all of their memories, he concludes the spiritual care intervention with a prayer of thanksgiving.

My integration of theophastic prayer into my spiritual care methodology is a silent version of prayer as the patient is led to their traumatic memories which contain their distorted beliefs. Unlike Smith, I do not ask any questions during the spiritual care intervention. In my own spiritual care practice some patients have accessed five traumatic memories during one spiritual care intervention. As adult survivors accessed their past memories in the present tense they also grieve their losses with an emotional release.

2.2.6 Burney’s Emotional Release: Used as a Spiritual Care Dynamic

Dr. Robert Burney’s teaching focuses on the importance of a patient’s emotional release and this is a key component in my new spiritual care methodology. Burney is a spiritual teacher, co-dependence counsellor, grief therapist and inner child healing practitioner who is also the author of a number of journals and two books, including audio tapes, “Co-dependence: Dance of Wounded Souls,”93 and “Co-dependence: Dancing in the Light.”94

A review of Burney’s literature has influenced my current thinking and spiritual care with adult survivors of childhood abuse. Burney reinforces more explicitly the key importance for an adult survivor to re-visit their past abuse and to grieve their losses with an


emotional release. My spiritual care methodology incorporates Burney’s concept of the emotional release as a spiritual care dynamic which often leads to a patient’s new spiritual perception of their past trauma. All seven participants’ grieved their losses with an emotional release and directly afterwards they received some new spiritual insight and a symbol of hope. These cases are found in Chapter 4.

Burney writes that adult survivors “need to own and honour the child” so that they are able to love who they are right now. The purpose of Burney’s approach to inner healing is not to accentuate or point the finger of blame or judgment against those who initiated the past abuse, but rather his focus is to bring inner healing. Burney believes that a person’s emotional grief release activates or opens a person to receive a positive experience: “Grief is energy that needs to be released through crying and raging. In order to own our self, it is vitally important to feel our pain, sadness and rage. If we are blocking these negative emotions from flowing, then we are also limiting our ability to feel joy, love and happiness.”95 Prayerful listening to the adult survivor as they re-visit their past traumatic events and grieve their losses is a profoundly spiritual experience.

Adult survivors often experience a new beginning as they are set free from their past hurts which, then, enables them to develop healthy and meaningful relationships with others. When a person grieves their losses with an emotional release they receive a greater capacity to form positive relationships and he writes that “people cannot be truly intimate with themselves or others without doing their grief work.” Emotional intimacy liberates us from the past abuse and propels a person forward into a new relationship with themselves and

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other people. As people do their grief work they are released from the pain of their past experiences and are free to love who they are right now. Burney writes that adult survivors “cannot fully feel the joy unless they are willing to feel their sadness.” So, to restate this more positively, Burney believes that adult survivors need to “experience their emotional healing, to heal their wounded souls in order to re-connect with the God-Force which is love, light, joy and truth.”

2.3 Religious and Spiritual Coping Research

In this section, I do not present the research in chronological order as my primary focus is to highlight the religious and spiritual coping research to address more specifically the various types of abuse as relevant for this research project. My focus is to determine the impact of an adult survivor’s spiritual resistance or spiritual receptivity with their spiritual source. Afterwards, I review the outcomes of those who are spiritually resistive and spiritually receptive to determine how they cope with life after their traumatic event.

2.3.1 Religious and Spiritual Coping after sexual abuse

Religious and spiritual coping research highlights the positive impact that occurs when adult survivors of sexual abuse are spiritually receptive to reconnect with their spiritual source. Harrison and Koenig, and their colleagues, conducted studies related to spirituality and well-being and found that, “very few studies have examined the way sexual assault survivors

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96 Ibid, 47.

rely on their spiritual beliefs or faith community for support." There are however, some research studies that document mental health outcomes associated with religious coping. Frazier and Tashiro and their colleagues conducted research to determine religious coping amongst sexual assault survivors. They examined a number of variables, including religious coping and positive changes over time. Although specific predictors of religious coping were not assessed, “results suggest that adult survivors who increased their use of religious coping over time experienced greater increases in posttraumatic growth.” Posttraumatic growth appears to be evident in the religious and spiritual coping research as it depicts spiritually receptive adult survivors and their transitional movement towards their religion or spirituality to help them cope with their past abuse.

Calhoun and Tedeschi identified five factors as being related to posttraumatic growth: new possibilities, relating to others, personal strength, spiritual change, and appreciation of life. These five factors form the criteria of one instrument used to measure posttraumatic growth in the current research (PTGI: Posttraumatic Growth Inventory). Calhoun and Tedeschi’s definition of posttraumatic growth appears to reflect adult survivors with an existing spiritual receptivity and spiritual accessibility. Conversely, my current research study represents adult survivors who initially fit the criteria of spiritual disconnection and no accessibility to their spiritual resources. Therefore, this research project represents adult survivors who initially fit the criteria of spiritual disconnection and no accessibility to their spiritual resources. Therefore, this research project represents adult

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survivors’ spiritual reconnection back to their spirituality or place of worship. Researchers’
conducted further research with adult survivors who had experienced sexual abuse.

Researchers continued their research by dividing these strategies into negative and
positive religious coping strategies. Pargament and his colleagues conducted religious
coping research and they identified twenty-one coping strategies for adult survivors of sexual
abuse: “Some of the coping strategies that were effective for adult survivors include their
ability to re-define the event as part of their story in God’s plan. Some adult survivors rely on
their relationship with God, or they turn to their church for support, and some people pray for
a miracle, or use religious beliefs to keep their mind off of the problem.” 101 Afterwards,
Pargament and his colleagues conducted a study by dividing the coping strategies into
positive and negative coping: “Positive coping includes a variety of methods to help
individuals feel close to God, to seek meaning and purpose in life and to feel spiritually
connected to others. Research confirms that many adult survivors rely on positive religious
coping mechanisms and their spirituality following a sexual assault.” 102

Spirituality research was conducted with adult survivors of sexual abuse to determine
and measure the impact on their well-being. Kennedy, Davis and Taylor’s research found
that “increases in spirituality were not significantly correlated with increased well-being, but
decreases in spirituality were related to decreased well-being.” 103 Glaister and Abel’s

101 K. I. Pargament, H.G. Koenig, and L.M. Perez, “The many methods of religious coping:
102 Ibid.
103 J. Kennedy, R. Davis, and B. Taylor, “Changes in spirituality and well-being among victims of
Research study highlights the fact that “women experienced support in their relationship with God, through church, religion, angels, or nature in the healing from childhood sexual abuse.”

Religious coping was conducted by researchers with 103 rape survivors and measured using the (RCOPE), Depression Scale, Posttraumatic Disorder Scale, Psychological Well Being Scale, Posttraumatic Growth Inventory. Campbell and Sefl’s colleagues conducted research including systematic sampling from 103 female rape survivors recruited from Long Beach, California: “The female rape study recruited survivors who are at least 18 years old and those whose most recent rape occurred after age 14 yrs. Participants included (37% African- Americans) (7% Asian), (11% Latina) and (38% Caucasian) and (15%, 12%,36% and 45% Long Beach, California, respectively). Participants were asked to describe their assault history, including when they were assaulted and their relationship to their perpetrator.” Results of this research study found that “the sexual assault survivors in this sample engaged in fairly high levels of religious coping. Survivors who incorporate high levels of spirituality or religious coping often focus on prayer by asking God to help them find the inner strength to deal with their sexual assault. Survivors scored high on good deeds subscale, active church participation, helping others and trying to lead a better life. They did not receive much help from the clergy or other members of their church. From a negative perspective they often used religious activities as a way to avoid dealing with their sexual assault.


assault.”

Further research was conducted with survivors of physical, emotional or psychological abuse to discover whether spirituality is a protective factor against depression, shame, and interpersonal difficulties.

Spirituality coping research was conducted with adult survivors of physical, emotional and psychological abuse who were at high risk for psychological difficulties. The research focus is to discover if spiritual coping is protective against depression, shame, and interpersonal difficulties. Valentine and Feinauer conducted research to address whether spirituality is a protective factor in adult survivors of physical and psychological abuse. Several themes of resilience emerged from their interviews: “They secured social support, a sense of positive self-regard and their spirituality was identified as a protective factor against the development of depression, shame and interpersonal difficulties. Adult survivors who were able to access their spiritual resources were able to establish new meaning, inner strength and self-confidence.” 

Weber and Cumming’s research study reveals that, “one major key to a sense of well-being is the use of their spirituality to overcome abuse and to find a sense of meaning and purpose in their lives. They also note that, “a proportion of young adult survivors of physical and psychological abuse indicated that their spiritual beliefs helped them to heal.”

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106 Ibid.


Researchers studied the impact of spiritual growth after the traumatic events of physical and emotional abuse took place. Decker, \footnote{L.R. Decker, “The role of trauma in spiritual development,” \textit{Journal of Humanistic Psychology} 33 (1993):33-46.} Garbarino and Bedard’s research, affirm that physical and emotional abuse is a traumatic experience, but their research points to the fact that “this trauma may have important consequences for spiritual growth.”\footnote{J. Garbarino and C. Bedard, “Spiritual challenges to children facing violent trauma,” \textit{Childhood} 3 (1996): 467-478.} Tedeschi and Calhoun’s research found that “traumatic abuse may paradoxically lead to an increase in one’s spirituality, as an attempt to re-establish a sense of meaning and this propels a person to a higher stage of spiritual development.”\footnote{R.G. Tedeschi and L. G. Calhoun, “Posttraumatic growth: Conceptual foundations and empirical evidence,” \textit{Psychological Inquiry} 15 (2004): 1-18. See also P. L. Ryan, \textit{Journal of Transpersonal Psychology} 30 (1998): 47.}

The following research with sexual abuse survivors focuses on the positive impact of belief in a higher power, and how religion or spirituality provides a sense of safety for people. Granqvist’s research finds that, “the higher power may function as a protective factor in the face of a high-risk childhood abuse situation.”\footnote{P. Granqvist, “Religious and perceived childhood attachments: On the question of compensation or correspondence,” \textit{Journal of Scientific Study of Religion}, 37/2 (1998): 350-367.} Chandy, Blum and Resnick’s research study with sexual abuse in adolescent girls who viewed themselves as religious or spiritual showed that they “tended to be less at risk of various psychological or interpersonal problems.”\footnote{J.M. Chandy, R.W. Blum, M.D. Resnick, “Female adolescents with a history of sexual abuse--Risk outcome and protective factors,” \textit{Journal of Interpersonal Violence} 11 (1996): 503-518.} Reinert and Smith’s research highlights that “a group of religiously involved lay women who had a history of childhood sexual abuse reported experiencing a greater sense of faith and spirituality. They suggested that for women who had accepted God,
spirituality and religion may act as a constant system on which to rely for personal safety and emotional comfort.”\textsuperscript{114} Kane, Cheston, and Greer’s research found that, “abuse survivors who experience God as more distant, still voice a need for spirituality in their healing and ability to make meaning of the trauma.”\textsuperscript{115}

Adult survivors who are spiritually receptive during a spiritual care intervention usually receive some new spiritual insight. Chapter 3 explores aspects of a person’s spiritual resistance or spiritual receptivity to their spiritual source.

**Summary**

Chapter two reviews the trauma research to assess the damage due to past childhood abuse and Section One reviews potential obstacles that might prevent an effective spiritual care intervention. Section Two reviews the religious and spirituality research with adult survivors in order to review their spiritual resistance or spiritual receptivity and the respective outcomes.


Chapter 3

Restless Until We Find Our Rest in You

“Lord, you have made us for yourself and our hearts are restless until we find our rest in you.”

— St. Augustine

In this chapter, I introduce Michael Washburn’s psycho-spiritual model as the theoretical and foundational spiritual care perspective with a focus on a person’s times of spiritual resistance and spiritual receptivity. His last three spiritual care stages are integrated as my internal spiritual assessment tool for this research project.

Washburn is Professor of Philosophy at Indiana University and the author of *The Ego and the Dynamic Ground Theory of Human Development.* Chapter 3 provides an overview of Washburn’s psycho-spiritual model from a human developmental perspective which offers some additional insight for spiritual caregivers to appreciate why some adult survivors are able to receive so much spiritual comfort, new insight and encouragement, while others do not appear to receive much spiritual comfort. An explicit overview of Washburn’s model is discussed later in this chapter. Therefore, I have integrated Washburn’s spiritual stages as the internal spiritual assessment tool to pinpoint a person’s transition through the stages from the onset to the conclusion of the spiritual care intervention. Washburn’s model reflects a transpersonal perspective committed to “the possibility of unifying the spiritual and psychological perspectives of human development which aims ultimately at spiritual

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117 Washburn, *The Ego and the Dynamic, I.*
fulfillment.”118 Washburn’s model encourages a theological reflection on the possibility of meeting with patients in crisis during their time of spiritual receptivity. At times, psychologists or social workers meet clients who are also encountering an underlying spiritual119 emergency.

3.1 How Does Spirituality Emerge?

How does spirituality emerge? Stanislav Grof writes, “Spiritual Emergence is a relatively new concept which unfolded at the beginning of the 1990’s as professionals were finding that many of the patients’ psychological difficulties were associated with an underlying spiritual crisis. The term spiritual emergence describes a gradual unfoldment of spiritual potential with no disruption in psychological-social–occupational functioning.”120 Spiritual Crisis is not discussed in mainstream psychology, so when psychological issues contain origins of spiritual crisis a new appreciation of the psycho-spiritual dimension emerges into what is defined as spiritual emergence. Drs. Christina and Stanislav Grof are experienced clinical psychiatric researchers with over fifty years of research focused on spiritual transformation with non-ordinary states of consciousness. They have published over 150 articles and 20 books discussing the theoretical and practical implications of modern consciousness research for psychiatry, psychology and psychotherapy. Spiritual emergence provides new spiritual care awareness and anticipation of meeting a patient as their spiritual emergence unfolds.

At various times on the K4E patients are hospitalized and diagnosed with a mental health disorder, yet there are times such as in the case of Jim as discussed in Chapter 1,

118 Ibid, 1.

119 The terminology spiritual emergency and spiritual emergence are used interchangeably yet are essentially used to describe a person who has an underlying spiritual crisis which causes no disruption in psychological–social or occupational functioning.

where he also experienced an underlying spiritual crisis. In Jim’s case, spiritual transformation unfolded almost immediately after he received some new spiritual insight. In my opinion, this case might be considered a case for spiritual emergence due to Jim’s underlying spiritual crisis. Stanislav and Christina Grof offer their professional opinion regarding such cases, “Many of the conditions, which are currently diagnosed as psychotic and indiscriminately treated by suppressive medication, are actually difficult stages of a radical personality transformation and of spiritual opening. If they are correctly understood and supported, these psycho-spiritual crises can result in emotional and psychosomatic healing, remarkable psychological transformation, and consciousness evolution.”  

Spiritual emergence often occurs unconsciously within a person’s belief system and therefore, they may not be consciously aware of what is “disturbing their spirit or taking away their sense of peace.

3.1.1 Unconscious Source of Spiritual Crisis

Spirituality indwells a person at the core of their being and within their belief system which is at work unconsciously within them. Because much of a person’s spirituality is directly related to their unconscious beliefs, when they are in a radical spiritual crisis they may not know what specific issue is “disturbing their spirit” or taking away their sense of peace and well being. Such is often the case when meeting with a patient who is in the midst of a radical spiritual care crisis. Examples of my spiritual care intervention with the seven adult survivors are found in Chapter 4 and these examples reinforce how deeply embedded traumatic memories are remembered and re-visited. Only as the patient remembers, re-visits,
and grieves each of their past traumatic events, then, they are able to name their own distorted beliefs and to receive a new spiritual perception.

Spiritual crisis encompasses a myriad of spiritual care challenges, yet each spiritual crisis is unique to the person who experiences it. A state of spiritual crisis unfolds when a person begins to doubt or question their faith, or when a person can no longer access their spiritual resources, or when a person encounters past or present traumatic events that continue to “disturb their spirit.” “Each culture and religion has their own interpretation and faith meaning attached to trauma or childhood abuse and as spiritual caregivers we must be cognizant of the faith and culturally specific values.”

Whenever a patient is “disturbed in their spirit” due to cultural and religious-specific factors, part of my spiritual care practice is to contact their own faith representative to offer them additional support. Some religious or cultural beliefs include a common theme that a person’s illness happened due to sin.

Some issues that constitute a patient’s spiritual crisis might include a false belief, spiritual confusion or a wrong perception or interpretation of their sacred text. For example, an adult survivor might believe that they have committed the unpardonable sin or that their illness happened due to God’s punishment. People who experience these issues are “troubled in spirit” and could benefit from a spiritual care intervention. In such cases, my spiritual care practice is to clarify the relevant teaching from their own faith tradition. More importantly my practice is to re-affirm that God loves them, God understands them and God stays with them. Some patients experience unexplained events that might fall into the category of anomalous experiences.

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122 A definition of spiritual crisis as inspired from my own spiritual care practice is found on page 9.

3.1.2 Anomalous Experiences

“The American Psychological Association published and reviewed scientific evidence of a variety of anomalous experiences which include: spiritual and mystical experiences and near-death experiences.”  

The majority of these experiences “do not cause disruption in psychological, social or occupational functioning and do not involve mental health treatment. Anomalous experiences have been associated with claims of positive life changes after the experience.”

Mystical experiences are defined by most scholars in the research and clinical publications in the following way: “A mystical experience diverges from ordinary conscious awareness and leaves a strong impression of having encountered a reality different from or higher than everyday reality.”

Numerous surveys have found that “30%-40% of the general population report having had mystical experiences which typically lasted between one to three hours and are described by those who experience them as ineffable in nature.”

Mystical experiences relate to a person’s new dimension of relationship with their spiritual source which Washburn refers to as the Dynamic Ground.

3.2 Washburn’s Psycho-Spiritual Model

Washburn’s psycho-spiritual model provides a human developmental perspective of the various stages of a person’s life in relationship to their spiritual resistance or spiritual

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126 Ibid.

receptivity to the Dynamic Ground or the source of their spiritual life. A brief overview of Washburn’s integration of the Freudian and Jungian theories offers one explanation of a person’s transition from spiritual resistance to their stage of optimum spiritual receptivity. The major focus in this section is an overview of the last three spiritual stages from the onset of the spiritual crisis with a transitional spiritual movement towards a possible experience of \textit{regeneration in spirit}.

\subsection*{3.2.1 What is the Dynamic Ground?}

Washburn’s concept of the Dynamic Ground presupposes that each person is born with an innate predisposition to the Dynamic Ground as the source of their spiritual life.\textsuperscript{128} His theory provides the theoretical framework for exploring the developmental cycle of a person’s spiritual resistance or spiritual receptivity to the Dynamic Ground as the source of their spiritual life. Therefore, I share a brief discussion of Washburn’s integration of the Freudian theory of the primal repression and how it relates to a person’s repression of traumatic memories and the onset and continuation of their spiritual resistance until the second half of adult life. Washburn’s integration of the Jungian theory unfolds in the second half of adult life when the primal repression lifts and this sets in motion a process whereby a person’s previously unconscious memories are now accessible and when a person has optimum spiritual receptivity.

Sigmund Freud is the Austrian founder of psychoanalysis, which is a dynamic psychology providing the first well-organized explanation of the inner mental forces determining human behavior. Washburn adapts the Freudian psychoanalytical theory which

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is a method by which the analyst unpacks unconscious conflicts which is based on the free associations, dreams, and fantasies experienced by the patient.

Washburn’s Freudian focus on the primal repression offers one explanation for the adult survivor’s memory lapse of their childhood abuse experience and their recurring memory of the abuse decades later. His integration of the Freudian primal repression is two-fold in that it is the onset of a child’s spiritual resistance and the time when a child represses or buries their traumatic memories into their unconsciousness which happens between the ages of 3-12 year old. The Freudian theory of the unconscious is best described with the analogy of a submerged ice-berg, because, as the ice-berg is hidden underneath the water, even so a person’s embedded traumatic memories are stored deep within their unconsciousness. Washburn writes: “In putting defensive distance between itself and its primary other, the child at the same time lays down a barrier of repression that separates it from its own inner depths. Primal separation and primal repression are not two different acts. They are two parts of the same act, which is called the primal closing.”

Therefore, the primal closing literally means that a person is psychologically, emotionally, and spiritually closed off from their traumatic memories during the primal closing. Washburn maintains that a person lives with the reality of the primal closing for many decades and this process does not lift until the second half of adult life. Afterwards, Washburn continues with a psychological integration of the Jungian analytical theory after the primal repression lifts.

Although historically there is a major disconnect between the Freudian and Jungian theories, Washburn weaves the two psychological theories together to explain a person’s times of spiritual resistance and times of optimum spiritual receptivity. Carl Jung is the

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founder of analytic psychology, and he advanced the idea of introvert and extrovert personalities and the power of the unconscious. Washburn integrates the Jungian perspective that human beings are inwardly whole, but that most people have lost touch with important parts of themselves. Washburn’s integration of the Jungian theory provides an explanation of a person’s transitional movement from spiritual resistance into the stage of optimum spiritual receptivity. From this radically different Jungian perspective a person would have to get in touch with their unconscious memories in order to explore them with their conscious awareness. This Jungian statement speaks volumes to my spiritual care intervention with adult survivors of childhood abuse as adult survivors’ re-visit their past trauma in the present context and therefore receive a new spiritual awareness of their past trauma. Some examples are found in Chapter 4. Washburn writes: “Accordingly at midlife or thereafter these dualistic structures (of the primal repression) sometimes begin to give way, thereby creating an opening for a transformative return of the ego to the nonegoic and interpersonal possibilities that long ago were buried and lost to experience. Early adulthood, then, is the time during which ego development is completed as the final step that prepares a person for entering postdualistic, transegoic, stages of life.”¹³⁰ This literally means that a person who has lived for several decades with no memory or accessibility to their past traumatic events or their spirituality, now experiences accessibility to both because the primal closing and primal repression barrier no longer exist. A person is now free to remember their past traumatic events in the present tense which may lead to a simultaneous movement back to the Dynamic Ground or a return to their spiritual source.

Therefore, Washburn’s integration of the Freudian and Jungian psychological perspectives serves as one spiritual perspective to establish the underlying theories of a person’s optimum times of spiritual resistance and spiritual receptivity to their spiritual source. Washburn’s model provides the spiritual care specialist with insight into the timing and opportunity of potentially meeting a person in their spiritual crisis at the time of their optimum spiritual receptivity. Washburn writes, “We must return to the sources of life that had expressed themselves in prepersonal ways, if, reconnected with those sources, we are enlivened and transformed by them in transpersonal ways.” Washburn’s spiritual care insight opens a door of hope for spiritual care specialists working in an acute care setting where patients are admitted for a short period of time and then discharged from the hospital. Therefore, spiritual caregivers working in the acute care setting would find significant value in meeting a patient during their time of optimum spiritual receptivity as the patient might be receptive enough to receive some new spiritual insight. Washburn’s model and his use of the terminology Dynamic Ground works well in the context of an acute care hospital where we meet patients’ within the inter-faith and multi-cultural setting.

Washburn’s open-ended concept of the Dynamic Ground provides an adaptable inter-faith and multi-cultural model; so for a Muslim patient the Dynamic Ground translates as Allah or for the Jewish patient the Dynamic Ground translates as Hashem. Washburn’s concept of the Dynamic Ground broadens and deepens the spirituality scope with a diverse spectrum of spiritual meaning which encompasses a person’s spiritual gifts of creativity, imagination, or passion for a social justice cause or any inclusive dimension of their own spiritual care perspective. A person’s spiritual connection and receptivity with the Dynamic Ground constitutes an abundance of meaning and purpose for living and is the essential

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factor that brings everything to life! A person’s interaction with the power of the Dynamic Ground adds a dimension of spiritual mystery along with a contagious movement of enthusiasm, inspiration, and generosity of spirit into a person’s ordinary life. To use a biblical parallel, John 10:10 records the following words: Jesus said that “I have come that you might have an abundant life.” Washburn’s model provides an overview of the human developmental cycle and highlights the stages of a person’s spiritual resistance and optimum spiritual receptivity.

### 3.3 How We Experience the Dynamic Ground Throughout Life

This section “How We Experience the Dynamic Ground,” offers an overview of the various stages of Washburn’s model. The major focus in this section illustrates the dual integration of Francis’ external spiritual care assessment tool as discussed in Chapter 1 and Washburn’s model which is based on the last three spiritual stages of the regression in the service of transcendence stages one and two and regeneration in spirit which is incorporated as the internal spiritual care assessment tool that forms the crisis intervention spiritual care model with Level 3 adult survivors of childhood abuse.

### 3.4 Ego and Dynamic Ground—Infant Stage

According to Washburn’s psycho-spiritual perspective, in the Infant Stage we come to understand that an infant has no spiritual resistance to the Dynamic Ground. Washburn writes that, “the infant being in an intra-psychical state of original embodiment is absorbed into the

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132 Three Levels of Spiritual Care is found in Chapter 1 on pages 11-13.
Dynamic Ground.”

This awesome state of original embodiment reflects the infant’s state of optimum spiritual receptivity in which “the newborn is bathed in the water of life” and this life rises from the Dynamic Ground and flows freely through the newborn’s body.

Washburn cites that “the unrestricted circulation of the power of the Dynamic Ground impacts the newborn in two ways. First, “the Dynamic Ground amplifies all contents of consciousness and quickens all psychic processes; secondly, the power of the Dynamic Ground as energy has fluidic and magnetic properties which draw the newborn into states of self-contained absorption.” Washburn does not agree with traditional theories expressed by Freud, and Mahler, Pine and Bergman, “which suggest that the newborn enters into an autistic state.” Washburn’s perspective is that, “the newborn is keenly attuned to the actions and gestures of their primary caregivers.”

Due to the fact that an infant is spiritually receptive to the Dynamic Ground this is an opportune time for parents and primary caregivers to incorporate spiritual practices and blessings for their infant. Some faith traditions practice infant baptisms or infant dedications in the context of their own faith community. Although the infant does not comprehend that something spiritual is taking place, due to their spiritual receptivity to the Dynamic Ground it

134 Ibid.
135 Ibid.
138 Ibid, 48-49.
is a positive experience for the entire family. The state of optimum spiritual receptivity is short-lived as they enter into the toddler and childhood latency stage.

3.5 Ego and Dynamic Ground—Toddler and Childhood Latency Stages

In contrast to the infancy stage of optimum spiritual receptivity there is a notable and dramatic spiritual resistance and movement away from the Dynamic Ground which occurs in the toddler and childhood latency stages (between 3-12 years). From this perspective, Washburn’s integration of the Freudian primal repression indicates that a new spiritual dynamic takes place when the child begins to repress or does not remember their traumatic memories. This process takes place within a child’s soul and belief system as the child relates to all negative and positive, verbal and non-verbal communication with their primary caregivers. During the intricate formulation and developmental processes within a child’s earliest belief system they process positive and negative memories that are interspersed and reinforced as time goes by. The following is Washburn’s description of the childhood latency stage.

Childhood Latency Stage is the symbolic-protoconceptual time when a child is vulnerable with respect to their own perception of life. At this stage, they operate out of a magical omnipotence and a sense of total vulnerability and defenselessness. The child tends to shift back and forth between a sense of omnipotent independence from the caregiver and a sense of vulnerability before her irresistible and threatening power. The young ego must eventually find some relief from the emotional upheaval in order to gain self-control. Primal repression severs the ego’s symbolic ties with the Great Mother.¹³⁹

Building on Washburn’s integration of the Freudian theory of the primal repression, it is possible that adult survivors have repressed their childhood memories of abuse for several decades. In the spiritual care setting often adult survivors, who have repressed their

childhood abuse memories for decades begin to disclose their experience for the first time in their early forties. Therefore, if the abuse took place in their adolescent years, the original repression lifts or dissolves approximately thirty years later. With the on-set of the primal repression a child continues their spiritual resistance to the Dynamic Ground. This also means that according to Francis’ model as discussed in Chapter 1, that a process of soul loss begins to take place in early childhood. Washburn’s integration of the primal repression echoes Susan Gaumer’s observation of adult survivors’ state of silence and self suspension.

3.5.1 Silence and Self- Suspension

Silence and self-suspension are two detrimental characteristics of adult survivors and this survival pattern often prevents them from seeking the spiritual care that could potentially bring healing. Silence and self-suspension is an unhealthy denial of a person’s true self, which sometimes results after they have endured years of verbal, emotional, physical, psychological, religious or sexual abuse. Fear of rejection, lack of trust, or fear of disclosure and re-traumatization are common root causes which prevent them from revealing their true self. Perhaps they are not aware of the powerful liberation and inner healing that is available for them to heal their traumatic memories. So, silence and self-suspension is the perceived place of safety that victims of abuse choose to huddle in. To expose their wounded true self which has never been valued or accepted by anyone is a risk that they are not willing to take. Susan Gaumer is a spiritual director and practitioner whose focus of spiritual direction is with adult survivors of abuse. Gaumer writes, “Silence for survival is not life, but a mere existence, and a person who comes to acknowledge their inner -woundedness might discover
that there is no apparent cure.”

Silence and self-suspension are ways that adult survivors try to protect themselves from further violation. However, as the primal repression lifts, adult survivors’ need for silence and self-suspension also lifts as they remember their past traumatic events in the present tense.

3.5.2 Memory Recovery Based on Washburn’s Theory

The following is an overview of my new perspective on memory recovery which is based on Washburn’s human developmental theory as discussed earlier in this chapter. Due to the fact that in the general research data collection that 27 out of 30 patients’ accessed their past traumatic memories in the present tense and that 23 out of 30 patients fit the criteria of being in the second half of adult life it is important to consider Washburn’s theory. Explicit examples of the seven participants’ recovered memories are found in Chapter 4. Washburn’s insight offers a new perception on how and why a person is able to recover previously repressed memories later in life. If the primal repression begins between the ages 3-12 years old, this means that a person does not have accessibility to their traumatic memories until the second half of adult life. When the primal repression lifts a person receives accessibility to their traumatic memories at the time of their optimum spiritual receptivity. Therefore, Washburn’s model opens the door to think anew and to consider the process in which recovered memories takes place. From Washburn’s perspective a person’s recovered memories are their original traumatic memories that were repressed. Washburn reflects on deeply buried memories:

The most deeply buried materials of the personal submerged unconscious are those that have their origin in serious abuse or trauma during early childhood. Physical,

sexual, or emotional abuse and the terrifying experiences such as being abandoned cause grave psychic injury. To survive, the child must cover over the wound in its soul and attempt to deny the reality of its experience. The child must cut itself off from much of itself and live in a dissociated fantasy realm. The consequences of this survival strategy is that powerful feelings and memories are lost to consciousness. They are buried at the very bottom of the personal submerged unconscious.¹⁴¹

The following overview reflects that number of years that each of the seven participants lived in a state of primal repression. Adam accessed repressed memories after 25 years. Ann accessed memories after 32 years. Bess accessed her memories after 30 years. Trudy accessed her repressed memories after 35 years. Cassandra accessed her repressed memories after 40 years. Jerry accessed his repressed memories after 30 years. Ted accessed his repressed memories after 12 years. Their psychiatric history as discussed in inter-disciplinary rounds records their previous suicide attempts, but their charts do not indicate a history of past childhood abuse. It is entirely possible that the primal repression was at play earlier within the seven patients’ lives and therefore, these memories were not accessible to them. Now, it makes sense that their childhood abuse was not disclosed in their patient care history notes. If the memories were not accessible to them, then, Washburn’s psychospiritual model provides a new perspective to consider.

As the inter-disciplinary team sought corroboration regarding their past abuse, family members affirmed that the abuse took place, but they did not know all of the details as shared with me during the spiritual care intervention. Much controversy exists regarding the years of research studies focused on recovered memories, and yet, other research questions whether adult survivors have false memory syndrome.

3.6 Research on Recovered Memories or False Memory Syndrome?

This review of the research on recovered memories is relevant to this research project because 27 out of 30 patients from the general research data collection recovered past memories that were shared during the spiritual care intervention. The following is an overview of the three perspectives from the body of research on the false memory syndrome, the first research perspective considers the validity of recovered memories with adult survivors as unreliable; the second perspective reviews some cases of recovered memories which are well documented with reliable corroboration including physical evidence or perpetrator confession. The third perspective reviews legal cases with claims from people that they have been falsely accused of abuse and they argue for the theory of “false memory syndrome.”

3.6.1 Research that finds the theory of repressed memories unreliable

Research involving repressed memories has been conducted by a number of researchers including Spanos, Baker, and subsequently, by Loftus and Yapko’s experimental and empirical research which indicates that “the long term memory, rather than being a reliable tape recording, is a reconstruction which is subject to distortions based on later experience and influence.” Due to this research they find the theory of recovered memories unreliable. Holmes is another researcher who questions the validity of recovered memories:

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“First, I want to point out that, despite over sixty years of research involving numerous approaches by many thoughtful and clever investigators, at the present time there is no controlled laboratory evidence supporting the concept of repression.”¹⁴⁶ Briere and Conte conducted research with 450 adults who self-reported sexual abuse cases: “59% reported that at some point prior to their 18th birthday they were not able to recall the abuse.”¹⁴⁷

The following researchers have major concerns with the reliability of the research that was conducted with reported cases of recovered memories. Some researchers question the therapist’s influence on the client’s response and this also raises a question as to the reliability of the research. Reliable research consists of a process of collaboration and validation of the person’s reports of recovered memories. Loftus¹⁴⁸ asserts that the effect of therapy may have contaminated the subjects’ responses and therefore, this research is not a reliable source. Briere and Conte’s¹⁴⁹ research study “with 450 adult self-reported cases of sexual abuse”¹⁵⁰ received a critical review by Wakefield and Underwager’s research, “because the reports of abuse were not corroborated.”¹⁵¹

Corroboration with authentic, reliable people who are able to validate and verify a person’s reports of sexual abuse provides an important aspect for research to be considered reliable. Loftus was the collaborator in cases of sexual abuse and her research found that


¹⁴⁸ Loftus, 518-537.

¹⁴⁹ Briere and Conte, 21-31.


“18% of their research sample of self-reported abuse victims reported a period of amnesia for the abuse.”  

3.6.2 Research of evidence and collaboration of abuse

The following is a brief overview of research from previously repressed memories that were later accessed and remembered by adult survivors. These cases hold up to the highest levels of evidence-based research and reliable collaboration, including physical evidence or perpetrator confession. Szanjnberg’s research documents the case of a 12-year-old boy who recovered a past memory that he shared with his therapist during a therapy session. When the therapist questioned his mother about this incident, she confirmed that she had tried to strangle her son. Szanjnberg comments: “This is another case where a patient recovered a repressed memory wherein corroboration was obtained.”

The next case was recorded by Szanjnberg in a journal article which emphasizes the process whereby a professor recovered memories that happened approximately twenty-five years ago. After hearing the news that his nephew was to join a boy’s chorus at the same camp where he had been molested, he felt sick and depressed. One night he woke up with memories of his past abuse. He contacted other men who had attended the same camp and they confirmed that they were all abused by the camp administrator. When he confronted the past administrator regarding this violation, he admitted that he had done this. Szanjnberg’s concludes that, “all of this suggests that some type of active, relatively unconscious process

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152 Loftus, 518-537.

which was, for a time, keeping the memories out of consciousness. I would call this process repression.”

Other research studies affirm the validity of a person’s recovered memories. D. Brown and colleagues conducted a number of research studies, “which at last count is over 68 studies have documented the reality of recovering forgotten memories of trauma.” At the same time, Brewin, Andrews, and Gotlib, conducted some research with adult survivors who recovered repressed memories and “discovered that the misremembering of childhood events is more often characterized by forgetting negative experiences that actually happened than it is by remembering ones that did not.”

3.6.3 Legal cases question the validity of recovered repressed memories

A number of legal cases emerged which were related to people who were being accused of sexual abuse that happened many decades earlier because the person who was abused recovered their memories many years after the actual incident took place. Lawson and Chaffin’s research reports two consistent findings which emerge from their research of child sexual abuse, and they found that “the problem is widespread and that child abuse is extensively undisclosed and underreported.” Park and Renner’s empirical research examines the content of 58 transcripts for the types of questions asked by the legal

154 Ibid,52.


representatives of child witnesses aged 4-13. “They affirmed that in all of the individual cases that the lawyers, particularly the defence lawyer, consistently exploited the children by asking them questions beyond their cognitive comprehension.”

Goodwin and colleague’s research reports that, “children rarely confabulate stories of abuse and offenders often convincingly argue that their accuser has falsely accused them.” In addition, Haugaard and Reppucci’s research study reports that, “the legal system has historically viewed children as the property of their parents and professionals have discounted womens’ reports of incestuous abuse as wishful fantasies.”

Clevenger’s research found that “the legal and mental health professionals have tended to be overly suspicious of and unresponsive to reports of sexual abuse.” Freyd’s research claims that “accused parents, many of whom were affluent and respected members of community sought out defence lawyers to act on their defence against abuse-related claims. A new concept, 'False Memory Syndrome,' was advanced by parents and professionals as an alternative explanation for delayed memories of sexual abuse, and in March 1992 the False Memory Syndrome Foundation was founded.”


162 See P. Freyd, “How do we know we are not representing pedophiles?” False Memory Syndrome Newsletter, 2 (March 1993): 2-3.

The false memory syndrome is challenged by Washburn’s psycho-spiritual model which affirms that the primal repression prevents adolescents’ from having any accessibility to their unconscious memories until the second half of adult life.

3.7 Ego and the Dynamic Ground—Adolescence and Adult Stages

Washburn’s adolescence stage continues to be a time of spiritual resistance, and a time of struggle to gain independence from their parents, while trying to forge their own identity. They face the fear of nothingness and guilt over striving for their independence.

3.7.1 Adolescence

According to Washburn, adolescence remains a time when the primal repression and spiritual resistance prevents the traumatic memories from being accessible. Adolescence marks the stage of many positive achievements and meaningful relationships. In adolescence, people occasionally report the occurrence of "peak experiences" as they strive for excellence by participating in aesthetic and athletic activities.\textsuperscript{164}

From a developmental perspective, the adolescent stage is a time of interior struggle and motivation to gain their own independence from their parents. Their quest to gain independence from their parents leads them to experience a dual internalized conflict of guilt and fear of nothingness. Fear of nothingness is directly related to their struggle to establish their own identity. As a result, in an effort to move away from their fear of nothingness they

\textsuperscript{164} A peak experience is a high point in the life of a self-actualizer and a time when they feel ecstatic and more fully alive.
“try on a variety of identity possibilities, but they do not really forge an identity.”\(^\text{165}\)

Washburn states that “adolescents seek to validate their self worth by seeking confirmatory identity recognition which they seek from their peers rather than their parents.”\(^\text{166}\) Positive identity development does not take place until early adulthood.

### 3.7.2 Adult Stage

According to Washburn’s adult stage there is a shift in the mental ego’s internal dialogue which transforms their initial fear of nothingness and guilt into feelings of meaning and worth. The internal dialogue aids the process which continues within them and leads them to a positive experience of identity construction. Washburn writes that, “the identity constructed in this way is always in process; it exists as an ongoing, ever-revisable, never-finished product of the mental ego’s self monitoring efforts.”\(^\text{167}\)

Occasionally, on the K4E when meeting with a patient who is in their early adult stage of life, they confide in me that there are certain beliefs and practices within their church that they no longer agree with. When people experience a sacred place in the context of the spiritual care setting, they feel unconditionally accepted, and are free to discover and name what it is that they still believe. Eventually, this patient will either be at peace to stay in their church and disagree with some of its teachings or they will have the peace and courage to change their place of worship.

In the second half of life, people who are at peace with their own spirituality or faith connection, adapt well to life’s challenges and find that their faith provides a constant source

\(^{165}\) Washburn, *The Ego and the Dynamic Ground*, 100.

\(^{166}\) Ibid, 103.

\(^{167}\) Ibid, 106.
of comfort and inner strength. However, some adults enter into the *dark night of the soul* experience where life appears to be meaningless or where all of their previous religious or spiritual beliefs are seriously questioned.

### 3.8 Washburn’s *Dark Night of the Soul*

Washburn describes the next stage in the developmental process as the *dark night of the soul* experience. As previously discussed, Washburn incorporates the Freudian and Jungian psychological perspective within his theoretical psycho-spiritual model of human development. Therefore, Washburn’s concept of the *dark night of the soul* follows directly after the Freudian primal repression lifts and ends a person’s decades of spiritual resistance. At this spiritual intersection, the Jungian psychological perspective accentuates a person’s new spiritual receptivity. It is important to reiterate that the lifting of the primal repression provides a time of optimum spiritual receptivity, which is contingent on each person’s free will and choice to move towards their spirituality as they enter into the difficult stages of *dark night of the soul* experience. There is an unspoken submission to this spiritual process that a person must go through to receive a potential experience of Washburn’s *regeneration in spirit*. The *dark night of the soul* experience consists of the *regression in the service of transcendence* Stage One which is a withdrawal from the world. The *regression in the service of transcendence* Stage Two highlights what I refer to as the U-turn when a person revisits their past traumatic events in the present tense and grieves their loss with an emotional release. After the U-turn a person often moves forward in the present tense with some new spiritual insight which is a parallel experience of Washburn’s *regeneration in spirit*. The second half of adult life provides the optimum time of spiritual receptivity for a person to re-
connect with the Dynamic Ground as the source of their spiritual life. Washburn affirms that the process from the dark night of the soul to regeneration in spirit begins with a season of spiritual desolation which he describes as the dark night of the soul experience.

Washburn describes the dark night of the soul experience as a time when people re-evaluate the meaning and purpose inherent within their individual experiences. In philosophical terms Washburn has this view: “The mental ego ceases feeling securely self-contained and protected from the overwhelming influences and increasingly feels cut off and empty and out of touch with life.”\textsuperscript{168} This feeling of emptiness and being out of touch with life is characteristic of people that request a spiritual care intervention. Therefore, I meet a number of patients who are experiencing spiritual emptiness. During this experience my spiritual care practice is to prayerfully listen to a patient’s pervasive themes of spiritual desolation as they re-visit their long-forgotten memories and events that have been “disturbing their spirit.” Dark night experiences often become the catalyst for a person to re-visit their past memories in the present tense. Ultimately, the dark night experience is a spiritually redemptive experience as a person moves from their interior darkness towards a new level of spiritual insight and reconnection with their spiritual source.

The Chinese word for crisis can connote either danger or opportunity.\textsuperscript{169} “For centuries religion and mythology have emphasized that human growth and positive change can arise from crisis and trauma.”\textsuperscript{170} Historically the dark night experience becomes an

\textsuperscript{168} Ibid, 118.


opportunity or catalyst for spiritual growth. Washburn’s *dark night of the soul* experience continues as the adult survivor enters into Washburn’s *regression in the service of transcendence* stages one and two.

### 3.9 Regression in the Service of Transcendence

Washburn’s psycho-spiritual model incorporates two distinct stages of the *regression in the service of transcendence* that are relevant from a theological and spiritual care perspective: Stage One and Stage Two.

#### 3.9.1 Regression in the Service of Transcendence Stage One

*Regression in the service of transcendence* stage one is a person’s withdrawal from the world. Washburn’s description of this stage is as follows: “The mental ego becomes apathetic, confused, and cut off and the world becomes barren, purposeless and out of reach. The mental ego, in a sense, loses its life, as it dies to the world.”171 Washburn explains *regression in the service of transcendence* stage one in the following way as “the mental ego feels as if it is in the presence of an oppressive gravity that draws the mental ego into an inner, dreadful unknown.”172 Washburn and other clinical psychologists and psychiatrists have encountered patients in a parallel experience to Washburn’s *regression in the service of transcendence* stage one. These patients were admitted into psychiatric units because they experienced a dramatic withdrawal from life and fear of the dreadful unknown. For some patients the *dark night* experience has been prolonged and it becomes so severe that it causes

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172 Ibid, 188-189.
them spiritual torment which leads them into a psychiatric state of clinical depression. Ken Culligan writes, “Here darkness is also used to describe their losses, real or symbolic, that are experienced in clinical depression.”173 It is during such a time that I met with the seven participants in this research study, as they were all in mental health crises and in a state of spiritual desolation and disconnection from their spiritual source or place of worship.

Patients in the midst of a parallel experience to Washburn’s regression in the service of transcendence stage one are often diagnosed with clinical depression while others have a psychiatric presentation of being mute or psychotic. Dr. John Welwood is a clinical psychologist and pioneer in integrating psychological and spiritual work and he describes Dr. Wilson Van Dusen’s work as a clinical psychologist with mentally ill patients. Patients in a mental health crisis often feel as if they are entering into a black hole experience. Welwood writes:

In the [black] hole one feels one has momentarily lost one’s self. What one intended is forgotten. What would have been said is unremembered. One feels caught, drifting out and weak. It is extremely important to know what people do when faced with encroaching blankness. Many must act to fill the empty space within. In all cases it must be filled up or sealed off.”174

Welwood’s account of Van Dusen’s clinical experience accurately describes what the inter-disciplinary team often observes as patients are admitted into the K4E with a clinical presentation of being psychotic or mute. Patients in this category might possibly be experiencing Washburn’s regression of the service of transcendence stage one or what Van Dusen refers to as the black hole experience. Washburn quotes Van Dusen’s description of

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the black hole experience: “These black holes are potentially restorative and creative wellsprings that pose no serious danger to those who experience them. Van Dusen, views black holes in the psychic space as points of contact between consciousness and the fertile depths of the soul.” Washburn notes that the second half of adult life is when people experience an optimum spiritual receptivity and return to their spiritual source. So, Washburn and Van Dusen are aware that patients who have a clinical presentation of psychosis or when they are mute that they might actually be entering into Washburn’s stages of the regression in the service of transcendence stage two which is the gateway to regeneration in spirit. New spiritual care insight is to recognize that when mental health patients are presenting as psychotic or mute that there is some potential opportunity to offer spiritual care.

3.9.2 Regression in the Service of Transcendence Stage Two

Due to a patient’s black hole experience and their possible experience of the regression in the service of transcendence stage two, a new spiritual dynamic unfolds as they remember their past traumatic events in the present tense. The primal repression which had previously acted as an invisible wall to keep the unconscious memories locked out and separated from a person’s conscious memories is now gone and there is no separation between a person’s conscious and unconscious spheres. Therefore a person is able to remember their past memories in the present tense. Washburn writes,

> When the primal repression is in place, the power of the Ground is restricted to the prepersonal unconscious and therefore, is discernibly present only in sleep and dreams. The lifting of the primal repression, however, liberates this power from its repressed, unconscious organization and allows it to re-enter the sphere of consciousness. Consciousness is supercharged with numinous energy, and consequently waking

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175 Washburn, Ego and the Dynamic Ground, 219.
experience is endowed with the eeriness and superabundance characteristic of dreams.\textsuperscript{176}

It is my responsibility as a spiritual care specialist to be cognizant and able to spiritually discern the distinctive features of black hole experiences, the regression in the service of transcendence stage one and two as a Level Three radical spiritual crisis. According to the general research data collection, 25 out of 30 patients’ initiated their own request for a spiritual care intervention, had emotional accessibility and were in a radical spiritual crisis. Examples of this are found in Chapter 4.

Physicians, theologians, and psychologists have experienced similar presentations in working with their patients in their own clinical practices, cases which run parallel to Washburn’s regression in the service of transcendence stage two. Donald Winnicott, the British pediatrician, child psychiatrist, and psychoanalyst, lived from 1896 to 1971. Much of his large output of work lives on and remains useful, stimulating, and much discussed within and well beyond the field of psychoanalysis.\textsuperscript{177} Kathryn Madden cites Donald Winnicott’s observation that “the fear of breakdown is the fear of a past event that has not yet been experienced in the present tense. Traces of the past events are carried around hidden away in the unconscious. One remembers by experiencing the past traumatic event in the present tense.”\textsuperscript{178} In theological terms Winnicott uses the term “ascensive” which illustrates the significance of the ascension of Christ in the Christian tradition. Winnicott observes that, “Christians momentarily enter into and experience the depths of sadness, despair, and

\textsuperscript{176} Ibid, 193.


hopelessness of the Good Friday experience. However, he also observes that the majority of Christians cannot stay in the depression of the Good Friday experience for too long. Most Christians prefer to focus on the ecstatic joy of the resurrection of Christ.” Winnicott’s “ascensive” analogy alerts the spiritual care specialist that most people are not able or willing to embrace the depths of their traumatic memories or to grieve their losses. Whenever a person is ready to embrace their own Good Friday experience then it is my spiritual care practice to offer them spiritual companionship in the context of a spiritual care intervention. St. Augustine contributes his own personal experience of the ascensive-depressive experience of spiritual transformation and restoration. As Henry Chadwick summarizes his experience:

As recorded in *Book Ten of St. Augustine’s Confessions*, he reflects on how the spirit is present to human beings and traces in some detail the soul’s journey to God. His memoria is a metaphor for the unconscious, where we find ourselves in the deepest halls of memory, we learn that what we mourn for and what memory strives for is the source of our wholeness. The soul, in these depths is reawakened to its primordial ground. St. Augustine tells us that what we long for is the soul we have been separated from at birth. We remain dissociated until God belongs to the soul in totality----- O truth everywhere.

From St. Augustine’s ascensive-depressive model, all seven participants in this research study were able to embrace the traumatic events of their own Good Friday experience and afterwards they went on to embrace their ascensive experience as they connected with the source of their spiritual life.

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179 Ibid, 32.

3.9.3 Washburn’s regression stage two observed as a U-Turn

Washburn offers a unique understanding of the inner-operational dynamics involved in relationship to his personal work and observations. Central to this model is the idea that the ego initially arose out of the Dynamic Ground. Washburn’s view of the nature and process of human development evolves from his observation that, “human beings tend to re-connect with their own unconscious memories which they left while they were growing up. He relates this regressive movement back to the Dynamic Ground as the catalyst for regeneration in spirit. Therefore, transpersonal psychology requires a return to the origins, before it can move on.”¹⁸¹ Michael Daniels summarizes Washburn’s model:

For Washburn, this voyage into the unconscious is not a psychotic breakdown, but represents a regression in the service of transcendence. Eventually, the ego learns to endure these experiences and to recognize them as expressions of the self’s own nonegoic¹⁸² core, it ceases the struggle against them. This change of attitude results in the ego becoming increasingly open to the positive potentialities of the nonegoic core. Washburn believes that this is the ego movement from the stage of regression in service of transcendence to that of regeneration in spirit. At this stage Washburn notes a definite change in a person’s attitude which results in spiritual rebirth, integration, religious ecstasy, love and a greater connection with other people.¹⁸³

My spiritual integration of what I refer to as the U-turn in my spiritual care practice, enables me to pinpoint the patients entry and exit points out of their previously unconscious memories. Washburn’s model is significant to this research study as it is my own spiritual care experience that patients’ briefly return and re-visit their original memories in order to grieve their losses. Washburn observes that the ego only re-visits and then moves forward to


¹⁸² Nonegoic core is another term used in Michael Washburn’s theory to represent the Dynamic Ground or source which is the fundamental source of psychic energy, instincts and creative imagination.

an experience of *regeneration in spirit*. I also agree with Washburn’s observation of *regression in the service of transcendence* stage two and the co-relationship between the ego’s re-visiting the original memories and then reconnecting with the Dynamic Ground. In the general research data collection 27 out of 30 patients reconnected back to their spirituality or place of worship. In seven cases this reconnection back to their spirituality or place of worship was sustained for one year. An overview from this research is found in Chapter 4.

### 3.10 Regeneration in Spirit

*Regeneration in spirit* is religious or spiritual terminology to describe a person’s spiritual transition from the *dark night* experience of spiritual desolation and spiritual disconnection to an experience of spiritual consolation or a spiritual reconnection back to their spiritual source or place of worship. Washburn refers to the *regeneration of spirit* in the following way:

“Once *regression in the service of transcendence* has returned the ego to the Dynamic Ground, a developmental reversal occurs: the *dark night* experience comes to an end and a period of psychic renewal begins. The period of regressive deconstruction is over and the ego enters a period of healing reconstruction, called *regeneration in spirit*.”

D.J. Hufford’s concept of spiritual transformation relates to the idea of “core spiritual experiences that show complex and consistent subjective patterns independent of cultural context which form a distinct class of experience with a stable perceptual pattern.”

An overview of the consistent spiritual care patterns recorded in Chapter 4.

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3.11 Spiritual Integration

Washburn offers a complex explanation of the stage of *spiritual integration*, but my focus in this section relates to the seven participants in this research study. Washburn writes that, “the *regeneration in spirit* is the process by which the two poles of the psyche are reconciled and united.”¹⁸⁶ Due to the seven participants’ parallel experience of *regeneration in spirit* they experienced a new spiritual perception with related symbols representative of this spiritual process. They found new meaning and purpose for living and focused on making meaningful changes related to their new spiritual reality. In this research project the seven participants in this study noted a parallel process of Washburn’s *spiritual integration* one year after their own experience of *regeneration in spirit*.

After the one year follow-up from the date of my initial spiritual care intervention, I received the research questionnaires from the seven participants. They answered the questionnaire to evaluate and name the critical spiritual transition points, including their reconnection back to their own spirituality or place of worship. The one year follow-up questionnaire defines their own process of spiritual integration within their new found spirituality or return to their place of worship. Most of the participants had new symbols or a new language to speak of their spiritual integration in an experiential way. Washburn cites the reconnection with the Dynamic Ground in the following way, “the ego beholds landscapes of new meaning as the inner nature of the object is imaginally-intuitively probed and disclosed.”¹⁸⁷ Washburn also writes that as a result of a person’s reconnection with the Dynamic Ground they experience visionary symbols: “Visionary symbols can also be

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¹⁸⁷ Ibid, 237.
contrasted with the images that arise during *regression in the service of transcendence* stage two and *regeneration in spirit*. They are creatively spawned images and insights that arise in the ego’s exploration of the unknown rather than manifestations that issue transcendentally from the unknown."  

Most of the participants in this study experienced new symbols of hope as a result of their parallel experience of Washburn’s *regeneration in spirit* and reconnection back to the Dynamic Ground. The process of *spiritual integration* and spiritual reconnection back to their spiritual source has improved the quality of life for the seven participants involved in this research study. All seven participants came to experience a new and positive self-perception and an entirely new perception of the divine within their experience. An overview of the seven cases is found in Chapter 4.

**Summary**

Chapter 3 introduces Washburn psycho-spiritual model and my integration of his last three spiritual stages as my internal spiritual care assessment tool. I share a brief psychological overview of the Freudian and Jungian integration into Washburn’s model as it pertains to a person’s times of spiritual resistance and optimum spiritual receptivity.

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188 Ibid, 239.
Chapter 4
Research Study Informs New Spiritual Care Practice

“Epiphanies appear to be in the nature of huge emotional displacements and rearrangements, ideas, emotions, and attitudes which were once the guiding forces of lives of these [people] are suddenly cast to one side. A completely new set of conceptions and motives begin to dominate them.” 189 Dr. William Silkworth

Chapter 4 provides an integration of Strauss and Corbin’s Grounded Theory as discussed in Chapter 1. In this chapter, I review the general research data collection from the thirty cases to discover the consistent themes, spiritual care patterns, and spiritual care assessment tools as this research data in conjunction with the specific information from the seven participants’ questionnaire answers inform my new spiritual care practice.

4.1 An Integration of New Spiritual Care Practices

Chapter 4 is an integration of new spiritual care practices that are specifically designed to counteract the six potential obstacles as discussed in the trauma research in Chapter 2. Chapter 4 provides a written and visual overview from the general research data collection of the consistent themes and spiritual care patterns as found in the data collection from the 30 patients. Strauss and Corbin’s Grounded theory has been consistently utilized to develop a "theory after" conclusion.

This chapter also provides an overview of my spiritual care intervention with each of the seven participants through a process and integration of quotes from the patient care notes, field notes, and their questionnaires, and the individual spiritual care analysis as it was

189 Cited in William R. Miller and Janet C’ de Baca, Quantum Change (New York: Guilford, 2001), 3.
written after each spiritual care intervention. The following is an overview of my action in ministry which essentially covers the research process in a more explicit way.

4.1.1 Action in Ministry

The action in ministry in this study is to evaluate the evolving spiritual care methodology from a patient’s perspective. The Grounded Theory is a unique research method which evolves into a theory-after conclusion. Initially, spiritual care was offered to thirty mental health patients with a history of childhood abuse who were in-patients on K4E. All of these patients are now psychiatrically stable and have been discharged from the hospital. Ten of these thirty patients changed their place of residence and could not be reached for this research study.\(^\text{190}\) Seven former patients completed the questionnaire answers which are integrated into this chapter.

The evolving spiritual care methodology is essentially based on a review of the trauma and spiritual and religious coping research to assess the aftermath of their past abuse and to determine their specific spiritual care needs. The spiritual and religious coping research highlights the fact that adult survivors who are spiritually receptive to embrace their spirituality or place of worship appear to find resilience through their spirituality or religious connections to cope with the aftermath of their abuse.

4.1.2 Structure of the Analysis

I have chosen to structure the research analysis in two stages. Analysis Part One summarizes the results from the twenty-three cases as found in the general research data collection with an overview of the general themes and consistent spiritual care patterns as found under the

\(^{190}\) A copy of the consent form and questionnaire questions is found in Appendix E.
heading General Research Data Findings from the 23 Cases. The categories from the research data collection are as follows: (1) Spiritual Crisis and Spiritual Receptivity; (2) Past Abuse and Spiritual Disconnection; (3) Spiritual Crisis, emotional accessibility, and patient initiated visit; (4) New Spiritual Insight and Reconnection back to their Spirituality or Place of Worship; (5) Longer Duration for spiritual care intervention and within One to Three spiritual care interventions; (6) Symbolism within the context of the spiritual care intervention; (7) Remembering, Re-Visiting and Restoration; (8) Spiritual Assessments of regression in the service of transcendence stage one; (9) Spiritual Assessments of regression in the service of transcendence stage two; (10) Francis soul loss with soul recovery assessment tool; (11) Francis’ soul loss without soul recovery assessment tool; (12) Patients in the second half of adult life; (13) Emotional Release as a spiritual care dynamic. Also, included in Analysis Part One is an overview and spiritual care analysis of the spiritual care interventions with the seven participants’ and their evaluation of my spiritual care methodology as found in their questionnaire answers. These spiritual care interventions incorporate an integration of Francis’ and Washburn’s spiritual care models to identify the multiple spiritual care assessments as they take place throughout the various stages of each spiritual care intervention.

The overview from the seven individual cases provides a validity check of the consistent themes and spiritual care patterns as found within the 23 cases. Each of the seven cases is numbered under the following headings: (1) Total Number of Visits (2) Physiological needs; (3) Emotional and Spiritual needs; (4) A Review of Accessed Memories; (5) New Spiritual Care Insight; (6) Current Emotional and Spiritual Status. The Questionnaire answers are

191 I do not use any personal information for these 23 cases.
interspersed appropriately for each case. I also include my spiritual care assessments for the seven cases by integrating Francis’ and Washburn’s spiritual care assessment tools. A visual chart reveals the outcome for the thirty cases of common themes and spiritual care patterns.

Analysis Part Two is an exploration of the general themes and spiritual care patterns as found within the research data: (1) Spiritual Crisis and Opportunity as Understood through Washburn’s psycho-spiritual model; (2) Abuse and Spiritual Disconnection; (3) Spiritual Crisis: emotional accessibility and patient initiated visits; (4) New Spiritual Insight reconnects adult survivors back to spirituality or place of worship; (5) Longer spiritual care interventions and only one to three visits; (6) Symbolism; (7) Re-visiting, Remembering and Restoration.

Throughout the general data research collection process as mentioned in Chapter 1, I have been integrating Strauss and Corbin’s Grounded Theory. The ultimate goal is to develop a theory after model which is based on the general spiritual care patterns, themes, and spiritual care assessments that are consistent within the thirty cases.

4.2 Mental Health Disorders and Types of Abuse

4.2.1 Mental Health Disorders of Adult Survivors’ in the Study

The participants in this study have psychiatric diagnoses of anxiety disorders, bi-polar disorders and clinical depression. Below is a list of all the relevant definitions to describe the mental health disorders and subsequently there is an overview of the seven definitions of abuse.

There are three underlying mental disorders that relate to this project: Anxiety Disorder, Bi-polar Disorder and clinical depression. Anxiety disorder is a cover term for a variety of
mental disorders in which severe anxiety is a salient symptom.\textsuperscript{192} Bi-polar disorder includes intermittent alternative episodes of mania and high energy and also times of depression which also drains the patient’s energy and greatly debilitates the patient’s quality of life. Clinical depression that is severe as to be considered abnormal, either because of no obvious environmental causes, or because the reaction to unfortunate life circumstances is more intense or prolonged than would generally be expected. \textsuperscript{193}Before beginning this review I will provide the relevant definitions of the mental health disorders and the seven types of abuse as relevant to the thirty patients.

\textit{4.2.2 Definitions of Abuse}

The following six definitions belong to the Cross Creek Family Counselling on-line. I have chosen to include a brief summary of the six definitions because they describe the types of abuse that are relevant to the seven participants involved in the Part One Analysis. The definition of religious abuse is taken from the Religious and Spiritual Abuse registered office in England and Wales.\textsuperscript{194}

There are seven types of abuse that relate to this project: Physical Abuse, Sexual Abuse, Tactile Abuse, Existence Abuse, Religious or Cult Abuse, Emotional Abuse and Psychological Abuse. \textit{Physical} Abuse includes beatings in the guise of corporal punishment but which are delivered with fists or to the child’s head. \textit{Sexual} abuse includes incest and rape. \textit{Tactile} abuse and \textit{Existence} abuse are directly related to parental rejection where the existence and rights of the child are ignored. \textit{Emotional} abuse is viewed as a refusal,

\textsuperscript{192}WordNet 3.0 (Princeton University, 2006).


\textsuperscript{194}This definition of religious and spiritual abuse is taken from the Registered Office: The Gables Bishop Meadow Road, Loughborough, Leics, LE11 5RQ Company registered in England and Wales 2012.
unwillingness, or inability to express love. *Psychological* abuse includes a refusal to value or to make eye contact with the child over a long period of time and the constant criticism of a trivial and unjustified nature.\(^{195}\)

The following definition of *Religious* and *Cult* abuse is taken from the Religious and spiritual abuse registered office in England and Wales. Religious and spiritual abuse occurs when a victim is prevented from carrying out their religious or spiritual practices or when they are forced to engage in activities that are in conflict with their beliefs.\(^{196}\)

### 4.3 General Research Data Findings from the 23 Cases

The following case studies reflect an overview from the 23 cases as found within the general research data collection. Seven subsequent cases confirm consistent themes, spiritual care patterns and spiritual care assessments throughout the thirty cases and a visual overview is also provided in this chapter.

Case One is a 19 year old female patient with a history of religious abuse. The general research data collection confirms that she fits the criteria of the following consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of three ninety minute spiritual care interventions. During the first two spiritual care interventions I assessed her with Francis’ Soul Loss: Stages 2-4 abuse, disconnection, loss of meaning. During the third spiritual care intervention she entered into Francis’ Soul Recovery: Stages 7-8 remembering and emotional

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\(^{196}\) This definition of religious and spiritual abuse is taken from the Registered Office: The Gables Bishop Meadow Road, Loughborough, Leics, LE11 5RQ Company registered in England and Wales 2012.
catharsis. She also entered into Washburn’s *regression in the service of transcendence* stage two and she received an emotional release and reconnected with her spirituality and received a new symbol of hope.

Case Two is a 41 year old female patient with a history of sexual abuse and a history of suicidal attempts. The general research data collection confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of three ninety minute spiritual care interventions. During the first two spiritual care interventions, I assessed her with: Francis’ Soul Loss: Stages 2-4 abuse, disconnection, loss of meaning. During the third spiritual care intervention she entered into Francis’ Soul Recovery: Stages 7-8 remembering, emotional catharsis and Washburn’s *regression in the service of transcendence* stage two and she received an emotional release. She reconnected back to her spirituality and experienced a symbol of hope.

Case Three is a 59 year old male patient with a history of emotional abuse. The general research data collection confirms that he fits the criteria and these consistent themes: he requested his own spiritual care intervention, he had emotional accessibility, and he was in a spiritual crisis. I had a total of two spiritual care interventions lasting sixty minutes. During both spiritual care interventions I assessed him with Francis’ Soul Loss: Stages 2-5 abuse, disconnection, loss of meaning, and loss of identity. I also assessed him with Washburn’s *regression in the service of transcendence* stage one and Francis’ soul loss without soul recovery. He was discharged from the hospital mentally stable, but in a state of soul loss without soul recovery.
Case Four is a 43 year old male patient with a history of emotional abuse and a number of suicide attempts. The general research data collection confirms that he fits the criteria and these consistent themes: he requested his own spiritual care intervention, he had emotional accessibility, and he was in a spiritual crisis. I had a total of three spiritual care interventions which lasted ninety minutes each. During my first two spiritual care interventions I assessed him with Francis’ Soul Loss: Stages 1-5 deprivation, abuse, disconnection, loss of meaning and loss of identity. During the third spiritual care intervention he entered into Francis’ Soul Recovery 7 and 8 remembering and emotional catharsis. He also entered into Washburn’s *regression in the service of transcendence* stage two and he experienced an emotional release. He reconnected with his spirituality and received a new symbol of hope.

Case Five is a 24 year old female with a history of sexual abuse and other childhood traumas and suicide attempts. I received a referral for spiritual care. I had a total of one spiritual care intervention which lasted ninety minutes. I made a spiritual care assessment of Francis’ Soul Loss: Stages 2-3 abuse, disconnection and she entered into Francis’ Soul Recovery: Stages 7-8 remembering and emotional catharsis. She entered into Washburn’s *regression in the service of transcendence* stage one and two and grieved her losses with an emotional release and she reconnected back to her Jewish faith and had a new symbol of hope.

Case Six is a 46 year old female patient with a history of abandonment, physical, emotional, sexual, and religious abuse. The general research data collection confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of one spiritual
care intervention which lasted ninety minutes. I assessed her with Francis’ Soul Loss: Stages 1-5 deprivation, abuse, disconnection, loss of meaning and loss of identity. Within the same spiritual care intervention she entered into Washburn’s *regression in the service of transcendence* stage one which is a withdrawal from the world. She was discharged from the hospital mentally stable, but in a state of soul loss without soul recovery.

Case Seven is a 63 year old female patient with a history of emotional abuse. The general research data collection confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of two spiritual care interventions which lasted ninety minutes each. During the first spiritual care intervention I assessed her with: Francis’ Soul Loss: Stages 2-4 abuse, disconnection and loss of meaning. She entered into Washburn’s *regression in the service of transcendence* stage one which is a withdrawal from the world. During the second spiritual care intervention I assessed her with: Francis’ Soul Recovery: Stages 6-9 longing for connection, remembering, emotional catharsis, authenticity and empowerment. Afterwards she entered into Washburn’s *regression in the service of transcendence* stage two and she grieved her losses with an emotional release. She reconnected back to her spirituality and received a symbol of hope.

Case eight is a 67 year old female patient with a history of sexual and religious abuse. The general research data collection confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of one spiritual care intervention which lasted ninety minutes. I assessed her with: Francis’ Soul Loss: Stages 2-4 abuse, disconnection, loss of meaning and Francis’ Soul Recovery 6-8 longing for connection, remembering and
emotional catharsis. She entered into Washburn’s regression in the service of transcendence stage two, and grieved her losses with an emotional release and reconnected back to her spirituality.

Case nine is a 52 year old male patient with a history of emotional abuse. I had a total of one spiritual care intervention which lasted ninety minutes. The general research data collection confirms that he fits the criteria and these consistent themes: he requested his own spiritual care intervention, he had emotional accessibility, and he was in a spiritual crisis. I made a spiritual care assessment of Francis’ Soul Loss: Stages 2-4 abuse, disconnection, loss of meaning and Francis’ Soul Recovery: Stages 7-8 remembering and emotional catharsis. He entered into Washburn’s regression in the service of transcendence stage two and grieved his losses with an emotional release and afterwards, he received some spiritual insight and he reconnected back to his place of worship.

Case ten is a 46 year old male patient with a history of emotional abuse. He was in a spiritual crisis and I received a referral and had one ninety minute spiritual care intervention. I made a spiritual care assessment of Francis’ Soul Loss: Stages 2-4 abuse, disconnection, loss of meaning and Francis’ Soul Recovery Stages 7-8 remembering and emotional catharsis. He entered into Washburn’s regression in the service of transcendence stage two and grieved his losses with an emotional release and afterwards, he reconnected with his spirituality and received a new symbol of hope.

Case eleven is a 38 year old female patient with a history of emotional abuse. The research data confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of two spiritual care interventions which lasted ninety minutes each. She
entered into Washburn’s *regression in the service of transcendence* stage two and grieved her losses with an emotional release and afterwards, she received some new spiritual insight and reconnected back to her spirituality.

Case twelve is a 45 year old female patient with a history of psychological abuse. I followed up on a referral from her psychiatrist. She had emotional accessibility, and was in a spiritual crisis. I had one ninety minute spiritual care intervention. I assessed her with Washburn’s *regression in the service of transcendence* stage two and she grieved her losses with an emotional release. Afterwards she received some spiritual insight, a new symbol of hope and reconnected back to her spirituality.

Case thirteen is a 44 year old female patient with a history of existence abuse. The general research data collection confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had one spiritual care intervention which lasted ninety minutes. I assessed her with Francis’ Soul Loss: Stages 2-4 abuse, disconnection, loss of meaning and Francis’ Soul Recovery 7-8 remembering and emotional catharsis. She entered into Washburn’s *regression in the service of transcendence* stage two and she grieved her losses with an emotional release. She afterwards received some spiritual insight and reconnected with her spirituality and received a new symbol of hope.

Case fourteen is a 50 year old female patient with a history of existence, physical beatings, and sexual abuse. The general research data collection confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of one spiritual care intervention which lasted ninety minutes. I assessed her with Francis’ Soul Loss: Stages 1-4
deprivation, abuse, disconnection, loss of meaning and Soul Recovery Stages 7-8 remembering and emotional catharsis. She entered into Washburn’s regression in the service of transcendence stage two and she grieved her losses with an emotional release. She received some new spiritual insight and a reconnection back to her spirituality.

Case fifteen is a 33 year old female patient with a history of existence and sexual abuse and suicide attempts. The general research data collection confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of two spiritual care interventions which lasted ninety minutes each. During my first spiritual care intervention I made a spiritual care assessment of Francis’ Soul Loss: Stages 2-4 abuse, disconnection, and loss of meaning. During my second spiritual care assessment I assessed her with Francis’ Soul Recovery: Stages 7-8 remembering and emotional catharsis. She entered into Washburn’s regression in the service of transcendence stage two and she grieved her losses with an emotional release. She received some new spiritual insight, a new symbol of hope and a reconnection back to her spirituality.

Case sixteen is a 52 year old male patient with a history of sexual abuse. The research data confirms that he fits the criteria and these consistent themes: he requested he own spiritual care intervention, he had emotional accessibility, and he was in a spiritual crisis. I had a total of one spiritual care intervention which lasted ninety minutes. I made a spiritual care assessment of Francis’ Soul Loss: Stages 2-4 abuse, disconnection, loss of meaning and Francis’ Soul Recovery stages 7-8 remembering and emotional catharsis. He entered into Washburn’s regression in the service of transcendence stage two and he grieved his losses
with an emotional release. He received some new spiritual insight, a new symbol of hope and a reconnection back to his place of worship.

Case seventeen is a 43 year old female patient with a history of emotional abuse and several suicide attempts. The general research data collection confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of three spiritual care interventions which lasted ninety minutes to two hours for each intervention. During my first two spiritual care interventions I made a spiritual care assessment of Francis’ Soul Loss: Stages 2-4 abuse, disconnection, loss of meaning. During the third spiritual care intervention I assessed her with Francis’ Soul Recovery: stages 6-8 longing for connection, remembering and emotional catharsis. She entered into Washburn’s regression in the service of transcendence stage two and she grieved her losses with an emotional release. She received some new spiritual insight and reconnected with her spirituality.

Case eighteen is a 59 year old male patient with a history of religious abuse. The general research data confirms that he fits the criteria and these consistent themes: he requested his own spiritual care intervention, he had emotional accessibility, and he was in a spiritual crisis. I had a total of one spiritual care intervention which lasted ninety minutes. I made a spiritual care assessment of Francis’ Soul Loss: Stages 1-5 deprivation, abuse, disconnection, and loss of meaning and loss of identity. I assessed him with Francis’ soul loss without soul recovery. He was discharged from the hospital mentally stable but in a state of soul loss without soul recovery.

Case nineteen is a 35 year old female patient with a history of existence and psychological abuse. I received a spiritual care referral from her nurse. She had emotional
accessibility, and was in a spiritual crisis. I had a total of three spiritual care interventions which lasted ninety minutes each. During my first two spiritual care interventions I made a spiritual care assessment of Francis’ Soul Loss: Stages 2-4 abuse, disconnection, and loss of meaning. During my third spiritual care intervention I assessed her with Francis’ Soul Recovery: Stages 7-8 remembering and emotional catharsis. She entered into Washburn’s regression in the service of transcendence stage two and she grieved her losses with an emotional release. She reconnected with her spirituality and received a new symbol of hope.

Case twenty is a 67 year old female patient with a history of existence, emotional, physical, and sexual abuse. The general research data collection confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of one spiritual care intervention which lasted two hours. I made a spiritual care assessment of Francis’ Soul Loss: Stages 1-3 deprivation, abuse, and disconnection and Francis’ Soul Recovery: Stages 6-8 longing for connection, remembering and emotional catharsis. She entered into regression in the service of transcendence stage two and she grieved her losses with an emotional release. She received some new spiritual insight, reconnected with her spirituality and received a new symbol of hope.

Case twenty-one is 27 year old female patient with a history of emotional abuse. The general research data collection confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of one spiritual care intervention which lasted ninety minutes. I made a spiritual care assessment of Francis’ Soul Loss: Stages 2-3 abuse and disconnection and Francis’ Soul Recovery: Stages 6-8 longing for reconnection,
remembering and emotional catharsis. She entered into \textit{regression in the service of transcendence} stage two and she grieved her losses with an emotional release. She reconnected with her spirituality and experienced a new symbol of hope.

Case twenty-two is a 40 year old female patient with a history of psychological abuse. The research data confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of one spiritual care intervention which lasted ninety minutes. She entered into \textit{regression in the service of transcendence} stage two and she grieved her losses with an emotional release. She experienced a new symbol of hope and reconnection back to her place of worship.

Case twenty-three is a 26 year old female patient with a history of sexual abuse. The general research data collection confirms that she fits the criteria and these consistent themes: she requested her own spiritual care intervention, she had emotional accessibility, and she was in a spiritual crisis. I had a total of one spiritual care intervention which lasted ninety minutes. She entered into \textit{regression in the service of transcendence} stage two and she grieved her losses with an emotional release. She received some new spiritual insight and she reconnected back to her spirituality. This concludes the overview of the 23 cases from the general research data collection. Spiritual Care Analysis Part One continues with a review of the seven cases.

\textbf{4.4 Spiritual Care Analysis Part One: Seven Cases Reviewed}

In this research study each patient was previously an in-patient on the K4E. They were admitted into the K4E and each patient in this study was receiving and continues to receive
psychiatric treatment and medication. They also received appropriate holistic interventions from members of the inter-disciplinary team, as mentioned earlier in the thesis. It has always been my perception that holistic healing requires the expertise of every professional discipline in order for patients to experience wellness in every dimension of their being. Spiritual care specialists’ make an assessment of past and present trauma, spiritual distress, spiritual pain, suffering, grief and loss.”197 A review of my role as spiritual care specialist on K4E is found in Chapter 1.198

Spiritual companionship with the adult survivor allows them to re-visit their past trauma in the present tense and to grieve their losses. It is not part of my spiritual care practice to ask or probe the patient to disclose their past trauma, but at times they share their traumatic memories. Whenever this happens, I incorporate a non-directive spiritual care model as I am specifically trained to listen at the unconscious and spiritual level if they choose to disclose their past trauma, soul secrets, or distorted beliefs which might be the source of their spiritual desolation. Within these seven cases, each adult survivor was experiencing a radical spiritual crisis and they were also disconnected from their spirituality or place of worship.

Case One: Adam-Creating A Sacred Place: Spiritual Care Analysis

Throughout this spiritual care intervention, I have consciously created a sacred place with prayers for spiritual direction, an authentic relationship of unconditional acceptance and empathy in a non-judgmental environment using a non-directive paradigm. An integration of Francis’ external spiritual care assessment tools and Washburn’s internal spiritual care

197 CASC/ACSS Manual, 3.

198 Each patients’ anonymity is maintained throughout this thesis.
assessment tools helped me to make the significant spiritual care assessments as I was able to prayerfully listen and pinpoint each stage as it unfolded in this spiritual care intervention.

1. **Total Number of Visits:** **Only one spiritual care intervention with Adam**

Adam is a 40 year old patient who requested his own spiritual care intervention and shortly thereafter he made a statement that I will never forget. Adam describes his life in the following words “I felt that I have committed spiritual suicide about six or seven times.” He further describes explicitly what he experienced: “When I actually realized my state of spiritual suicide and named it—in a spiritual way I was “jumping off of the bridge.”

Adam’s Questionnaire states the following: **What was the turning point for you and how did it impact you at the time of the spiritual care intervention?** “When I actually realized my state of spiritual suicide and named it—in a spiritual way I was “jumping off of the bridge.” Adam’s description of spiritual suicide reflects Francis’ description of soul murder which is “a disconnection from self, others and God.”

I also made a spiritual assessment of Washburn’s regression in the service of transcendence stage one. Adam’s Questionnaire states the following: **What issue or situation made you ask for a visit from the Chaplain?** “I felt sadness, depression and spiritual suicide.”** How were you feeling**

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199 Adam’s words as transcribed from the patient care notes.

200 Ibid.

201 Adam’s questionnaire one year later.

202 Francis, 47.

203 Adam’s questionnaire one year later.
and what did you experience before your meeting with the Chaplain? “I felt very sad.”

2. Physiological Needs

Aside from Adam’s personal account of “spiritual suicide” he was also experiencing what the trauma research refers to as rejection sensitivity as discussed in Chapter 2. Vivid memories of rejection are pervasive themes in Adam’s story. Adam’s failed relationships led him to contemplate spiritual suicide numerous times. Creating a non-judgmental atmosphere of unconditional acceptance helped to establish a relationship of trust with Adam.

Adam’s Questionnaire states the following: How did you feel during the spiritual care intervention? “I was able to release my feelings and she listened so that I felt that she cared.” He was free to trust me and he relaxed in the experiential knowledge that he was unconditionally accepted in this sacred place. As discussed in Chapter 2 this new spiritual care methodology is specifically designed to counteract the six potential obstacles that might prevent effective spiritual care from taking place.

3. Emotional and Spiritual Needs - Emotional Release

Non-directive spiritual care invited Adam to feel safe, not rushed or interrupted. As I provided an environment of unconditional acceptance and empathy he felt free to unburden his heavy-laden soul which had carried layers of spiritual crisis and humiliating memories. Prayerful listening to Adam at the third level helped him to access, re-visit and grieve his

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204 Ibid.

205 Ibid.
losses. Adam invited me to share his “soul secrets” as I was comfortable with his heart-wrenching memories. He expressed his anguish, tears, humiliation and grief. During this time Adam shared his vivid memories and experiences that had taken place decades ago. Adam’s Questionnaire states the following: **What helped or enabled you to share your experiences with the Chaplain?** “She listened to me. I was very sad, depressed and grieving—I missed my Dad.”

When these original traumatic events actually took place many decades ago Adam was traumatized but his emotional expressions were muted and not shared until this spiritual care intervention. Adam begins to share his past memories in the present tense and my spiritual assessment is that Adam is entering into a parallel experience to Washburn’s regression in the service of transcendence stage two. According to Washburn’s model this stage could potentially lead a person to a spiritual experience of regeneration in spirit.

As I prayerfully listen to Adam, he shared his long-forgotten and earliest traumatic memories. Adam was comfortable and able to re-visit the previously unconscious memories of his formative years. These memories had disturbed Adam’s spirit or caused him spiritual unrest even though he was not consciously aware of it. Unconscious memories from childhood were accessed during this visit and he was able to remember, name, re-visit, and grieve his losses with an emotional release. Adam invited me to re-visit his four traumatic past events in this sacred place where he felt unconditionally accepted and welcomed. Emotionally devastating memories were beginning to surface.

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206 Freud’s Theory of Personality has three levels of awareness: “conscious – aware nce, preconscious which is retrievable information, and the unconscious in which a person has no immediate access or insight to discern what is happening within them.”

207 Adam’s questionnaire one year later.
4. A Review of Accessed Memories

Adam entered into what I refer to as the U-Turn which is the entry point of what Washburn defines as the *regression in the service of transcendence* stage two which means that Adam is remembering and re-visiting his past traumatic events in the present tense. Kathryn Madden cites Winnicott’s observation that, “the fear of breakdown is the fear of a past event that has not yet been experienced in the present tense. Traces of the past events are carried around hidden away in the unconscious. One remembers by experiencing the past traumatic event in the present tense.”²⁰⁸

First Adam took me back to his earliest memory which was previously inaccessible to him. Adam said, “my peers at school would abuse me by talking down to me, calling me names, beating me up and then, they threw my clothes into the toilet.”²⁰⁹ Adam says that “I felt unworthy and rejected.”²¹⁰ His first memory evoked words that reflect the distortion in his belief system as he was being bullied by his peers. Vivid memories re-surfed as he received repeated beatings from his peers. Afterwards they humiliated him by throwing his clothes into the toilet. As I listened to Adam, I empathized with Adam’s humiliation and I felt compassion for Adam’s experience.

The second memory he accessed was his parent’s divorce and this was a traumatic event to an impressionable young person. Adam said, “I wonder whether I was in any way responsible for this event.”²¹¹ During the original event Adam’s soul was in turmoil and he

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²⁰⁹ Adam’s words transcribed from the patient care notes.

²¹⁰ Ibid.

²¹¹ Adam’s words transcribed from the patient care notes.
was not able to find the words to express his sense of loss. Now the only way that Adam expresses his grief is to say that “something inside me died.” 212 Adam says: “I find people who I think will be friends with me, but they all leave me.” 213 When Adam’s parents’ divorced he said, “I went to live with my father.” 214 He treasured his relationship with his father and had visits with his mother. Adam made the best of it, but he carried this unnamed ache within him.

The third memory he accessed is the traumatic shock of his father’s death on his fourteenth birthday. Re-visiting this memory with Adam invited me to prayerfully listen and empathize with the full impact Adam’s shock when he walked in from school to celebrate his fourteenth birthday with his father. He said “I called out for my father but there was no response. Then I found him on the floor in the bathroom and I called 911 and paramedics showed up, but it was too late as my father was already dead.” 215 Adam said, “I wish that I had died when my father died.” 216 He also said that “I lost my father’s love when he died.” 217 My own spiritual care awareness in listening to Adam is that his life was devastated with grief due to the shock and traumatic death of his father. His world no longer made any sense to him and he was overwhelmed and felt as if he had lost his own meaning and purpose for living. Adam’s loss of identity was also compromised as his whole world was turned upside down through this process of transition. Adam’s life changed dramatically as he went

212 Ibid.
213 Ibid.
214 Ibid.
215 Ibid.
216 Ibid.
217 Ibid.
through the painful transitional process of grief and had to adapt anew to living with his mother.

Living and adapting to life with his mother was not easy, and he concluded, “I wanted to find a way out.” Adam’s fourth memory happened as “I sent my application to join the military because it was my childhood dream, but I was rejected from the military.” An accumulation of these four traumatic experiences caused Adam to experience what he refers to as spiritual suicide. The following is my spiritual care assessment: Francis’ Soul loss: Stages 1-5 deprivation, abuse, disconnection, loss of meaning, and loss of identity.

Francis’ Soul Recovery: Stages 7-8 remembering and emotional catharsis. As Adam was grieving his losses, I was praying that he would have a new perception of his trauma. Adam cried his tears and expressed his pain. In Adam’s questionnaire answer he wrote: What helped or enabled you to share your experiences with the Chaplain? “She listened to me. I was very sad, depressed and grieving—I missed my Dad.” Adam’s final memory concludes as he exits the U-Turn and he returns to the present tense. Adam’s Questionnaire states the following: How did you feel during this spiritual care intervention? “I was able to release my feelings and she listened so that I felt that she cared.” Adam’s new perception of himself is transformed because he experienced a new symbol of himself as being a “courageous spiritual soldier.” Adam’s previous sense of despondency and hopelessness about himself was radically transformed as he receives a new self perception which leads him to find some new spiritual hope. Did your life change as a result of this

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218 Ibid.
219 Adam’s questionnaire one year later.
220 Ibid.
221 Ibid.
spiritual care intervention? If so, how? “I view my life as having the “courage of a
soldier.” Having courage and peace inspires hope for the future. I know that my Dad still
loves me.” Francis’ Soul Recovery: 9-10 authenticity and empowerment and meaning
and mission. This stage also parallels Washburn’s regeneration in spirit.

5. New Spiritual Insight

Adam’s Questionnaire states the following: Did you experience any new emotional or
spiritual awareness? If so, explain. “Yes, I now envision myself as having the spiritual
courage of a soldier. I know that my father’s love did not die when he died.”

6. Adam’s Current Emotional and Spiritual Status

Adam lives with courage and peace which inspires hope.

Case Two: Ann—Creating A Sacred Place: Spiritual Care Analysis

First & Second Visits with Ann – Summary of this Visit

Throughout this spiritual care intervention, I have consciously created a sacred place with
prayers for spiritual direction, an authentic relationship of unconditional acceptance and
empathy in a non-judgmental environment using a non-directive paradigm. An integration of
Francis’ external spiritual care assessment tools and Washburn’s internal spiritual care
assessment tools helped me to make the significant spiritual care assessments as I was able to
prayerfully listen and pinpoint each stage as it unfolded in this spiritual care intervention.

1. Total Number of Visits: I had a total of three spiritual care interventions with Ann.

222 Ibid.

223 Adam’s questionnaire one year later.
Due to the fact that I had three separate spiritual care interventions with Ann, at times I discern the same spiritual care needs within the context of each individual spiritual care intervention. In Ann’s case I have just summarized visits one and two together and noted her spiritual care needs under the three headings. I had a total of two in-patient spiritual care interventions with Ann, age 42 yrs old while she was a patient on K4E.

2. **Physiological Needs**  
3. **Emotional and Spiritual Needs**  
3. **Accessed Memories.**

During spiritual care interventions one and two, Ann re-visited her past traumatic events as she disclosed her emotional and psychological abuse as she said “My parents always put me down, I was not allowed to make any choices and my parents did not want to hear from me. I lived in fear and did not say a word.” As I listened to Ann it appears that she feels that her voice was muted because her parents did not want to hear from her. Ann said, “I was sexually abused by one of my relatives during my adolescent years.” She was so distraught, and I empathized with her, but she did not share anything else about this event. Ann was not ready to enter into her memory and I respected her personal space in keeping with my non-directive model.

Ann’s voice was muted throughout her life but it is clear that she has a number of unspoken existential questions about why all of these events have transpired in her life. Her unspoken question appears to be: Why did I have to be abused? Ann experiences a loss of meaning and hope in the midst of her spiritual desolation. Spiritual desolation means that Ann is “disconnected from herself, others and God.” During these two spiritual care

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224 Ann’s words as transcribed from the patient care notes.  
225 Ibid.  
226 Francis, 47.
interventions with Ann I assessed her with Francis’ Soul Loss: Stages 1-4 deprivation, abuse, disconnection and loss of meaning which is soul loss without soul recovery, so I gave her my business card in case she wanted to receive some extra spiritual care. Before Ann was discharged from the hospital she received some follow up crisis support contact information. I did not hear from her for several years. Then, one day Ann placed a phone call to me while I was at work.

2. Physiological–Safety Needs

Because this is my third spiritual care intervention with Ann, I have noted her specific area of physiological–safety needs as a primary focus. Each new spiritual care intervention begins with a new assessment of the prominent ways I am creating a sacred place in the spiritual care setting.

Several years later, after being discharged from the hospital Ann placed a phone call to me because she was in a state of crisis and she was passively suicidal and very disconnected from herself, others and God.²²⁷ Ann’s Questionnaire states the following:

**What issue or situation made you ask for a visit from the Chaplain?** “I was suicidal and Mary Ann said to call whenever I needed help.”²²⁸ Ann kept saying that she wanted to “fade away and die” but Ann is now reaching out for help so, it is fair to summarize that Ann does not want to die. **How were you feeling and what did you experience before your meeting with the Chaplain?** “Suicidal.”²²⁹ Ann was, in fact, starving herself because she felt that she did not have the right to exist. She said “I am tired of being fearful and lonely all the

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²²⁷ Passively suicidal is my own description Ann’s starvation as she wanted to “fade away and die.”
²²⁸ Ann’s questionnaire one year later.
²²⁹ Ibid.
time.” What was life like for you before this spiritual care intervention? “I felt lonely and isolated.” Ann kept calling herself “a parasite.” During this crisis intervention Ann was in a radical spiritual crisis and exhibiting Francis’ Soul Loss: Stages 1-5 deprivation, abuse, disconnection, loss of meaning and loss of identity—as she wants to “fade away and die.” She is also experiencing a parallel to Washburn’s regression in the service of transcendence stage one which is distinctly discerned as person’s desire to withdraw from the world.

My previous years of training and experience as a Telecare counsellor at a distress center had prepared me for this crisis intervention with Ann. Her physiological needs were enormous as she was physically and mentally deteriorating due to a complete inability to care for herself. Emotionally, she was in such a crisis that she was barely able to reach out for the life-sustaining help that she needed. Her spiritual needs at this particular moment were to stay alive as she barely had the will to live.


Listening to Ann’s emotional devastation and tears over the phone evoked a compassionate response. It became apparent to me that Ann did not want to have to struggle with her mental health disorder anymore. Ann’s Questionnaire states the following: How were you feeling and what did you experience before your meeting with the Chaplain? “Suicidal.” She said “I am tired of being fearful and lonely all the time.” “I felt lonely and isolated.” She

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230 Ibid.

231 Ann’s words as transcribed from the patient care notes.

232 Ibid.

233 Ibid.

234 Ann’s questionnaire one year later.
wanted to be successful, working at a full time job. Ann needed to grieve her losses, so I listened to her knowing that an emergency crisis intervention was the most prominent need.

**What helped or enabled you to share your experiences with the Chaplain?** “She listened and cared. I knew that she was always praying for me.”

**How did you feel during this spiritual care intervention?** “I felt some hope.”

According to Washburn’s psycho-spiritual model my spiritual care assessment is that

**Ann is experiencing a parallel experience to regression in the service of transcendence stage one which is a withdrawal from the world.** Ann was able to reach out for a life saving crisis intervention in the midst of her deteriorated medical state. She reached out for help after several years had passed and this is when she felt suicidal. I compassionately affirmed Ann’s value and worth are more important than her ability to sustain a full time job.

5. **Crisis Intervention for Ann**

During my crisis intervention with Ann over the phone, she became so despondent that she hung up the phone. Contacting her psychiatrist and her brother to establish Ann’s address and speaking directly with the police on her behalf were essential elements of creating the sacred place for Ann. Her hospitalization in this crisis was life saving as she did not have anything to eat for six days and she had not taken her medication for two months. She needed an immediate medical and psychiatric intervention. Every professional worked together to help create this sacred place that saved Ann’s life. Ann’s Questionnaire states the following:

**What was the turning point for you and how did it impact you at the time of this spiritual care intervention?** “She called the police to get help for me. I admitted that I

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Ibid.
needed help and they (the police) took me to the hospital psychiatric ward. The following is my spiritual care assessment Francis’ Soul Recovery Stages 7, 8 and 10 remembering, emotional catharsis and meaning and mission.

5. New Spiritual Insight

According to the trauma research adult survivors experience rejection-sensitivity, lack of trust, fear of disclosure and re-traumatization, self esteem issues, and they are often suicidal. Creating a sacred place according to the trauma research findings as discussed in Chapter 2 helped me to create this sacred place according to the spiritual and religious coping research. Strategies that helped Ann to experience a sacred place are discussed explicitly in Chapter 2 and include my ability to communicate unconditional acceptance and empathy for her spiritual pain and prayerful spiritual direction in a non-directive atmosphere where Ann felt safe enough to trust me and to share what was “disturbing her spirit.” My years of previous training and experience in crisis intervention enabled me to remain calm and act appropriately to intervene with the necessary help.

Ann was able to break through her sense of silence and self suspension so that she could call for help. She consented and co-operated with the police and she was admitted into the hospital. Accepting help from the police officers was a major breakthrough for Ann as previous to this crisis, she had sustained a number of very serious suicide attempts. Therefore, for a person in this category and state of medical and psychiatric de-compensation to be able to reach out for help, this is a significant life-saving experience.

6. Ann’s Current Emotional and Spiritual Status

Ann lives with self-awareness and acceptance of her illness. Now she is compliant with taking her medication. Ann loves herself and knows that she has value and worth as a person.

\[236\] Ibid.
She lives by faith one day at time and she now has a sense of peace. Ann’s Questionnaire states the following: Did you experience any new emotional or spiritual awareness? If so, explain. “I have value and worth. I am going to live by faith one day at a time. I need to take my medication.”

Did your life change as a result of this spiritual care intervention? If so, how? “My self esteem has improved.” In this case I was only able to discern regression in the service of transcendence stage one, however, she was definitely in a radical spiritual crisis and she experienced a discernible emotional release as she grieved her losses and cried her tears. One year later she affirms a reconnection back to her spirituality and faith. Previously she was disconnected from her spirituality and faith so this is a parallel experience to Francis’ soul recovery or Washburn’s regeneration in spirit.

Case Three: Bess—Spiritual care interventions: A Summary of Visits One and Two

Throughout this spiritual care intervention, I have consciously created a sacred place with prayers for spiritual direction, an authentic relationship of unconditional acceptance and empathy in a non-judgmental environment using a non-directive paradigm. An integration of Francis’ external spiritual care assessment tools and Washburn’s internal spiritual care assessment tools helped me to make the significant spiritual care assessments as I was able to prayerfully listen and pinpoint each stage as it unfolded in this spiritual care intervention.

1. Total Number of Visits: Three spiritual care interventions with Bess.

The following overview from Bess’s questionnaire answers states how she finally received the courage to request a spiritual care intervention as she was admitted into the K4E with a

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237 Ibid.
238 Ibid.
major depression and she was suicidal. Bess’s Questionnaire states the following: **What helped or enabled you to share your experiences with the Chaplain?** “I went to Spirituality Groups which were led by the chaplain and other patients’ shared their own stories. I received courage to share my story with the chaplain during a private visit.”

**What issue or situation made you ask for a visit from the Chaplain?** “I was receiving treatment for a major depression and was suicidal.”

**What aspect of the spiritual care was most helpful? If not, what might have been more helpful?** “Two aspects of the spiritual care helped me, were visits from the Chaplain and Spirituality groups.”


The following summary of my two spiritual care interventions with Bess provides an overview of her physiological, emotional and spiritual needs as she reviews her accessed memories. Bess is a 40 year old patient who requested her own spiritual care visit. During my initial spiritual care intervention with Bess she said that “my parents lived through the Holocaust and shared their memories of what they and other Jewish people endured and this made me question my faith.” Due to Bess’s secondary trauma of listening to her parents’ experiences of the Holocaust she was greatly influenced by their experience of spiritual desolation and abandonment by Yahweh. Therefore, themes of spiritual abandonment by Yahweh were already present in Bess’s youngest memories.

Later, Bess shared that “I married a man from my own faith and we had two children, and I tried everything to make my marriage work, but he walked out and I was left to raise

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239 Bess’s questionnaire one year later.

240 Ibid.

241 Ibid.

242 Bess’s words as transcribed from the patient care notes.
my children alone. Life was difficult and I tried my best to raise the children in the Jewish faith and to give them a good education but everything fell apart and nothing worked out as I had planned.\textsuperscript{243} As I prayerfully empathized with Bess I came to understand that she had tried so hard to re-claim and re-gain her Jewish faith, even though life was very difficult. She wanted to provide a strong Jewish heritage for her children in an effort to gain Yahweh’s favour.

My spiritual care assessment is that Bess is in the midst of a parallel experience of what Washburn refers to as the dark night of the soul as she believes that she has lost Yahweh’s favour and she does not know how to find Yahweh’s favour once again. An accumulation of her efforts to gain Yahweh’s favour and to feel that she was not able to accomplish her desire was more than Bess could take. Unfortunately, Bess was admitted into the psychiatric unit and diagnosed by her psychiatrist with a major depression. She was under psychiatric care and receiving appropriate psychiatric medication and treatment. The following is my spiritual assessment and integration of Francis’ Soul Loss 1-4 deprivation, abuse, disconnection, and loss of meaning. Bess is experiencing Francis’ soul loss without soul recovery.

Third Spiritual care intervention: Spiritual Care Analysis

Due to my previous two spiritual care interventions with Bess I knew that she was in the midst of Francis’ soul loss without soul recovery. Therefore, I was already aware that she was in a state of spiritual crisis. Bess was disconnected from the source of her spiritual comfort and it was taking its toll on her. During this spiritual care intervention with Bess she had just returned back to the hospital. She had been out on a psychiatrically approved day pass as her psychiatrist thought that she was psychiatrically stable and almost ready to be

\textsuperscript{243} Bess’s words as transcribed from the patient care notes.
discharged from the hospital. Bess wanted to talk to me, so I spent some time with her as I was not aware of what had just transpired because I had just arrived on the K4E. Bess was still an inpatient on the K4E unit when this spiritual care intervention took place. She is still under the care of her psychiatrist, receiving appropriate medication and holistic interventions from members of the inter-disciplinary team.

Bess’s life was certainly in a state of crisis as she wrote in her Questionnaire answers one year later: **How were you feeling and what did you experience before your meeting with the Chaplain?** “I feel like I am going to jump out of my skin.”

Bess said that “it would be better for me to die than to live” she also said that “I feel so out of control.”

While she was out on a pass from the hospital Bess became suicidal and she told me “I was tempted to use a knife to end my life.”

**What was life like for you before this spiritual care intervention?** “I wanted to end my life.”

Bess was in a psychiatric crisis and also in a radical spiritual crisis and I made a spiritual care assessment of a parallel experience of Washburn’s *regression in the service of transcendence* stage one which is characterized as a person’s withdrawal from the world.

2. **Physiological and Safety Needs**

Bess was completely “out of control” and her physical safety was now at stake due to her suicidal thoughts and now, she had an impulsive plan to end her life. “I was tempted to use a

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244 Bess’s words transcribed from the patient care notes.

245 Ibid.

246 Ibid.

247 Ibid.

248 Bess’s questionnaire one year later.
knife to end my life.\textsuperscript{249} I also discerned that silence and self suspension were at play as Bess was so depressed that she had not disclosed her suicidal thoughts or this event with her psychiatrist. Up until this point, her psychiatrist thought that she was ready to be discharged from the hospital. As her spiritual caregiver, Bess’s safety was paramount. I knew my immediate spiritual care intervention was to “be a voice” to the team for Bess. Her life was definitely in danger and she needed a psychiatric intervention and I contacted her psychiatrist. The psychiatrist and nursing staff incorporated their standard protocol of close patient observation to watch Bess in order to prevent a suicide attempt.

3. Emotional and Spiritual Needs  

4. A Review of Accessed Memories

As I prayerfully listened to Bess she entered into what I refer to as the U-Turn which is the entry point into Washburn’s regression in the service of transcendence stage two. Bess begins to access previously repressed memories and she re-visited the events that broke her heart. She spoke out her lamentation which was a spilling over of her emotions to express her utter spiritual desolation and pain. During the next ninety minutes she grieved her losses which included re-visiting memories of her divorce and the loneliness of being a single parent and raising her children alone. Bess said, “I have given, given and given everything to inspire the values and principles of my Jewish faith and now my son wants to marry a non-Jewish woman.”\textsuperscript{250} She had hoped that Yahweh would have provided a Jewish wife for her son and when this did not happen she entered into a state of spiritual desolation. Obviously she had carried this grief around for a very long time without any emotional release. I prayerfully listened to her tears of anguish, spiritual desolation and spiritual pain. After

\textsuperscript{249} Ibid.

\textsuperscript{250} Bess’s words as transcribed from the patient care notes.
sharing her spiritual pain she exits out of the U-turn and enters into the present tense. Bess’s Questionnaire states the following: **How did you feel during this spiritual care intervention?** “I felt that I was safe and that she listened and cared about me.”

After spending over ninety minutes listening to her at the source of her spiritual pain, Bess started to enter into a new spiritual perception and understanding of her own needs. The following statement represents Bess’s new insight and she said, “I have a broken heart, I am so lonely and I need companionship, I need new meaning and hope for my life. I will turn my needs into a Hebrew prayer.”

The following is my spiritual care assessment of Francis’ Soul Recovery: 6-10 longing for connection, remembering, emotional catharsis, authenticity and empowerment, meaning and mission.

Bess’s Questionnaire states the following: **What was the turning point for you and how did it impact you at the time of this spiritual care intervention?** “The turning point happened as I named my feelings of desolation and disconnection from Yahweh. I was able to name my “broken heart” over my son’s relationship with a non-Jewish woman. After this pain was out in the open, I was able to understand my true need as finding new meaning and purpose for my life, naming my own loneliness and need for companionship. My greatest blessing was to turn this into a Hebrew prayer which brings me hope.”

**Did you experience any new emotional or spiritual awareness? If so, explain.** “Yes, sharing my pain opened the door to a new understanding of my needs and a sense of enthusiasm for life and prayer.”

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251 Bess’s questionnaire one year later.

252 Bess’s words as transcribed from the patient notes.

253 Bess’s questionnaire one year later.

254 Ibid.
My spiritual care to Bess was to be “a voice for Bess” to her psychiatrist when she returned from her visit home as suicidal. I also made a decision to contact a Rabbi because now Bess had received her new spiritual insight and she was receptive to receive a visit from the Rabbi. She was previously unable to accept her son’s choice to marry a non-Jewish woman. She was now able to name and take ownership for her own needs as she had a broken-heart, she needed companionship and she needed a reason to live.

5. New Spiritual Insight

Bess identified her own loneliness, loss of meaning and purpose as contributing to her sense of spiritual desolation. After her emotional release she named her need for companionship and her quest to find meaning and purpose for her own life. She formulated a Hebrew prayer to incorporate her new spiritual insight that she has a “broken heart,” she needs a new purpose for living and companionship in her life.

6. Bess’s Current Emotional and Spiritual Status

A meeting with the Rabbi was arranged to help Bess re-connect with her Jewish faith community. As a result of her meeting with the Rabbi she was able to accept her son’s choice to marry a non-Jewish woman. Bess has peace and a new enthusiasm for life, friendship and a new appreciation for prayer. Bess’s Questionnaire states the following: Did your life change as a result of this spiritual care intervention? If so, how? “Yes, I am more at peace about my life right now. The Chaplain arranged a meeting with the Rabbi which opened the door for me to re-connect with my Jewish community.”

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255 Ibid.
Case Four: Cassandra--Creating A Sacred Place: Spiritual Care Analysis

Throughout this spiritual care intervention, I have consciously created a sacred place with prayers for spiritual direction, an authentic relationship of unconditional acceptance and empathy in a non-judgmental environment using a non-directive paradigm.

1. Number of Spiritual Visits: Two spiritual care interventions.

Cassandra’s Questionnaire states the following: What issue or situation made you ask for a visit from the Chaplain? “I was in a lot of emotional and spiritual pain.” Cassandra is a 54 year old woman with a history of sexual abuse and subsequent religious abuse. She was sexually abused by her father forty years ago. Since her sexual violation she has lived most of her life with religious confusion and a distorted belief system. The greatest desecration and violation to Cassandra’s soul was that her father chose to sexually abuse her on Yom Kippur. “Yom Kippur is the holiest celebration in the Jewish faith and it represents the forty days of repentance. It is the only service of the year in which the doors of the Ark (where the Torah scrolls are stored) remain open from beginning to the end of the service, signifying that the gates of Heaven are open at this time.” Cassandra shared that “after the abuse took place he made me go to the synagogue for the Yom Kippur service.”

Cassandra’s Questionnaire states the following: What were you feeling and what did you experience before your meeting with the Chaplain? “I thought that there was something

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256 Cassandra’s questionnaire one year later.

257 Leviticus 23:27.


259 Cassandra’s words as transcribed from the patient care notes.
wrong with me.”

What was life like for you before this spiritual care intervention? “I was depressed and did not like myself.”


Creating a sacred place for Cassandra’s physiological and safety needs turned out to be essential for developing a relationship of trust with her. Although she had been sexually abused many years ago, she was still traumatized and religiously confused. Non-directive spiritual care along with the spiritual care practice of unconditional acceptance and empathy with Cassandra’s state of religious confusion provided her with a comfortable place to explore her memories which caused her spiritual unrest. Cassandra’s Questionnaire states the following: What helped or enabled you to share your experiences with the Chaplain? “Mary Ann’s kind and loving manner made me feel comfortable.”

How did you feel during this spiritual care intervention? “I felt safe and loved.”

What aspect of the spiritual care was most helpful? If not, what might have been more helpful? “She provided a safe and loving presence where I came to see God with me.”

Did your life change as a result of this spiritual care intervention? If so, how? “I feel safe and more hopeful.”

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260 Cassandra’s questionnaire one year later.
261 Ibid.
262 Ibid.
263 Ibid.
264 Ibid.
265 Ibid.
4. A Review of Accessed Memories

This section describes a patient initiated spiritual care intervention requested by Cassandra.

My spiritual assessment is that Cassandra is a Level Three radical spiritual crisis.

Cassandra’s entry point is what I refer to as the U-turn which is a notable turning point where Cassandra remembers her past trauma in the present tense and this is also Washburn’s regression in the service of transcendence stage two. I listened and empathized with Cassandra as she re-visits her memories of sexual abuse as if it happened yesterday.

Cassandra cried throughout this visit as she reflects, “My father continued to terrorize, overpower, and humiliate me into something so beyond my own comprehension.”

Her father then forced her to go to the synagogue for Yom Kippur after this violation. Cassandra said, “while I was in the synagogue thoughts and feelings of the violation and the unholy were confused with the holy presence and prayers taking place” in this house of worship.

Sexual violation and worship were two things at opposite poles away from each other. She said, “I was screaming inside of myself the screams which nobody would ever hear or understand.”

Cassandra said, “I felt silenced, shamed, confused and dirty.” She broke down and cried out her tears of shame, confusion, and inner turmoil and afterwards, she received her emotional release. The following is my spiritual assessment of Francis’ Soul Loss: 1-5 deprivation, abuse, disconnection, loss of meaning and loss of identity and Francis’ Soul Recovery: 7-8 remembering and emotional catharsis Cassandra’s Questionnaire states the following: What helped or enabled you to share your experiences

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266 Cassandra’s words as transcribed from the patient care notes.

267 Ibid.

268 Ibid.

269 Ibid.
with the Chaplain? “Mary Ann’s kind and loving manner made me feel comfortable.”

**How did you feel during this spiritual care intervention?** “I felt safe and loved.”

5. *New Spiritual Insight*

Cassandra had been disconnected from the source of her spiritual comfort since her original experience of sexual abuse which happened forty years earlier. By listening and empathizing with her as she entered into a parallel experience of Washburn’s *regression in the service of transcendence* stage two she grieved her losses with an emotional release. From a previous visit with Cassandra, I had given her a book of Psalms to read. Cassandra read through Psalm 23:2 and 6 and she said “I realized that I was never alone during the sexual abuse and that the running brooks are God’s cleansing and healing presence.”

The following is my spiritual care assessment of Francis’ Soul Recovery: 10. Meaning and Mission.

Cassandra’s Questionnaire states the following: **What was the turning point for you and how did it impact you at the time of the spiritual care intervention?** “The turning point happened when I understood God’s presence with me through the metaphors of Psalm 23, the angels and running brooks, as both cleansing and healing.”

**Did you experience any new emotional or spiritual awareness? If so, explain?** “I realized that I was never alone during the sexual abuse and that the running brooks are God’s cleansing and healing presence.”

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270 Cassandra’s questionnaire one year later.
271 Ibid.
272 Cassandra’s words as transcribed from the patient care notes.
273 Cassandra’s questionnaire one year later.
274 Ibid.
6. Cassandra’s Current Emotional and Spiritual Status

Due to Cassandra’s new spiritual insight she received new metaphors of hope as found in Psalm 23:2 and 6, and she reconnected back to her spirituality. She knows that she is never alone because God is always with her. Cassandra’s Questionnaire states the following: Did your life change as a result of this spiritual care intervention? If so, how? “I felt safe and more hopeful.” What aspect of the spiritual care was most helpful? If not, what might have been more helpful? “She provided a safe and loving presence where I came to see God with me.”

Case Five: Jerry—Creating A Sacred Place: Spiritual Care Analysis

Throughout this spiritual care intervention, I have consciously created a sacred place with prayers for spiritual direction, an authentic relationship of unconditional acceptance and empathy in a non-judgmental environment using a non-directive paradigm.

1. Number of Spiritual Visits: Two spiritual care interventions

Jerry is a 43 year old patient with a history of physical abuse in the form of physical beatings by his father. He was also sexually abused by his nephews. He was religiously abused by his priest.

2. Physiological and Safety Needs

Jerry’s psychiatrist had recommended that he contact me as he thought that having a spiritual care intervention might aid his spiritual healing. What issue or situation made you ask for a visit from the Chaplain? “My psychiatrist recommended that I speak to the Chaplain,

275 Ibid.

276 Ibid.
since he realized that this visit would be an aid to my spiritual healing.”

During this spiritual care intervention Jerry shared his story of abuse as if it happened yesterday. The following is an overview of my spiritual care intervention with Jerry as recorded from my field notes. Jerry suffered from physical abuse in the form of physical beatings by his father. He was also sexually abused by his nephews. He was religiously abused by his priest. Because Jerry shared, “I still have nightmares of my father coming to beat me and I remind him that he is dead.” My spiritual care insight is that in essence the torment of his past abuse is far from over, as the nightmares are real, vivid and still frightening for Jerry. Jerry’s Questionnaire states the following: **What was life like for you before this spiritual care intervention?** Life was difficult, sad and traumatic.

The following is my spiritual care assessment Francis’ Soul Loss: Stages 1-4 deprivation, abuse, disconnection and loss of meaning.

Because Jerry has experienced religious abuse it is fair to summarize that he might have felt some anxiety and fear as he met another clergy representative. Jerry’s questionnaire answer is as follows: **How were you feeling and what did you experience before your meeting with the Chaplain?** “I was nervous and apprehensive.” As previously discussed in Chapter 2 some of the major obstacles that might prevent a survivor from receiving effective spiritual care is their lack of trust and fear of disclosure and re-traumatization.

Creating a sacred place for Jerry was imperative as he is still traumatized thirty years later, with nightmares from his traumatic childhood. “Hearing the fear and trembling within

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277 Jerry’s questionnaire one year later.
278 Ibid.
279 Ibid.
Jerry’s voice and witnessing the fear in his eyes made me realize that he needed to feel safe and secure enough to trust another clergy representative. Due to the fact that Jerry was in crisis, he remembered and re-visited the deep agony which had resided in his soul for decades. I made eye-contact with him and had such compassion for his wounded inner self. As Jerry’s spiritual care companion a process of unconditional acceptance and empathy were effective ways to invite Jerry into a relationship of trust. Because Jerry had experienced spiritual abandonment due to his past religious abuse my spiritual care approach was to offer him spiritual companionship. Jerry respectfully invited me to enter in through the door of his soul as we explored the trauma together. Jerry’s Questionnaire states the following: **What helped or enabled you to share your experiences with the Chaplain?** “Her empathy put me very much at ease.”

3. Emotional and Spiritual Needs  
4. A Review of Accessed Memories

Jerry has carried memories from his early childhood, adolescent years and adult life for approximately thirty years. According to the trauma research some of the obvious signs and lasting impact of childhood abuse and trauma are the following signs, as Teegen writes:

> Trauma changes the body with a chronic hyper-arousal system which impacts sleep, 45% of people report repetitive nightmares 53% report intrusive thoughts and images from the past and early trauma rewires the neural networks increasing overall arousal.

His memories still lingered in the depths of Jerry’s soul and were kept alive through his vivid nightmares. One adult survivor of sexual abuse made the following comment about the

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280 This is my own spiritual care awareness as I met with Jerry.

281 Jerry’s questionnaire one year later.

nightmares associated with abuse: “It may well be that you do not consciously remember how you felt when you were abused, but your subconscious will not have forgotten.”

Nightmares of his deceased father literally tormented him as he would tell his father to “go away and reminded him that he is dead.” At this point, Jerry is leading me into the U-Turn, which is the entry point back to the original trauma. This is a parallel experience from Melanie Klein’s work and Bott Spillius writes: “What begins as withdrawal in the presence of another may culminate in a process of infolding which may become a replication of the whole self upon itself, leading through the layers of mourning to an original wound, an original loss.”

Jerry is now entering into his past memories in the present tense which is a parallel experience to Washburn’s regression in the service of transcendence stage two. Unconditional acceptance and empathy were enhanced by prayerful listening to create a sacred place. A sacred place allows the deep emotional and spiritual pain to be spoken and re-visited with a prayerful spiritual companion who believes and knows that one has to walk through the darkness into the light. As prayerful listening continues, Jerry re-visits three terror–stricken memories. Jerry’s Questionnaire states the following: How did you feel during this spiritual care intervention? “I felt relaxed.” Creating this sacred place allows one the uninterrupted freedom to express their spiritual pain and the underlying words used to describe their distorted belief system.

283 Starman’s Abuse Recovery U.K. (March, 1997) 1-2. (This quote comes directly from an adult survivor who experiences nightmares in relationship to their own abuse experience.)

284 Jerry’s words as transcribed from the patient care notes.

285 Madden, The Dark Interval, 34.

286 Jerry’s questionnaire one year later.
Jerry shared his memories of sexual abuse by his nephews and re-explored his deep shame and years of confusion over his sexual identity. Once again, although at one level Jerry had received a resolution to this heart-rending experience, he needed the deeper spiritual healing within his soul. He needed to re-visit his terror-filled memories that had never been shared with anyone—and he broke the silence in this sacred place. Previously he felt spiritual abandonment, but now he found spiritual companionship.

Jerry shared his third memory as religious abuse by his priest. “I asked my priest to help me during a major crisis and he was not available and afterwards my family and I left the church.”287 As I listen to Jerry he is able to name his own disconnection from God, but he is now lonely for God and longing for his reconnection back to his faith and church. The following is my spiritual care assessment of Francis’ Soul Recovery: 6-10 longing for connection, remembering, emotional catharsis, authenticity and empowerment, meaning and mission. After the third memory is shared the U-Turn is complete and Jerry returns to the present tense. What aspect of the spiritual care was most helpful? If not, what might have been more helpful? “To narrow down what was most helpful was re-visiting painful memories and recognizing my need to re-connect with God.”288 Francis’ stage 6 Longing for connection was very clear as Jerry voiced his longing to reconnect with God and the church. He and his family had truly missed having their spiritual connection. Jerry’s new spiritual insight is that he needs to find his spiritual connection back to the Roman Catholic faith. Jerry’s questionnaire answer is as follows: What was the turning point for you and how did it impact you at the time of this spiritual care intervention?

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287 As transcribed from the field notes.

288 Ibid.
“The turning point was when I named my longing to return to God. I found a new church and a priest that is welcoming and attentive.” 289 Non-directive spiritual care helped Jerry to enter into a parallel process of Washburn’s regression in the service of transcendence stage two where he shared his trauma with an emotional release, and re-connected back to his place of worship.

5. New Spiritual Insight

Jerry’s new spiritual insight consists of naming his disconnection from God. Jerry and his family found their re-connection back to God. They joined a church where they now experience acceptance and love.

6. Jerry’s Current Emotional and Spiritual Status

Jerry’s questionnaire answers are as follows: Did you experience any new emotional or spiritual awareness? If so, explain? “I learned to forgive my father for the physical beatings, my nephews for the sexual abuse and the priest for not being present when I really needed him. I found new inner strength to focus on doing good deeds for others. My family and I are active members of the Roman Catholic Church and we feel accepted and welcomed.” 290 Did your life change as a result of this spiritual care intervention? If so, how? “I have a new awareness that God really loves me. I also realize that I have new inner strength to draw on and I learned how to forgive myself and others. I also believe that I have a responsibility to share God’s love with others by doing good deeds.” 291

289 Ibid.
290 Ibid.
291 Ibid.
Case Six: Trudy--Creating A Sacred Place: Spiritual Care Analysis

Throughout this spiritual care intervention, I have consciously created a sacred place with prayers for spiritual direction, an authentic relationship of unconditional acceptance and empathy in a non-judgmental environment using a non-directive paradigm.

1. Total Number of Visits: **Only one spiritual care intervention with Trudy.**

Trudy is a 47 year old patient with a history of early childhood abuse due to her father’s psychological, emotional, and existence\(^{292}\) and sexual abuse. In reality, she was punished because she was born a girl rather than a boy. Trudy did not receive any affection and she felt that she did not exist in her father’s opinion. Trudy’s questionnaire answer is as follows:

**How were you feeling and what did you experience before your meeting with the Chaplain?** “I felt worried, afraid and hopeless about my future.”\(^{293}\) **What was life like for you before this spiritual care intervention?** “I felt very isolated, and very, very ashamed of my condition.”\(^{294}\)

2. **Physiological**  
3. **Emotional and Spiritual Needs**

In looking into Trudy’s eyes I realize how hurt she is and how she is filled with what the trauma research calls the rejection sensitivity. Rejection sensitivity is indicative of an adult survivor’s lack of trust and their fear of rejection. Life has been confusing for Trudy because she shares that, “My father disowned me from the day I was born because I was not a boy and he always told me that “I had to be a boy to count.”\(^{295}\) Trudy was crying throughout my spiritual care intervention as she shares that, “my uncle, my mother’s brother sexually abused

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\(^{292}\) Trudy’s existence abuse is related to her father’s rejection of her since birth.

\(^{293}\) Trudy’s questionnaire one year later.

\(^{294}\) Ibid.

\(^{295}\) Trudy’s words as transcribed from the patient care notes.
me and told me not to tell anyone or else something would happen to my grandmother.”\textsuperscript{296}

She said, “I don’t trust my mother either, as she knows about the abuse and did not step in to stop it. Trudy’s questionnaire answer is as follows: \textbf{What issue or situation made you ask for a visit from the Chaplain?} “I was in utter anguish, heartbreak and confusion due to sexual abuse.”\textsuperscript{297}

Eventually, Trudy realizes that I do not want to impose my own agenda and time-line on her as I am using a non-directive and prayerful approach to my spiritual care. Trudy realizes that she is in control of this visit and that I am present to listen to her. She is free to begin where she wants to begin and disclose whatever she wants to disclose, because she is in a sacred place. As her spiritual companion, I simply follow her lead. The following is my spiritual care assessment of \textbf{Francis’ Soul Loss: 1-5 deprivation, abuse, disconnection, loss of meaning and loss of identity}. 

Themes of rejection and betrayal from her parents and her uncle have reinforced an overwhelming lack of trust towards all people. So, she wonders who she can trust. Lack of trust for her parents and uncle form the earliest belief system according to the object relations theory as discussed in Chapter 2. As the spiritual caregiver for Trudy, it is absolutely essential to establish a sacred place where she experiences an authentic relationship of unconditional acceptance. Empathy is expressed as compassion for Trudy, and I made eye-contact with her.

\textsuperscript{296} Ibid.

\textsuperscript{297} Trudy’s questionnaire one year later.
4. A Review of Accessed Memories

Trudy took me back in time at the entry point of the U-turn or “regression in the service of transcendence” stage two as she shares her earliest memories of her original trauma. I prayerfully listen and empathize with her five horrendous memories as she shares her tears until she fully expresses her memories and grief. As Fiona Tulk writes, “a series of unrelated traumas can overlay one another in such a way that cripples the adult until the patterns of all related childhood incidents are accessed.”

Trudy’s father’s words to her were, “you have to be a boy to count,” and this statement by her father is reinforced within the context of her second memory.

Her second memory is of being sexually abused by her uncle. After being sexually abused, Trudy said, “My uncle threatened me and told me not to tell anyone or something would happen to my grandmother.” Fear and terror tormented her and then, she opts to hope for some justice.

The third memory she accesses is when, “I took my uncle to court and my mother testified against me in order to stand up for her brother.” The legal system represents a place of authority and justice, but there is no justice for Trudy. She receives triple shame from her uncle, mother and the justice system.

The fourth memory that Trudy shares is that “for years after the abuse I struggled with my sexual orientation, but over time I met and married my husband.” Her fifth memory starts with her short-lived joy as she shares “my husband and I wanted to have children, but I

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298 Tulk, *Hidden Trauma Patterns*, 1.

299 Ibid.

300 Ibid.

301 Ibid.
developed a medical condition and had to have a complete hysterectomy.” Having her hysterectomy again reinforces Trudy’s distorted belief system that “she needs to be a boy to count.” After listening to the five layers of Trudy’s accessed memories and her many tears during this encounter I told her that God has her tears in His special bottle. For the first time in Trudy’s life she came to understand that God is with her and cares for her tears and this reality revolutionized Trudy’s spirituality. This concludes the U-turn or the regression in the service of transcendence stage two “as Trudy returns to the present tense. The following is my spiritual care assessment of Francis’ Soul Recovery: 7, 8, 10 remembering, emotional catharsis and meaning and mission. Trudy’s questionnaire answers are as follows: What helped or enabled you to share your experiences with the Chaplain? “There was an atmosphere of unconditional love and acceptance. I appreciated that the atmosphere was non-judgmental.” How did you feel during this spiritual care intervention? “I felt safe, cared for and even valuable.” What was the turning point for you and how did it impact you at the time of this spiritual care intervention? “The turning point came when Mary Ann told me that God has my tears in his special bottle. God cares.”

5. New Spiritual Insight

Her theological question and the unspoken cry of her heart surfaces as: “Is God punishing me?” My answer to Trudy is that God has placed all of her tears into His heavenly bottle, which means that God knows and cares about her tears. “Thou tellest my wanderings: put thou my tears into thy bottle: are they not in thy book?” (Psalm 56:8). God takes Trudy’s tears seriously and has taken the time to place them into His heavenly bottle. She does not

302 Trudy’s words as transcribed from the patient care notes.
303 Trudy’s questionnaire one year later.
304 Ibid.
have any answers to her questions, but she has a new metaphor of a God who has taken the time to gather every tear into His own heavenly bottle, so that her tears are precious, valuable and recorded by this God who loves her. I also gave her Ed Smith’s book entitled: “Healing Life’s Greatest Hurts.” Trudy’s questionnaire answers are as follows: **Did your life change as a result of this spiritual care intervention? If so, how?** “Yes, when I went back to study a spiritual book that Mary Ann gave me entitled: *Healing Life’s Greatest Hurts* by Dr. Ed Smith, which helped me to overcome my past hurts.”*305 Did you experience any new emotional or spiritual awareness? If so, explain?* “Oh yes! I now experience hope and a revelation of God’s divine care.”*306 What aspect of the spiritual care was most helpful? If not, what might have been more helpful? “Mary Ann’s approach was so accepting, yet so practical.”*307

6. **Trudy’s Current Emotional and Spiritual Status**

Trudy has a deeper sense of peace and acceptance of her past because the Lord has recorded her tears in His special bottle.

**Case Seven: Ted—Creating A Sacred Place: Spiritual Care Analysis**

Throughout this spiritual care intervention, I have consciously created a sacred place with prayers for spiritual direction, an authentic relationship of unconditional acceptance and empathy in a non-judgmental environment using a non-directive paradigm.

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*305 Ibid.*

*306 Ibid.*

1. Total Number of Visits: One visit with Ted.

“Ritual abuse of adolescents, and participation by adolescents in perpetrating ritual abuse, can take place in family or school settings, or in youth gangs which orient themselves toward a self-styled satanism or other ritualism, and violence.” In this case, Ted is in a radical spiritual crisis as he has been living for many years under this evil influence and in a state of silence and self suspension. Since Ted is only 24 years old he is not in the second half of adult life, when the primal repression is to lift. Ted has been tormented by this evil ritual and living under satanic bondage for twelve long years. Ted’s questionnaire answers are as follows: **What issue or situation made you ask for a visit from the Chaplain?** “I wanted freedom from the past satanic ritualistic practices.” **How were you feeling and what did you experience before your meeting with the Chaplain?** “I was always frustrated, guilty and full of remorse.”

Ted describes very explicitly how he got involved in the occult and went through a satanic blood ceremony and sold his soul to an entity called Patrick. He felt possessed by this evil presence for twelve years. Ted was disconnected from his own identity, as he lost his sense of self, he was disconnected from others and God. **The following is my spiritual care assessment Francis’ Soul Loss: Stages 1-5 deprivation, abuse, disconnection, loss of meaning and loss of identity.**

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309 Ted’s questionnaire one year later.

310 Ibid.
2. *Physiological and Safety Needs*

Ted’s experience of satanic ritual abuse is perhaps more frightening than other types of abuse because he shares, “that his life has been possessed and controlled by an evil presence for twelve long years.”\(^{311}\) As I prayerfully empathized with Ted the analogy of being imprisoned for life without any way of escape might be close to what Ted had experienced. Obviously, he felt trapped for all of these years due to his distorted belief that because “he sold his soul” that he could never be free again.

Ted re-visited his past trauma in the present tense at the entry point of the U-Turn and he entered into Washburn’s *regression in the service of transcendence* stage two as he shared his past trauma. Ted told me, “I hate my life, I hate myself and I hate all the vile activities that I have done for the last twelve years,”\(^{312}\) and he decided to face his relentless sense of “entrapment with evil” and do whatever was necessary to receive some relief from his enormous burden. It was difficult for Ted to separate his own identity from this pervasive entrapment of embodied evil within him. He said “I don’t know who I am anymore.”\(^{313}\) Silence and self suspension were definitely the spiritual dynamics at work in this young boy’s life as he could not tell anyone what he had done. Ted’s experience of evil power and control are contrasted in this visit by a sense of freedom. He was safe to unburden his soul without interruption. **What helped or enabled you to share your experiences with the Chaplain?** I felt safe because she was calm and confident about how to help me. **How did you feel during this spiritual care intervention?** I felt very hopeful.

\(^{311}\) Ted’s words as transcribed from the patient care notes.

\(^{312}\) Ibid.

\(^{313}\) Ibid.
Prayer for inner spiritual direction was crucial in this spiritual care intervention. He had a loss of identity and felt a deep sense of shame and guilt as he had carried “his secret” for so long. Ted’s emotional and spiritual care needs were enormous as he needed to re-visit and grieve the traumatic events that were still “disturbing his spirit.” He had literally lost twelve of the best years of his life and he needed to grieve his many losses. Being under demonic control for twelve years without turning to anyone for help prior to this had taken its toll on him. Allowing Ted to share his fearful experiences in this atmosphere of unconditional acceptance in a non-judgmental environment invited him to grieve his losses and to express his spiritual feelings of remorse with tears of repentance. Listening to Ted’s deep sense of loss and remorse helped him to unburden his soul. The following is my spiritual care assessment of Francis’ Soul Recovery: Stages 6-10 longing for connection, remembering, emotional catharsis, authenticity and empowerment and meaning and mission.

Compassionate eye contact and a non-judgmental attitude helped Ted to feel that he could trust me with his “secret.” I felt a new level of compassion for his tormented soul. Afterwards, Ted enters into the U-turn or the regression in the service of transcendence stage two as he begins at this point to take me back in time to re-visit his traumatic memories. Ted enters into his past memories and I felt as if I were actually meeting the naïve and innocent twelve year old boy who was lured into something that he did not fully understand. My spiritual care intervention with Ted brought me back to meet him in the context of the original terror–filled event. I felt a sense of anger at the injustice and spiritual violation which was inflicted on Ted by the occult leader as he imposed this satanic ritual on him. He also re-
visited a number of vile activities that he had participated in over his twelve years of demonic influence. Ted exits the U-turn or the regression in the service of transcendence stage two as he comes back into the present tense. Afterwards, I shared Christ’s sacrificial blood covenant and the Christ-event to connect him with the one who could free his soul from all evil. Ted was awestruck as he remembered his Roman Catholic background and realized the answer.

Ted’s questionnaire answer is as follows: **What was the turning point for you and how did it impact you at the time of this spiritual care intervention?** “The turning point happened as Mary Ann shared the Christian covenant and blood sacrifice of Christ to set my soul free. Also, when the Roman Catholic priest anointed me with the holy oil and I renounced all of my satanic practices and received Christ by faith.”

Reconnecting Ted back to his Roman Catholic faith was essential for him to be reconciled back to God. Contacting a Roman Catholic priest provided a deeply spiritual contrast from the occult initiation ritual. “The priest and I were present with Ted as he renounced his association with the occult and the entity Patrick.” Ted renounced his satanic ritual and received the blood covenant of Christ. By receiving the Roman Catholic sacramental reconciliation and Holy Communion he felt ritualistically reinstated to his faith. Ted prayed that the Lord would completely transform his life. Afterwards the priest anointed Ted with holy oil and prayed for psychological, emotional and spiritual healing. Ted reconnected back to his Roman Catholic faith as well.

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314 Ted’s questionnaire one year later.

315 Ted wanted me present during this time and the priest requested me to stay. Usually the sacrament of reconciliation is between the priest and the person in need of the sacrament.
5. New Spiritual Insight

Ted previously believed that it was not possible to reverse the spiritual bondage that was imposed on him through a satanic blood ceremony that happened twelve years ago. He had lived out of this reality of evil for twelve years because he did not believe that there was any way out of it. Ted’s new spiritual insight is that Christ’s blood covenant is powerful enough to break satanic bondage. He found his way back to God and the Roman Catholic Church.

6. Ted’s Current Emotional and Spiritual Status

Ted’s current emotional state is a radical attitude of gratitude because he is free from past bondage. He records his emotional and spiritual growth in a daily journal and he is re-connected back to his Roman Catholic faith. Ted’s questionnaire answers are as follows: Did you experience any new emotional or spiritual awareness? If so, explain. “I realized that we are all God’s children. My pain, guilt, remorse was lifted by Christ’s blood covenant for me.” Did your life change as a result of this spiritual care intervention? If so, how? “I am very grateful and keep a daily gratitude journal and self-growth resource journal.”

What aspect of the spiritual care was most helpful? If so, how? “Mary Ann’s unconditional acceptance, her keen insight and ministry of the Christian blood covenant, my renunciation of evil practices and the priest’s anointing with oil and prayers. Mary Ann continues to pray for me.”

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316 Ted’s questionnaire one year later.
317 Ibid.
318 Ibid.
### Overview of the Questionnaire Answers from One to Six

<table>
<thead>
<tr>
<th>Question</th>
<th>Case One: Adam</th>
<th>Case Two: Ann</th>
<th>Case Three: Bess</th>
<th>Case Four: Cassandra</th>
<th>Case Five: Jerry</th>
<th>Case Six: Trudy</th>
<th>Case Seven: Ted</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. What issue or situation made you ask for a visit from the Chaplain?</strong></td>
<td>I felt sad, depressed</td>
<td>I was suicidal and Mary Ann said to call when I needed to talk</td>
<td>I was receiving treatment for a major depression</td>
<td>I was in a lot of emotional and spiritual pain</td>
<td>My psychiatrist recommended that I speak to the Chaplain, since he realized that this visit would be an aid to my psychological well being</td>
<td>I was in utter anguish, heartbreak and confusion due to sexual abuse</td>
<td>I wanted freedom from my past satanic ritualistic practices</td>
</tr>
<tr>
<td><strong>2. How were you feeling and what did you experience before your meeting with the Chaplain?</strong></td>
<td>I was very sad</td>
<td>I was very sad</td>
<td>I wanted to jump out of my skin, I was “out of control” and suicidal</td>
<td>That there was something wrong with me</td>
<td>Life was difficult, sad and traumatic</td>
<td>I felt worried, afraid and hopeless</td>
<td>I wanted freedom from my past satanic ritualistic practices</td>
</tr>
<tr>
<td><strong>3. What helped or enabled you to share your experiences with the Chaplain?</strong></td>
<td>Adam-She listened to me, I was very sad, depressed and grieving – I missed my Dad.</td>
<td>She listened and cared. I knew that she was always praying for me.</td>
<td>She listened and cared. I knew that she was always praying for me.</td>
<td>Mary Ann’s kind and loving manner made me feel comfortable.</td>
<td>She was receiving treatment for a major depression.</td>
<td>She was receiving treatment for a major depression.</td>
<td>She was receiving treatment for a major depression.</td>
</tr>
<tr>
<td><strong>4. What was life like for you before this spiritual care intervention?</strong></td>
<td>I was very sad</td>
<td>I was very sad</td>
<td>I wanted to jump out of my skin, I was “out of control” and suicidal</td>
<td>Life was difficult, sad and traumatic</td>
<td>I was in utter anguish, heartbreak and confusion due to sexual abuse</td>
<td>I was in utter anguish, heartbreak and confusion due to sexual abuse</td>
<td>She was receiving treatment for a major depression.</td>
</tr>
<tr>
<td><strong>5. How did you feel during the spiritual care intervention?</strong></td>
<td>I was able to release my feelings and she listened so that I felt that she cared.</td>
<td>I felt some hope.</td>
<td>I felt that I was safe and that she listened and cared about me.</td>
<td>I felt safe, cared for and even valuable.</td>
<td>I felt very relaxed.</td>
<td>I felt safe and loved.</td>
<td>I felt very hopeful.</td>
</tr>
<tr>
<td><strong>6. What was the turning point for you and how did it impact you at the time of this spiritual care intervention?</strong></td>
<td>When I realized my state of spiritual suicide and named it- in a spiritual way I was “jumping off of the bridge.”</td>
<td>The turning point came as I named my feelings of abandonment by Yahweh and broken heart and turned this into a Hebrew prayer.</td>
<td>The turning point happened when I understood God’s presence with me through the metaphors of Psalm 23, the angels and running brooks, as both cleansing and healing.</td>
<td>The turning point was when I named my longing to return to God. I found a new church and a priest that is welcoming and attentive.</td>
<td>The turning point came when I understood God’s presence with me through the metaphors of Psalm 23, the angels and running brooks, as both cleansing and healing.</td>
<td>The turning point came when I understood God’s presence with me through the metaphors of Psalm 23, the angels and running brooks, as both cleansing and healing.</td>
<td>The turning point came as Mary Ann shared the Christian covenant and blood sacrifice of Christ to set my soul free.</td>
</tr>
</tbody>
</table>

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319 Ibid.
320 Ibid.
### Overview of Questionnaire Answers from Questions Seven to Nine.

7. Did you experience any new emotional or spiritual awareness? If so, explain.

- **Case One: Adam** - Yes, I now envision myself as having the spiritual courage of a soldier. I know that my father’s love did not die when he died.
- **Case Two: Ann** - I have value and worth. I am going to live by faith one day at a time. I need to take my medication.
- **Case Three: Bess** - Yes, sharing my pain opened the door to a new understanding of my needs and a sense of enthusiasm for life and prayer.
- **Case Four: Cassandra** - I realized that I was never alone during the sexual abuse and that the running brooks are God’s cleansing and healing.
- **Case Five: Jerry** - I learned to forgive my father for the physical beatings, my nephews for the sexual abuse and the priest for not being present when I really needed him.
- **Case Six: Trudy** - Oh yes, I now experience hope and a revelation of God’s divine care.
- **Case Seven: Ted** - I realize that we are all God’s children. My pain, guilt and remorse was lifted by Christ’s blood covenant for me.

8. Did your life change as a result of this spiritual care intervention? If so, how?

- **Case One: Adam** - I view my life as having the “courage of a soldier.” Having courage and peace inspires hope for the future. I know that my Dad still loves me.
- **Case Two: Ann** - My self esteem has improved.
- **Case Three: Bess** - Yes, I am more at peace about my life right now. The Chaplain also arranged a meeting with the Rabbi which opened the door for me to re-connect with my Jewish community.
- **Case Four: Cassandra** - I feel safe and more hopeful.
- **Case Five: Jerry** - I have a new awareness that God really loves me. I also realize that I have new inner strength to draw on and I learned how to forgive myself and others. I also believe that I have a responsibility to share God’s love with others by doing good deeds.
- **Case Six: Trudy** - When I went back to study a spiritual book that Mary Ann gave me entitled: *Healing Life’s Greatest Hurts* by Dr. Ed Smith, which helped me to overcome my past hurts.
- **Case Seven: Ted** - I am very grateful and keep a daily gratitude journal and self-growth resource journal.

9. What aspect of the spiritual care was most helpful? If so, how?

- **Case One: Adam** - She listened and cared.
- **Case Two: Ann** - She called the police to get help for me. I admitted that I needed help and they (the police) took me to the hospital psychiatric ward.
- **Case Three: Bess** - Two aspects of the spiritual care helped me, were visits from the Chaplain and Spirituality Groups.
- **Case Four: Cassandra** - She provided a safe and loving presence where I came to see God with me.
- **Case Five: Jerry** - To narrow it down what was most helpful was re-visited painful memories and recognizing my need to re-connect with God.
- **Case Six: Trudy** - Mary Ann’s approach was so accepting, yet so practical.
- **Case Seven: Ted** - Mary Ann’s unconditional acceptance, her keen insight and ministry of the Christian blood covenant, my renunciation of evil practices and the priest’s anointing with oil and prayers. Mary Ann continues to pray for me.

The following is a Total Overview of Themes and Consistent Spiritual Care Patterns in Thirty Cases which consists of a breakdown from the general research data collection with a focus on the common themes, spiritual care patterns, and spiritual care assessments as found within the general research data collection. The diagram has the headings at the top and the research outcomes directly in the next box below.
# Total Overview of Themes and Consistent Spiritual Care Patterns in Thirty Cases

<table>
<thead>
<tr>
<th>Theme</th>
<th>Cases</th>
<th>Intervention Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Spiritual Crisis and Spiritual Receptivity</strong></td>
<td></td>
<td><strong>2. Past Abuse And Spiritual Disconnection</strong></td>
</tr>
<tr>
<td></td>
<td>27 out of 30 cases</td>
<td><strong>3. Spiritual Crisis, Emotional Accessibility and Patient Initiated Visit</strong></td>
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<tr>
<td></td>
<td><strong>30 out of 30 cases</strong></td>
<td><strong>4. New Spiritual Insight and Reconnection Back to their Spirituality or Place of Worship</strong></td>
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<tr>
<td></td>
<td><strong>25 out of 30 cases</strong></td>
<td><strong>5. Longer Duration for spiritual care intervention and within one to three spiritual care interventions</strong></td>
</tr>
<tr>
<td></td>
<td><strong>27 out of 30 cases</strong></td>
<td><strong>6. Symbolism within the context of spiritual care intervention</strong></td>
</tr>
<tr>
<td></td>
<td><strong>29 out of 30 cases</strong></td>
<td><strong>7. Remembering, Revisiting and Restoration</strong></td>
</tr>
<tr>
<td></td>
<td><strong>8. Spiritual Care Assessments of regression in the service of transcendence</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Stage One</strong></td>
<td><strong>Stage Two</strong></td>
</tr>
<tr>
<td></td>
<td><strong>21 out of 30 cases</strong></td>
<td><strong>9. Spiritual Care Assessments of regression in the service of transcendence</strong></td>
</tr>
<tr>
<td></td>
<td><strong>27 out of 30 cases</strong></td>
<td><strong>10. Francis’ soul loss with soul recovery assessment tool</strong></td>
</tr>
<tr>
<td></td>
<td><strong>12 out of 30 cases</strong></td>
<td><strong>11. Francis’ soul loss without soul recovery assessment tool</strong></td>
</tr>
<tr>
<td></td>
<td><strong>27 out of 30 cases</strong></td>
<td><strong>12. Patients’ in the second half of adult life-spiritual receptivity</strong></td>
</tr>
<tr>
<td></td>
<td><strong>13. Emotional Release as spiritual care dynamic</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>3 out of 30 cases</strong></td>
<td><strong>23 out of 30 cases</strong></td>
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<tr>
<td></td>
<td><strong>27 out of 30 cases</strong></td>
<td><strong>24 out of 30 cases</strong></td>
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<td></td>
<td></td>
<td><strong>27 out of 30 cases</strong></td>
</tr>
</tbody>
</table>
4.5 Spiritual Care Analysis Part Two: Themes of Radical Spiritual Crisis and Spiritual Receptivity

Analysis part two provides an overview of the consistent themes and spiritual care patterns as found within the general research data collection and more specifically within the seven cases. The seven major themes bring about a mosaic that appears to be uniquely consistent and discernible within the data. This section’s major focus is: Themes of Radical Spiritual Crisis and Spiritual Receptivity and the sub-sections are the seven that follow: (1) Spiritual Crisis and Spiritual Receptivity; (2) Past Abuse and Spiritual Disconnection; (3) Spiritual Crisis, Emotional Accessibility, and Patient Initiated Visits; (4) New Spiritual Care Insight Reconnects Adult Survivors back to Spirituality or Place of Worship; (5) Longer Duration of Spiritual care interventions and only one to three visits; (6) Symbolism is another recurring theme as found in the patients’ New Spiritual Insight; (7) Remembering, Re-visiting and Restoration is the biblical parallel as found in the context of celebrations which take place in the Jewish and Christian faith traditions. People throughout history actively engage in spiritual celebrations such as the Sabbath, Yom Kippur, Christmas and Easter in order to experience a sense of spiritual restoration.

4.5.1 Spiritual Crisis and Spiritual Receptivity

Up until this research project I had never considered the possibility of meeting a patient in the midst of their spiritual crisis and at the time of their optimum spiritual receptivity. According to the general research data collection the theme of radical spiritual crisis and spiritual receptivity occurs in 27 out of 30 cases. New spiritual care insight, when meeting with spiritually receptive survivors in the midst of a Level Three radical spiritual crisis is to
recognize the spiritual process of Washburn’s *regression in the service of transcendence* stages one and two and *regeneration in spirit*. As already discussed in the research study with the seven participants this process often takes between one to three visits before *regeneration in spirit* unfolds. Another consistent theme as found in the general research data collection relates to a patient’s past abuse and their spiritual disconnection.

4.5.2 Past Abuse and Spiritual Disconnection

As previously discussed within the spiritual and religious coping research in Chapter 2, past childhood abuse often leaves adult survivors’ with a negative image of God which causes a spiritual rupture or disconnection from their spiritual source. Past abuse and spiritual disconnection are found in the general research data collection in 30 out of 30 cases as discussed earlier in the chapter. Explicit examples are provided in each of the seven case studies. Case One, Adam suffered during his adolescent years with peer bullying and humiliation. Adam’s spiritual disconnection is clearly seen through his questionnaire answers: **What issue or situation made you ask for a visit from the Chaplain?** “I felt sadness, depression and spiritual suicide.”321 “I felt that I have committed spiritual suicide about six or seven times.”322 Case Two, Ann suffered from psychological and sexual abuse throughout her childhood and adolescent years. Ann’s spiritual disconnection is most prominent in the following questionnaire answer: **How were you feeling and what did you experience before your meeting with the Chaplain?** “Suicidal.”323 She said, “I am tired of

321 Adam’s questionnaire one year later.
322 Adam’s words as transcribed from the patient care notes.
323 Ibid.
being fearful and lonely all the time.” Case Three, Bess suffered from psychological and spiritual abuse during childhood as her life was greatly influenced by her parents’ shared memories of the Holocaust. Bess’s spiritual disconnection is most prominent in the following questionnaire answer: **What was life like for you before this spiritual care intervention?** “I wanted to end my life.”

Case Four, Cassandra suffered from sexual and religious abuse which occurred during her adolescent years. **Cassandra’s spiritual disconnection is most prominent in the following patient care notes:** After her father sexually abused her, he then forced her to go to the synagogue for Yom Kippur after this violation. Cassandra said, “While I was in the synagogue thoughts and feelings of the violation and the unholy were confused with the holy presence and prayers taking place” in this house of worship.

Case Five, Jerry lived in constant fear of being beaten by his father. He was also sexually abused by his nephews and religiously abused by his priest. **Jerry’s spiritual disconnection is most prominent as transcribed from my field notes:** “I asked my priest to help me during a major crisis and he was not available and afterwards my family and I left the church.”

Some of the adult survivors have suffered as a result of existence abuse from the day that they were born. Case Six, Trudy is a prime example of existence abuse as she was rejected by her father right from the day she was born. **Trudy’s spiritual disconnection is most prominent in the following patient care note:** “My father disowned me from the day I was born because I was not a boy and he always told me that, 'I had to be a boy to count.'”

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324 Bess’s Questionnaire one year later.
325 Ibid.
326 Jerry’s words as transcribed from the field notes.
327 Trudy’s words as transcribed from the patient care notes.
co-relation between a child’s earliest relationship with the primary caregivers and their later perception of God. In some cases adult survivors experience a negative image of God as a result of their past abuse. Case Seven, Ted suffered from ritualistic satanic abuse from the age of twelve. Ted’s spiritual disconnection was most prominent in this questionnaire answer: What issue or situation made you ask for a visit from the Chaplain? “I wanted freedom from the past satanic ritualistic practices.” Past childhood abuse often results in the adult survivors’ experience of spiritual disconnection.

4.5.3 Spiritual Crisis, Emotional Accessibility and Patient Initiated Visits

Common themes found within the general research collection data is that in 25 out of 30 cases the patients were in a spiritual crisis, they had emotional accessibility and they initiated their own spiritual care intervention. This research data brings to mind a parallel concept which applies as an essential framework within the Twelve Step Program. The first step of this program highlights that a person must admit that their lives are “out of control,” and when they can name this reality they reach out for help. There is something very spiritual and profound about a person being able to name their own need and seek out their own help.

According to the research questionnaires each patient shared their reason for requesting the spiritual care intervention: Adam felt sad and depressed, Ann was suicidal, Bess wanted to end her life, Cassandra was in a lot of emotional and spiritual pain, Jerry was tormented with nightmares of his deceased father who had abused him, Trudy was in anguish, heartbreak and confusion, Ted was tormented due to his satanic ritualistic practices.

They were in touch with their emotions: Adam expressed his emotional feelings and

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describes them with the metaphor of having committed spiritual suicide six or seven times, Ann felt like a parasite, Bess was “out of control” and she wanted to “jump out of her skin,” Cassandra was very depressed and she did not like herself, Jerry was worried and apprehensive, Trudy felt worried, afraid and hopeless about her future, Ted was frustrated, guilty and full of remorse.

Washburn’s model offers at least one possible explanation as to why 25 out of 30 patients within the general research data collection followed the same spiritual care pattern. If Washburn’s spiritual care insight regarding the lifting of the primal repression and a person’s optimum time of spiritual receptivity is valid, then it is possible that I met these 25 patients during their optimum spiritual receptivity. Further research is needed to evaluate if other spiritual care specialists experience a similar spiritual care process.

4.5.4 New Spiritual Insight Reconnects Adult Survivors back to Spirituality or Place of Worship

According to the general research data collection within one to three spiritual care interventions 27 out of 30 cases patients reconnected back to their spirituality or place of worship. Of course, it is not possible to confirm whether the other 20 patients continued to be connected with their spirituality or place of worship after a one year period. It is only possible for me to confirm that the seven participants remained connected with their spirituality or place of worship for a one year period. This is good news for the adult survivors and great news for the churches. Research shows the positive impact of a person’s religious affiliation towards holistic health. John Patton, author of a book entitled, Spiritual Care in Context, has this to say about the nature of community:
Community is the guardian of the story of God’s care for God’s creation, and for the human community in general and the community of faith in particular. But remembering the “story” corporately in worship and in every relationship in which the story is manifested emphasizes that both the giver and the receiver of care stand before God as peers, each of whom is the object of God’s doing for each. As God remembers God’s people, the community’s act of remembering its members reassures them that they are in the forefront of the congregation’s care.\textsuperscript{329}

A meta-analysis of religion and depressive symptoms in which (Smith et al, 2003) “conducted 147 studies that were examined and the investigators found that religion was protective for depressive symptoms in 113 of them (77%).”\textsuperscript{330} Pat Murphy (2000)\textsuperscript{331} conducted one of the few studies that examined the role of religion among people diagnosed with depression. “Murphy found that belief in a caring God was associated with lower levels of hopelessness and fewer depressive symptoms in 271 patients diagnosed with clinical depression.”\textsuperscript{332} According to this research project and this meta-analysis of religion and depressive symptoms a patient’s reconnection back to their spirituality or place of worship helps to provide good community support and the spiritual resources to cope with life’s challenges. In this research project it is important to note that in 29 out of 30 cases the spiritual care interventions went longer than the traditional fifty minutes and the patients’ received some new spiritual insight within one to three visits.

\textsuperscript{329} John Patton, \textit{Spiritual Care in Context} (Louisville, KY: Westminster/John Knox, 1993), 228.


4.5.5 Longer Spiritual care interventions and Only One to Three Visits

According to the general research data collection in 29 out of 30 cases each spiritual care intervention was ninety minutes to two hours as I was integrating a non-directive model of care in which I only followed the patients’ lead. I had one to three visits with each patient. According to this research study it appears that patients in a radical spiritual crisis might require extra time to re-visit their past trauma, grieve their losses, and receive new spiritual insight.

This research project points to the significance of brief spiritual care interventions in acute care settings. Up until this research project I wondered if anything of lasting spiritual significance could occur within the context of brief spiritual care interventions. The following is an overview of the research outcomes. Each visit is recorded between ninety minutes to two hours. Case one, Adam had one spiritual care intervention. Case two, Ann had three spiritual care interventions. Case three, Bess had three spiritual care interventions. Case four, Cassandra had two spiritual care interventions. Case five, Jerry had one spiritual care intervention. Case six, Trudy had two spiritual care interventions. Case seven, Ted had one spiritual care intervention.

“Traditional timeframes and number of visits at the U.K. National Health Service records Brief Cognitive Therapy research and it shows that clients receive between eight to sixteen sessions each fifty minutes in length.”

Research studies affirm that “Brief Cognitive Therapy provides a longer duration of effectiveness for depression with less

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The immediate significance of these research timeframes and positive outcomes affirms the role of spiritual care on the acute care psychiatric unit. Another consistent theme as found within the general research data collection is that patients often received new symbols of hope.

4.5.6 Symbolism

According to the general data research collection 21 out of 30 patients’ received new symbols of hope. During my spiritual care intervention with the seven adult participants in this research study each patient received some new spiritual insight and identified with some symbolism that they were able to relate to. When looking at the trajectory from the beginning of the visit until the end it is clear that a process of new spiritual insight has taken place.

Adam transitions from “spiritual suicide” to identifying with the symbolism of a “courageous soldier.” Ann transitions from wanting to “fade away and die” to “finding her yes to receive help.” Bess transitions from believing that it would be better for her to die than to live, to finding some peace by saying a Hebrew prayer. Cassandra transitions from the “religious confusion” of her sexual abuse to the symbolism of “running brooks” for cleansing and “angels” as God with her. Jerry transitions from “horrendous nightmares” to being “lonely for God.” Trudy transitions from her experience of “rejection and betrayal” and relates to the symbolism and belief that “God records her tears in His bottle.” Ted transitions from his experience of “satanic blood ritual” to receiving the symbolism and reality of “Christ’s blood sacrifice.”

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Symbolism in each of these seven cases appears to provide a tangible touchstone to confirm the significance of their new spiritual insight with a lasting symbol of hope. It is almost as though the traumatic event had its own devastating symbol which needed to be transformed into a symbol of healing and hope. Vernon H. Kooy writes about biblical symbols and names some of the significant symbols from the Old Testament. Kooy writes:

**Symbolic objects.** A certain symbolism, by way of association, or representation, was attached to numerous objects—objects of nature, as the pillar of witness, indicative of a covenant (Gen. 31:44-53; Josh. 24:26-27), the pillar of cloud, divine guidance (Exod. 13:21) and glory (Exod. 16:10); fire, the divine presence and glory (Exod. 3:2-6; 24:17; Lev. 16:2), guidance (Exod. 13:21), and wrath (Num. 11:1; Deut. 4:24; cf. Heb. 12:29); cult objects, as the ark, symbolic of the covenant (Exod. 25:10-22) and the presence of God (Num. 3:31; I Sam. 4:3-8); the tables of testimony, the law (Exod 25:16, 21; 31:18; 40:20); the altar of incense, prayer (Ps. 141:2), the altar of sacrifice, revelation (Gen. 12:7-8; 26:25; 35:1; II Kings 16:15); personal objects, as phylacteries denoting service to God (Exod. 13:16; Deut 6:8; 11:18), and fringes, the commandments (Num. 15:37-41; Deut. 22:12).

Whether the symbolism has international, national, community or personal relevance it is given to each person so that they will remember it with thanksgiving. The seven participants, who experienced spiritual reconnection back to their spirituality or place of worship named their inner healing and their related symbols that happened as a result of their new spiritual insight. Old and New Testament faith stories are rich with meaningful themes of remembering, re-visiting to find spiritual restoration.

4.5.7 **Remembering, Re-visiting and Restoration**

Biblical theology is rich with themes and spiritual practices which invite us to re-visit and remember past events in the present tense. The general research data collection records that

in 27 out of 30 cases patients’ experienced consistent spiritual care patterns which consist of remembering their trauma, re-visiting their memories, with some restoration.

In this research study seven participants re-visited their past traumatic memories, grieved their losses and experienced a degree of restoration. Case one, Adam said that he was able to remember, re-visit and release his feelings. Case two, Ann remembered to call, re-visited and released her feelings and therefore, received help that brought a degree of spiritual restoration. Case three, Bess remembered, re-visited her painful memories and was restored back to her Jewish faith. Case four, Cassandra remembered and re-visited her sexual abuse and found restoration through Psalm 23. Case five, Jerry remembered and re-visited his memories and on-going nightmares of his abusive father and afterwards he found his spiritual restoration through a reconnection with his place of worship. Case six, Trudy remembered and re-visited all of her traumatic memories and her faith was restored as she came to believe that God loves her enough to record her tears. Case seven, Ted remembered and re-visited his satanic ritual and was restored through a Christian ritual.

When I tried to find a biblical or theological parallel to illustrate the importance of my research outcomes, I came across a consistent theme of remembering, re-visiting and restoration. Remembering, re-visiting and restoration are thematic, biblical parallels which are interspersed within the faith and lived experience of both Jewish and Christian people of faith. Examples of remembering, re-visiting and restoration are located in the Old and New Testaments. Although I will not take time to do an exhaustive review in this thesis, I will offer several examples to enliven this redemptive process.

People of the Orthodox Jewish faith follow strict adherence to religious celebrations and holy days as commanded in the Torah. Jewish religious life is lived by their calendar
year which means set times to religiously remember, re-visit and re-enact the sacred events as recorded in the Old Testament. First and foremost they are commanded to stop work in order to remember the Sabbath, which begins Friday sundown and ends Saturday sundown. Here is a brief overview of their obedience to this biblical commandment to remember the Sabbath. Aside from honouring and worshipping Yahweh, the observation of Sabbath was meant to bring a holistic sense of healing and restoration:

Remember the Sabbath day, to keep it holy. Six days shalt thou labour, and do all thy work: But the seventh day is the Sabbath of the LORD thy God: in it thou shalt not do any work, thou, nor thy son, nor thy daughter, thy manservant, nor thy maidservant, nor thy cattle, nor thy stranger that is within thy gates.336

THE SABBATH is a day of rest on the seventh day of the week (Saturday)—after six days of creation God rested and declared the seventh day holy and a day of rest:

The Jewish Sabbath begins at home with blessings said over the candle lighting, blessings over and sharing of wine and Challah bread followed by a family meal. Then it is off to the synagogue, as a family, for Friday evening prayers to welcome the Shabbat. On Saturday morning observant Jews will, once again, attend synagogue for prayers and Torah readings and discussions of the designated Torah portion for that week. Then, at home, there is another family meal and an afternoon of relaxing talk and fun for the youngsters. Some of the most observant Jews will gather once more for a brief closing ceremony in the late afternoon.337

Likewise, similar biblical parallels are evidenced in the New Testament and celebrated with an international recognition of Christmas. Around the world, manger scenes reflect a touchstone experience with the original event in Bethlehem. We remember the angel’s words “Glory to God in the highest, and on earth peace among men with whom He is pleased.” Christians spiritually prepare their hearts to “make room” anew for the birth of

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336 Exodus 20:8-11.
337 Yosf Karo, Shulchan Aruch Orach Chaim (NY: Kehot Publication Society, 2005), 261.
the Christ-child. Although this event occurred over two thousand years ago, at a different moment and a different place in the world, Christians around the world take the time to remember, reflect about the original event and find spiritual restoration.

Easter is another international celebration where Christians around the world take time to go back to another historical event and to remember. Many Christians set apart time to re-enact and remember Christ’s passion, suffering, death and resurrection. We remember by reading the biblical texts and singing songs that remind us of the original event. Christians often meditate on the resurrection of Christ and this helps them to experience a measure of spiritual restoration.

**Summary**

Chapter 4, Analysis Part One shares an overview of the consistent themes and spiritual care patterns as found within the twenty-three cases from the general research data collection. Specific examples from the seven participants’ confirm the same themes and spiritual care patterns as found within the general research data collection. This research data provides the relevant spiritual care patterns and integration process of the new spiritual care model and spiritual assessment tools. Analysis Part two, highlights the relevant themes and consistent patterns as found across the thirty cases within the general research data collection with specific examples from the seven cases.

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Chapter 5

Spiritual Resistance and Spiritual Receptivity

“God whispers to us in our pleasures... but shouts to us in our pain.” In our grief is the opportunity to hear God’s voice even if, in our own minds, it is late in coming and our hearts are full of sadness and anger.  
-C.S. Lewis

5.1 Meeting Spiritual Resistance

How does inner-woundedness impact spiritual resistance?

During the last twelve years on the K4E, I have often met patients in what Washburn refers to as their stage of spiritual resistance. According to Washburn, spiritual resistance begins between the ages of 3-12 years old and continues until the second half of adult life.

Washburn’s integration of the Freudian concept of the primal repression refers to the stage when a child begins to repress their traumatic memories into their unconsciousness. It is important to understand the spiritual care dynamics to discover how inner woundedness due to past childhood abuse reinforces a person’s distorted belief system. Therefore, in this chapter I review a number of theories to interconnect the relationship between inner-woundedness and how it relates to a person’s state of spiritual resistance.

Adapting the object relations theory, along with Francis’ and Washburn’s psycho-spiritual models gives credence to the developmental process which translates into the culmination of many layers of beliefs that are formed, reinforced, and repressed over many years. By following Francis’ five stages of soul loss which include: deprivation, abuse, disconnection, loss of meaning and loss of identity, I am able to offer a spiritual assessment of a patient’s state of soul loss without soul recovery.
Ana Maria Rizzuto’s research and her integration of the object relations theory in her book, *The Birth of the Living God* 340 establishes the connection between a person’s first image of God as influenced by their earliest relationship with their primary caregivers. Due to childhood abuse some adult survivors continue to live unconsciously with a distorted belief system and a negative image of God. A person’s spiritual resistance is directly related to their distorted beliefs about themselves, others and God. In such cases, Lemoncelli and Carey’s research finds that, “God would be viewed as punishing, wrathful, distant, and conditional, while the self would be seen as unworthy of love, guilty of wrong-doing, and deserving of punishment.” 341 My new spiritual care awareness is to pay close attention especially when the adult survivor’s story reflects a negative concept of themselves, others or God.

In reviewing the research data, with the seven participants involved in this study some patients’ explicitly expressed their own negative image of God. Others only implicitly raise their existential questions related to God’s care for them. Unconsciously, the seven participants may have initially interpreted their past abuse from their faulty and distorted belief system. Washburn highlights the second half of adult life as the time of optimum spiritual receptivity which might potentially lead them to an experience of regeneration in spirit. Ironically, this is the time that often co-relates with a person’s radical spiritual crisis and *dark night of the soul* experience. The general research data collection affirms that 23 out of 30 cases fit into Washburn’s criteria as they were in the second half of adult life which is also their time of optimum spiritual receptivity.

340 Rizzuto, 30.

Within this research project, six out of seven adult survivors fit the criteria of being in the second half of adult life, but all seven were experiencing a radical spiritual crisis and emotional accessibility. In listening carefully to their memories, their phrases, themes and repeated words it was possible for me to pinpoint their distorted belief system or what Smith refers to as their lie-based thinking. An overview of Ed Smith’s theory is found in Chapter 2.

The following examples from the seven participants’ case studies reflect their distorted beliefs. Case Three, Bess’s image of Yahweh was formed in early childhood and deeply influenced by her parent’s shared memories of the Holocaust. Themes of spiritual abandonment by Yahweh resonated deeply within Bess’s unconscious memories and filtered into every facet of her life. Therefore, her earliest memories of Yahweh influenced her distorted belief system, negative image of God, and spiritual resistance. Consequently, Bess came to interpret all of her losses as well as her son’s upcoming marriage to a non-Jewish woman as spiritual abandonment by Yahweh. Bess’s distorted belief system may have contributed to her spiritual resistance and her initial inability to receive any spiritual comfort.

Case Four, Cassandra’s earliest introduction into her Jewish faith provided her with a good understanding and perception of Yahweh. However, after her father sexually abused her during her adolescent years, spiritual resistance became a reality in her life as she entered into a profound state of spiritual confusion. Cassandra said “while I was in the synagogue thoughts and feelings of the violation and the unholy were confused with the holy presence and prayers taking place” in this house of worship. Sexual violation and worship were two things at opposite poles away from each other. She said, “I was screaming inside of myself

\[342\text{Ibid.}\]
the screams which nobody would ever hear or understand.”\textsuperscript{343} Cassandra’s experience of sexual abuse and spiritual confusion influenced her distorted belief system forty years after this violation. Her inner-woundedness greatly impacted her spiritual resistance.

Case Five, Jerry had a distorted image of God due to his experience of physical, sexual and religious abuse. Jerry’s distorted belief system caused him and his family years of spiritual resistance as they departed from the church. Religious abuse kept Jerry and his family away from their previous spiritual practices and place of worship for many years.

Case Six, Trudy had a distorted image of God due to her existence abuse and rejection by her father from birth. Trudy’s father rejected her because she was born a girl rather than a boy. She was also sexually abused by her uncle and suffered a violation with the court system. Spiritual resistance became a reality within Trudy’s life and she no longer believed in the concept of justice. These events caused her to have a distorted perception of justice and she wondered whether a place of justice actually existed anywhere.

Case Seven, Ted’s image of God was metaphorically obliterated out of his conscious memory due to his satanic ritual initiation which happened when he was twelve years old. Ted’s distorted belief system caused his spiritual resistance for twelve long years. Although Ted had been raised in a Roman Catholic home and had attended church for the first twelve years of his life, his memory of God’s grace was all but forgotten. He believed that because he had “sold his soul to the devil” through his satanic ritual initiation that there was no way back to God for him.

Up until this research project, I had absolutely no conceptual model of when and how the earliest belief system was formed or how beliefs were reinforced and lived out by each of

\textsuperscript{343} Ibid.
us in an unconscious way. This aspect of spiritual care learning has revolutionized my spiritual care practice. As the seven participants involved in this research project shared their memories, a process of spiritual assessment helped me to locate their distorted belief system and to follow the trajectory back to where these beliefs originated. Washburn explains a person’s spiritual resistance as part of the developmental stage which begins between the ages of 3-12 years old.

5.2 Washburn’s Psycho Spiritual Model: Stage of Primal Repression

Washburn’s model incorporates the Freudian concept of the primal repression. During this time, a person is not receptive to interact or move towards the comfort of their spiritual source. Washburn’s model accentuates how the primal repression blocks a person’s accessibility to their past traumatic memories until the second half of adult life when the primal repression lifts. The following poem reflects Washburn’s stage of primal repression or a person’s time of spiritual resistance.

_The Elephant in the Room_344

There’s an elephant in the room.
It is large and squatting, so it is hard to get around it.
Yet we squeeze by with, "How are you?" and "I'm fine," and a thousand other forms of trivial chatter. We talk about the weather. We talk about work.
We talk about everything else, except the elephant in the room.
There’s an elephant in the room.

We all know it’s there. We are thinking about the elephant as we talk together.
It is constantly on our minds. For, you see, it is a very large elephant.

But we don't talk about the elephant in the room.

Oh, please say his (her) name.

For if I cannot, then you leave me....alone .......in a room........with an elephant.

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5.3 Regression in the Service of Transcendence—Stage One: Weakening of the Will

According to the general data research collection 12 out of 30 patients initially entered into a parallel experience to Washburn’s regression in the service of transcendence stage one. Washburn describes a person’s transition through the regression in the service of transcendence stage one as follows, “The weakening of the will that goes with the dark night of the senses is symptomatic of a transformative process that disarms and deactivates the ego so that, naked and still, it can be brought into the presence of spiritual power.” Therefore, it is important to understand Washburn’s regression in the service of transcendence stage one as part of the difficult spiritual transitionary stage towards a person’s potential experience of regeneration in spirit. Within the context of this research project all seven patients subsequently entered into regression in the service of transcendence stage two.

Initially, all seven participants’ followed a consistent spiritual care pattern and a parallel process of Washburn’s regression in the service of transcendence stage one which is predominately marked by a person’s withdrawal from the world. Nothing appears to fulfill people in this stage. Disillusionment with the world and a loss of their identity and meaning in the world reflect their state of crisis. Confrontation with the dark side of their own personality causes a person much angst and regret. Dostoevsky’s literary works explore human psychology in the troubled political, social and spiritual context of 19th-century Russian society. Dostoevsky’s statement gives forceful expression to a person regression in the service of transcendence stage one: He writes:

Oh, if I had done nothing simply from laziness! Heavens how I should have respected myself......because I should at least have been capable of being lazy; there would at least have been one quality, as it were, positive in me, which I could have believed myself. Question: What is he? Answer: A sluggard; how very pleasant it

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would have been to hear that of oneself! It would mean that there was something to say about me. “Sluggard”—why, it is a calling and vocation, it is a career.\footnote{Walter Kaufmann, \textit{Existentialism from Dostoevsky to Sartre} (Cleveland, OH: World Publishing Company, 1956), 66.}

The following statements reflect the seven research participants parallel experience of Dostoevsky’s observation of people who are in Washburn’s \textit{regression in the service of transcendence} stage one.

In Case One, Adam expressed some vivid aspects of Dostoevsky’s \textit{regression in the service of transcendence} stage one. Adam’s own words state, “I feel that I have committed spiritual suicide six or seven times.”\footnote{Adam’s words from the patient care notes.} He lived his life always on the verge of not wanting to exist. Adam was in so much spiritual pain that he describes himself as—in a spiritual way I was jumping off of the bridge.”\footnote{Adam’s words from the patient care notes.} From Adam’s own description of his life, it is clear that he is very despondent as he often imagined himself committing spiritual suicide by figuratively “jumping off of the bridge.” Adam’s vivid description and imagery accentuates his pervasive rehearsal of Dostoevsky’s \textit{regression in the service of transcendence} stage one which is a withdrawal from the world.

In Case Two, Ann called me on the phone with a similar statement as to Dostoevsky’s stage one example “‘Sluggard’—why, it is a calling and vocation, it is a career” closely parallels Ann’s statement.\footnote{Both phrases are Ann’s words from the patient care notes.} Ann refers to herself as a “parasite” because she was not able to achieve acceptable social norms or sustain a full time job. Therefore, her repeated statements were that “I am a parasite” and I want to “fade away and die.”\footnote{Kaufmann, \textit{Existentialism}, 66.} An overview of this case is
found in Chapter 4, as we come to realize that Ann was in reality passively\textsuperscript{351} suicidal and actually trying to permanently withdraw from the world. So, in Ann’s case it was much more than a metaphor, it was an actualization of her own words “I am a parasite” and I want to “fade away and die.” Washburn’s statement reinforces what Dostoevsky’s writes about regression in the service of transcendence stage one while reinforcing the spiritual stage.

Washburn writes:

Despair, it turns out, is worse than the mental ego’s worst fears about itself. Despair, therefore pushes the mental ego to the brink, from which it jumps. That is to say, the mental ego does what, for it, is impossible: it accepts its “nothingness” and “guilt” and takes the leap of faith. In taking this leap, the mental ego “lets go” at the deepest level of its being and thereby loosens primal repression and reopens the Dynamic Ground or [the source of their spiritual life].\textsuperscript{352}

In meeting Case Three, Bess, she was very definitely expressing a parallel to Dostoevsky’s regression in the service of transcendence stage one as she wants to “jump out of her skin” she was so “out of control”\textsuperscript{353} that she wanted to end her life. She was tempted to use a knife to end her life. Bess wanted to withdraw from the world in a literal sense and her own words parallel Dostoevsky’s example: “I wanted to end my life.”\textsuperscript{354}

Case four, Cassandra was expressing Dostoevsky’s example of regression in the service of transcendence stage one as she said “something is wrong with me, I do not like

\textsuperscript{351} Passively suicidal is my own description of starvation in relationship to her desire to “fade away and die.”

\textsuperscript{352} Washburn, Ego and the Dynamic Ground, 176.

\textsuperscript{353} Both of these phrases are Bess’s words from the patient care notes.

\textsuperscript{354} These are Bess’s words from the patient care notes.
myself. I do not trust other people.” Cassandra’s lack of self-esteem caused her to withdraw from herself and her lack of trust caused her to withdraw from other people. It appears that Cassandra’s own withdrawal from herself and other people is a form of withdrawal from the world.

In meeting with Case Five, Jerry, during regression in the service of transcendence stage one, he describes his life as “difficult, sad and traumatic.” He is “nervous and apprehensive.” Jerry’s words reflect a world that is devoid of any pleasure. Jerry does not sleep well at night, due to his nightmares of his deceased father’s attempts to physically beat him again and he replies, “Go away.” Jerry’s words reflect his own sense of disillusionment with his life. Jerry’s life reflects his difficult, sad and traumatic life as Dostoevsky’s example of regression in the service of transcendence stage one.

Meeting with Case Six, Trudy reflects Dostoevsky’s example regression in the service of transcendence stage one. Trudy’s own words “I feel utter anguish, heartbreak and confusion. I am worried, afraid and hopeless about the future.” Trudy believed her father’s words “you have to be a boy to count.” Nothing in life appears to be meaningful or hopeful for Trudy, and in fact, she is hopeless about her future.

Case Seven, Ted’s words reflect Dostoevsky’s example of regression in the service of transcendence stage one. Ted’s words “I am always fearful, angry and upset. I am always stressed, full of guilt and remorse.” Ted’s words express a withdrawal from a meaningless life.

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355 These phrases are Cassandra’s words from the patient care notes.
356 These phrases are Jerry’s words from the patient care notes.
357 These phrases are Trudy’s words from the patient care notes.
358 These phrases are Ted’s words from the patient care notes.
My own spiritual receptivity when meeting patients during Washburn’s *regression in the service of transcendence* stage one is to offer on-going personal prayer for them.

On-going personal prayer represents my own spiritual receptivity for those discerned with *regression in the service of transcendence* stage one. One major reason for this spiritual care practice is because this patient is spiritually disconnected and unable to access their inner spiritual resources. From a spiritual care perspective, knowing that I am praying specifically for them appears to be helpful. Persistence in prayer is my commitment to “stand in the gap” for them. Continued prayer comes with the realization that my commitment of prayer continues until the adult survivor experiences some new spiritual insight.

Brilliant historical figures accentuate that prayer is the spiritual component and essential ingredient for other dimensions of life. Albert Einstein made the following statement: “Science without religion is lame. Religion without science is blind.” Some of the most recent prayer research appears to indicate that people are becoming more holistic in their thinking, which allows for an exploration of the role of prayer and religious coping in the health care system. Some scientists are more receptive to the role of faith and prayer in relationship to healing. The following research articles open a window of hope towards a holistic paradigm which includes spiritual and religious coping as an important focus in the healthcare setting. The *Journal of the American Medical Association* wrote the following: Of the ten most often utilized alternative treatments in the United States, “prayer for self (43%) and prayer for others (24.4%) are the two most commonly used therapies and being in a

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prayer group (9.6%) ranks fifth.”360 Another article reviews the concept of prayer as being a central value of many faiths and cultures: Edman and Koon’s research found the following, “Prayers for health concerns are common in Christianity, Judaism and Islam. There is evidence from several countries outside the U.S. that prayer is commonly used.”361 Tracy and colleagues conducted a national survey of critical care nurses and found that, “73% of critical care nurses use prayer in their practices, 81% had recommended it to their patients and 79% had been requested by patients and their families to pray on their behalf.”362 Dr. Daniel Benor, wrote the following excerpt in Complementary Medical Research:

After reviewing the literature, Dr. Daniel Benor (Complementary Medical Research 4:1, 1990) found 131 controlled studies involving prayer or spiritual healing. Of these, 77 showed statistically significant results. A sample of some of these studies follows: Prayer-like consciousness has been shown to inhibit the growth of cancer cells, protect red blood cells, alter blood chemistry, and increase oxygenation. In one study, skin wounds healed at a much greater rate when treated with a spirituality-related treatment (perhaps a therapy option for pressure sores).363

Prayer and holy listening provides the foundational essence of my own faith and practice. An on-going practice of personal prayer continues for patients that are discerned with Washburn’s regression in the service of transcendence stage one or Francis’ “soul loss without soul recovery.” Regression in the service of transcendence stage two marks a patient’s entry into re-visiting their past trauma in the present tense.


5.4 *Regression in the Service of Transcendence*—Stage Two: Spiritual Receptivity

People who are entering into Washburn’s *regression in the service of transcendence* stage two are in a radical spiritual crisis. Often their clinical presentation during the *regression in the service of transcendence* stage two is characteristic of a pathological mental health disorder.

Washburn writes:

> The first stage of the *regression in the service of transcendence* has often been grouped together as symptoms of “existential vacuum,” “existential neurosis,” or “existential sickness” (Frankl 1962, 1969; Maddi 1967, 1970; Yalom 1980) or as symptoms of a schizoid or “divided self” (Fairbairn 1940; Guntrip 1952, 1961, 1969; Laing 1960) And experiences belonging to the second stage have as a rule been considered symptoms of one or another of the psychoses, usually either schizophrenia or bipolar psychosis. In many if not most instances it may be correct to categorize experiences like those belonging to the stages of *regression in the service of transcendence* as pathological phenomena. In some instances, I propose, the experiences in question have a redemptive rather than a pathological significance and, therefore, are properly understood as part of the process of *transcendence* rather than as symptoms of mental illness.³⁶⁴

Chapter 4 provides examples of the mental health presentation that often takes place before a person enters into the *regression in the service of transcendence* stage two. Two examples as already discussed in Chapter 4 reflect a parallel process as described by Washburn. Case Two, Ann’s mental health presentation was that she was passively suicidal as she had not eaten any food for six days because she wanted to fade away and die. Because Ann was in a radical mental health crisis and a radical spiritual care crisis she was able to revisit the issues that “disturbed her spirit” with an emotional release. Afterwards she received the emergency medical intervention and some new spiritual insight. Case Three, Bess was suicidal before she re-visited her past trauma in the present tense with an emotional release and new spiritual insight.

New learning and the spiritual care lesson that originates from Washburn’s teaching is that when a person is in the midst of a mental health crisis it is essential for me to rule out a spiritual crisis. In ruling out a radical spiritual crisis it is especially important to make a spiritual assessment of Washburn’s regression in the service of transcendence stages one or two and if so, to recognize the specifics of each stage. Washburn describes people who enter into the regression in the service of transcendence stages one and two as presenting with bizarre behaviour or psychiatric-like symptoms which I often witness when patients are admitted into the psychiatric unit. Chapter 4 describes the seven patients’ parallel experience of the regression in the service of transcendence stages one and two through a review of the seven cases. Washburn’s overview of the symptoms alerts the reader that something strange actually does take place. His exaggerated symptoms are meant to describe the most radical case scenario, not anyone’s real presentation:

1. Disconcerting feelings;
2. Strange bodily phenomena;
3. Dread and a sense that the world has become strange;
4. Disturbances to cognitive processes; and,
5. Recurrence of the ego-Ground conflict accompanied by fear of ego death.

Meeting with a patient during this parallel process of Washburn’s regression in the service of transcendence stage two alerts the spiritual care specialist of the turning point as the patient shares previously unconscious memories of their past trauma in the present tense. As this new spiritual care dynamic unfolds within the spiritual care setting the patient enters “the prepersonal unconscious stage which encompasses three major spheres: the social, psychological and spiritual categories.” In 27 out of 30 cases from the general research data collection a parallel process of Washburn’s regression in the service of transcendence

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365 Washburn, Ego and the Dynamic Ground, 173.
stage two and regeneration of spirit unfolds. The general research data verifies that 21 out of 30 cases received new symbols of hope. According to the research questionnaires filled out by the seven participants, they were still connected with their spirituality or place of worship after one year. Washburn writes: “In some instances, I propose, the experiences in question have a redemptive rather than a pathological significance and, therefore, are properly understood as part of the process of transcendence rather than as symptoms of mental illness.”366 As a spiritual care specialist it would be wise for me to remember Van Dusen’s words, “in the black holes of psychic space, there is a definite restorative process.”367 In this thesis I use the words new spiritual insight to describe this restorative process.

Because this research represents a small sample, further research is necessary to determine if other spiritual caregivers also find a parallel to Washburn’s last three spiritual stages in their own spiritual care practice. The seven participants’ implicitly or explicitly named eight benefits from their spiritual care experience. Eight Benefits of Seven Participants in the Research Study,

1. Enables a person to have the insight to seek help because they are in crisis.

2. Allows them to respond in trust and comfort to the atmosphere of unconditional acceptance.

3. Helps a person to relax and feel comfortable knowing that the spiritual caregiver is deeply present and listening to them.

4. They know that they are free to re-visit very traumatic events because they have a spiritual companion.

5. They know that they can take as much time as they need to explore each memory and express their emotions and pain without being judged.


367 Washburn Ego and the Dynamic Ground,189.
6. A person emerges from expressing their pain and they feel the deep emotional release within their soul.

7. They begin to have new spiritual insight, a new perception, symbol or metaphor that they are able to relate to. They understand their spiritual disconnection and want to be re-connected back to their spirituality or religious community.

8. A person receives new spiritual insight and names their spiritual reconnection.

Other spiritual care specialists’ record similar experiences as their patients receive what appears to be parallel experience of Washburn’s regression in the service of transcendence stage two into the regeneration in spirit as found in the Susan MacDonald Roddey’s poem entitled “The Space Between Us.”

The Space Between Us

You carry in the gifts,
Birthed in the layers of your life and the ones before you,
Carefully gathered from the cupboards of your tent
Hidden behind the curtains of your temple
    And tentatively lay them
But maybe quickly dump them
    With soul piercing power
In the space between us.
    You may not know,
(As indeed I often forget)
That this space is a table where the sacraments are carefully laid out,
    And slowly yet also suddenly
are transformed to become visible signs of the invisible grace
of the Broken yet Restored Body of
I AM WHO I AM; I WILL BE WHO I WILL BE
    Adonai
    In the space between us
the sacraments become visible
    in holy, fleeting moments
    that pierce my soul.
The parts of yourself you carry in
Declare ugly
Describe with heartbreaking pain
And hurl into my heart
With such force that I can only sit helpless,
Are precious treasures
Twisted and distorted
So that the imago dei seems to be emptied out
Into a terrifying nothingness.
In the space between us

We flounder in our helplessness together
But in “Kairos Moments”
The Holy gives my eyes the sight to see
How beautiful and precious these
Seemingly ugly gifts indeed are
As I separate them from the parts of myself that I declare ugly.
And in the space between us
A mystery happens.
While I remember that the gifts you lay out
Upon what you might think (and I often believe)
is the altar of me,
are gifts not for me to carry and possess,
but are laid on the table of the Broken One,
whose Glory has tabernacled within the tent
we have spread out
in the space between us…
…While I remember the mystery of this space…
The parts of yourself
You have spread out with such shame
On a table that holds the sacraments of what was Death,
Become molded into the precious vessel of yourself
Through whom the Imago Dei is revealed
as you hold Life within your cracked chalice.
And as the space between us slowly widens as it holds more Life
I realize I am joyful for Life and experience Awe,
And I also am sad to let go and release.
And You, O Yahweh, Adonai, Christ, the Three-in-One, Lover of my Soul
Gently remind me that if I were to possess
the sacraments laid out on the table
and believe that they were laid out on the teetering altar of myself,
then the Broken Glory, El-Shaddai, Immanuel,
could no longer tabernacle in the tent that I helped spread
in the space between Us.  

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368 Susan Mac Donald-Roddey, “The Space Between Us,” Journal of Methodist Counseling and Consultation Services 2/3 (Fall 2008): 4-5. I received written permission from the author to include this poetry.
Summary

Chapter 5, Meeting Spiritual Resistance and Spiritual Receptivity in the spiritual care setting reviews my new spiritual care methodology which is based on Francis’ and Washburn’s psycho-spiritual models. As recorded in the general data collection, 27 out of 30 patients entered into what appears to be a parallel process of *regression in the service of transcendence* stage two and they received new spiritual insight and reconnected with their spirituality or place of worship. After a one year period the seven participants’ recorded that they are still connected to their spirituality or place of worship.
Chapter 6

A Sacred Place for Wounded Souls

“You must make them feel loved and wanted. They are Jesus for me. I believe in that much more than doing big things for them.” -Mother Teresa

After reflecting on the time that has been set apart for this study, I cannot help but be amazed at the process and learning that has taken place. Upon entering into the DMin studies a new world of learning unfolded as these studies beckoned me to ask more questions about what the spiritual care obstacles for adult survivors of childhood abuse might be. Reviewing the trauma research for adult survivors provided the necessary insight to name at least six potential obstacles that might prevent an effective spiritual care intervention from happening. A review of the spiritual and religious coping research affirms that adult survivors of childhood abuse who embrace their spiritual connection experience a degree of posttraumatic growth. Researching other spiritual care practitioners who are pioneers working with adult survivors of childhood abuse helped me to establish six spiritual care practices to counteract their potential spiritual obstacles. Throughout my spiritual care intervention with the adult survivors in this research study I have consciously created a sacred place with prayers for spiritual direction, an authentic relationship of unconditional acceptance and empathy, in a non-judgmental environment using a non-directive paradigm. A complete overview is found in Chapter 2.

Incorporating Francis’ and Washburn’s psycho-spiritual models as assessment tools definitely improves my spiritual care methodology with adult survivors as I am able to make spiritual care assessments from the onset of their spiritual crisis throughout the various
stages until I recognize Francis’ soul loss with soul recovery or Washburn’s *regeneration in spirit.*

6.1 New Spiritual Care Practice: A Crisis Intervention Model

As stated earlier in this thesis, according to Washburn’s psycho-spiritual model during the second half of adult life the primal repression lifts and this is a person’s time of optimum spiritual receptivity and potential experience of *regeneration in spirit.* Therefore, in my own spiritual care practice it is my observation that 23 out of 30 adult survivors fit the criteria and were in the second half of adult life. In this study 25 out of 30 adult survivors were spiritually receptive, requested their own spiritual care intervention, and had emotional accessibility and were in a radical spiritual crisis before they entered into a process of *regression in the service of transcendence* stages one and two.

This new spiritual care practice includes an integration of six spiritual care assessment tools: (1) Prayer for Spiritual Direction, (2) Francis’ External Spiritual Care Assessment Tool, (3) Washburn’s Internal Spiritual Care Assessment Tool (4) The U-Turn, (5) Emotional Release as a Spiritual Care Dynamic, (6) New spiritual insight, or Washburn’s *Regeneration in Spirit.* The following is an overview of this new spiritual care methodology.

6.1.1 Prayer for Spiritual Direction

Prayer for spiritual direction is based on the wisdom inherent in Ed Smith’s theophistic prayer, which translates into two prayers. These prayers are said at appropriate times throughout the visit. This is a simplified version as I believe that it only takes a simple faith to believe for spiritual direction. Lord, guide this person to the memories that they need to re-visit. As they re-visit their trauma I pray, Lord, help them to receive new spiritual insight.
6.1.2 Francis’ Ten Stage Spiritual Care: External Spiritual Care Dynamics External

Assessment

**Soul Loss stages:**
1. Deprivation
2. Abuse
3. Disconnection
4. Loss of meaning
5. Loss of identity

**Soul Recovery:**
7. Remembering
8. Emotional Catharsis
9. Authenticity and empowerment.

Francis’ ten stage spiritual care model is a valuable spiritual care assessment tool that I have incorporated as the external spiritual care assessment tool, as it helps the spiritual caregiver to listen to patients’ stories as they review their lives, and to pinpoint some of the external factors that have influenced and contributed to stages of soul loss. The spiritual assessment of soul loss without soul recovery has led me to be spiritually receptive to continue to pray for them.

As noted in the general research data that 3 out of 30 patients’ were discharged from the hospital in a state of soul loss without soul recovery and are therefore disconnected from the source of their spiritual life. I was able to make a spiritual care assessment of 24 out of 30 cases of soul loss with soul recovery. It is an absolutely redemptive spiritual care experience to hear and pinpoint the patient's spiritual movement from soul loss into stage 6 longing for connection, as this usually means that the patient is moving from spiritual resistance to spiritual receptivity.
6.1.3 Washburn's Regression in the Service of Transcendence Stage One

As a spiritual care specialist my practice is to prayerfully listen to the adult survivor as they move through a parallel experience of Washburn’s regression in the service of transcendence stage one which he describes as a person’s withdrawal from the world. During this stage the adult survivor shares their sense of meaninglessness and disillusionment within their own experience. I continue to empathize with their spiritual desolation, while creating the sacred place for them to give full expression as they grieve their losses.

6.1.4 Washburn's Regression in the service of transcendence stage two is the prepersonal unconscious stage where the adult survivor re-visits their long-forgotten memories. At times, they may be led to more than one memory during the spiritual care intervention. Within the general research data collection in 27 out of 30 cases this process unfolded within one to three visits.

6.1.5 The U-turn enables the spiritual care specialist to pinpoint the entry and exit points as the patient enters into Washburn’s regression in the service of transcendence stage two. At this point, I am able to discern a patient’s entry into previously unconscious memories where the adult survivor re-visits and grieves their losses with an emotional release.

6.1.6 After the Emotional Release occurs, 27 out of 30 patients as found in the general research data collection also experienced some new spiritual insight and a reconnection back to their spirituality or place of worship. The seven participants in this research study are recorded as maintaining their spiritual connection one year after the spiritual care
intervention. Washburn defines this experience as *regeneration in spirit* and subsequently as *spiritual integration*.

I provide a sacred place where the adult survivor feels comfortable to shed their tears and grieve their losses with an emotional release. This spiritual care dynamic is based on my own comfort level and spiritual care wisdom to offer spiritual companionship, without disturbing or interrupting the spiritual care process.

After the adult survivor experiences their emotional release, I silently pray that they will receive a new spiritual perception of their memories. As they receive new spiritual insight, they also receive a new sense of spiritual peace concerning their past traumatic events. In the general research data collection 21 out of 30 adult survivors also experienced a new symbol of hope for their lives. This is Washburn’s stage of *regeneration in spirit*.

### 6.2 Conclusion

Washburn’s model is most effective when meeting with adult survivors who are in the midst of a Level Three radical spiritual crisis. As mentioned in Chapter 1, the four prominent and common factors of people in a radical spiritual crisis are these. First, an important initial sign of a radical spiritual crisis is that a person is “disturbed in their spirit” or in a state of spiritual unrest. 

Spiritual unrest is an observable lack of spiritual peace which is also symptomatic of a person’s disconnection from their spirituality or place of worship. Due to their spiritual disconnection they do not have spiritual accessibility to their inner spiritual resources and they are unable to receive any comfort through their previous religious practices. Second,

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369 Throughout this thesis I use the terminology “disturbed in their spirit” to describe the adult survivor’s spiritual care crisis, distorted belief system or the spiritual unrest that exists within a specific area of their life.
they have spoken or unspoken existential questions about the meaning and purpose of their life. Those experiencing a spiritual crisis tend to ask spiritual caregivers existential questions: “Is God punishing me?” “What did I do to deserve this?” “Why would God allow this to happen to our family?” “Who and where is God for me now?” Third, there are discernible signs that they are in Washburn’s dark night experience as they feel that their life is meaningless and they have no hope.”

Fourth, they have entered into some, most, or all stages of Francis’ loss soul without soul recovery.

Another significant and essential research observation is that this methodology is most helpful for survivors experiencing a radical spiritual crisis, who requested their own spiritual care intervention, and those who have emotional accessibility as they appear to be most spiritually receptive to re-visit their past trauma in the present tense. The major focus is that survivors are essentially ready to do their grief work with an emotional release. These signature characteristics provide key components to evaluate patients that will most probably benefit from this particular crisis intervention spiritual care model. This research study brings forth the consistent spiritual care pattern which occurred within 27 out of 30 cases. Patients’ ability to re-visit and grieve their past abuse with an emotional release appears to be a consistent pre-requisite to their parallel experience of Washburn’s regeneration in spirit.

The other point to reinforce is that survivors of childhood abuse require a sacred place with a flexible timeframe to meet their spiritual care needs. Therefore survivors respond best to an authentic relationship of unconditional acceptance in a non-judgmental environment with a non-directive paradigm, theophostic prayer and an integration of Burney’s emotional

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370 Chapter 3 gives an overview of Michael Washburn’s psycho-spiritual model.

371 Francis’ spiritual care model is discussed explicitly in chapter 1.
release dynamic as a spiritual care dynamic. This model has been specifically designed to meet the spiritual care needs of adult survivors of childhood abuse.

The success which I experienced with a non-directive spiritual care model leads me to commend it to other spiritual care specialists who are counselling adult survivors of childhood abuse. This includes the willingness to move away from the strict fifty minute spiritual care intervention. According to my research stats the duration for each spiritual care intervention is between ninety minutes to two hours. The reason for the expanded time frame is that when a person is accessing more than one memory during the same spiritual care intervention they need extra time to grieve each of their losses before they enter into the next memory.

I observe that it is important to allow the survivor to lead the spiritual care specialist as they re-visit their past trauma. If they only name their memory, but do not enter into or re-visit it, that is a signal they are not ready to disclose this event. To do so prematurely would be to violate their sacred space. Always honor the survivor and follow their lead as this helps to reinforce their trust. It has been my practice before and during my research study never to ask a survivor to share or disclose their past traumatic event. When they are ready, they will share it. An essential part of my spiritual care practice is to meet them in the hospital setting where psychiatric professionals are always available. My research process allowed me to be the spiritual care specialist initially and then the researcher one year later. Future researchers might consider this process for their own research project.

I am deeply aware that my spiritual care research represents a small research sample and that further research needs to be conducted to verify if other spiritual care specialists discover similar spiritual care patterns, themes, and outcomes when meeting with adult
survivors of childhood abuse. Other research studies are essential to confirm if other adult survivors request their own spiritual care intervention, are in the midst of a radical spiritual crisis, with emotional accessibility during their time optimum spiritual receptivity. It is my sincere hope that further research is conducted with adult survivors of childhood abuse.

My critique of Washburn’s psycho-spiritual model and his integration of the Freudian and Jungian theories invited me to consider at least one new perspective to the age old question regarding a person’s times of spiritual resistance and spiritual receptivity. Washburn’s integration of the Freudian theory invites one to consider how a child might engage in a process of repression of traumatic memories into their unconscious sphere for decades and how these memories are inaccessible to their conscious memory. The Jungian theory invites us to envision the dramatic lifting of the primal repression whereby a person now has complete accessibility to previously unconscious memories. My research study confirms that the majority of patients within the general research data and the actual participants within the research study did fit the criteria of being in the second half of adult life. I can certainly appreciate Washburn’s explanation for encountering people in the midst of their times of spiritual resistance and times of spiritual receptivity.

Integrating Washburn’s psycho-spiritual model into this thesis and research project has led me to observe discernible stages of the regression in the service of transcendence stages one and two as a parallel spiritual care process within my own practice. Being able to spiritually discern the stages of this process from the onset of Washburn’s dark night of the soul to regeneration in spirit provides a spiritual process to follow. All in all, Washburn’s psycho-spiritual model is very effective when meeting patients during a Level Three Radical Spiritual Crisis. There is one question that causes me to offer some critique to Washburn’s
theory and this is because some young patients also received a parallel experience to Washburn’s *regeneration in spirit*.

Research findings point to the fact that patients who did not fit the criteria of being in the second half of adult life also experienced Washburn’s *regeneration in spirit*. This reality prompts me to question Washburn’s concept by asking a new question: Is there a possibility that a radical spiritual crisis might also cause the primal repression to lift or dissolve?

General research data suggests that some patients in their late teens, early twenties, and thirties also had a positive response to this research methodology. Case seven, Ted had a very positive response to this research methodology and he was only twenty-four years old. Although my research project focused on adult survivors of childhood abuse I suggest the other spiritual care specialists might find my spiritual care methodology effective with younger patients. Other spiritual care specialists might consider a future research project using this methodology with younger patients as a prospective focus.

After reviewing a substantial amount of literature related to adult survivors of childhood abuse it has come to my awareness that there is a lack of literature and qualitative research studies to examine the impact of spiritual care interventions with adult survivors of childhood abuse within the Acute Care setting. Perhaps spiritual care specialists working within the Acute Care setting are wondering if their spiritual care interventions are having a positive impact on their patients. Some spiritual care specialists might dismiss or minimize their focus away from engaging in a research project due to the brevity of time spent with their patients before they are discharged. Until my meeting with Jim, I had no idea that a positive contribution to spiritual care could take place in a relatively short timeframe. Now, I
realize that the spiritual care perspective as based on the prayer of St. Francis can happen in a short timeframe.

The Prayer of St. Francis characterizes my concept of spiritual care par excellence. As a spiritual care specialist, my constant challenge is to become an instrument of God’s peace, joy, faith, hope, forgiveness and consolation. As the prayer proclaims--believers are instruments of God’s amazing grace, and as such, spiritual transformation from hatred to love, from injury to pardon, doubt to faith, darkness to light and from sadness to joy is absolutely possible! At the heart of my research project my hope was to create a comprehensive spiritual care practice and to evaluate it from a patient’s perspective. Washburn’s psycho-spiritual model is instrumental in helping me to gain some new spiritual care insight into discerning the adult survivors’ optimum time of spiritual receptivity and the stages towards their experience of *regeneration in spirit.*

*Regeneration in spirit* or a parallel experience occurred within the lives of 27 out of 30 cases in the general research data and seven participants in this research study maintained their spiritual connection for a one year period. The exciting news is that the positive outcomes happened within one to three spiritual care interventions. Duration of the time spent in the spiritual care intervention with each person is recorded between ninety minutes to two hours. Recognition of a patient’s radical spiritual crisis and the spiritual care opportunity enlightens me to move with them during their time of optimum spiritual receptivity. Creating a sacred place for wounded souls has provided a liberating process for adult survivors of childhood abuse to re-visit their traumatic events, grieve their losses with an emotional release and to receive a profound spiritual reconnection back to the source of their spiritual life.
Appendices

Appendix A

Doctor of Ministry Thesis Proposal

A Sacred Place for Wounded Souls

   a. Personal Background and Research Interest

   In my role as on the Mental Health Unit, I work in the context of an Interdisciplinary Team with six psychiatrists, nurses, pharmacists, social workers, a dietician, a recreation therapist and an art therapist. During Mental Health rounds each discipline gives its specialized perspective in the process of offering a high quality of holistic care to each patient. Each week I make visits to patients who are struggling with emotional and spiritual issues, questions of meaning and purpose for their lives, abuse problems and questions related to their spirituality. Often patients share an overview of their life, beginning where they are in the present and then moving back to highlight memories and experiences that they wish to re-visit. During this time of sharing they often grieve over their losses and gain a new perspective of the events that they re-visited.

   From a social perspective, I have met many adult mental health patients who shared their stories with themes of childhood abuse. In the safety of the pastoral care setting patients feel a warm welcome, unconditional love, acceptance and empathy which often opens them up to feel safe enough to trust me and share their secrets. Often patients tell me that this is the first time they have ever shared their secret with anyone. In this safe place these wounded souls find the freedom to shed their tears, express their emotions, as they re-visit a traumatic event with a loving and empathetic companion who understands and journeys with them.

   In my pastoral care practice, I re-visit these experiences with patients and often
feel as if I was actually back with them at the original event. An example of this took place at Humber River Hospital, with a patient who I will call Jim. Jim is an intelligent, young engineer who was diagnosed with bipolar disorder. Bipolar disorder includes intermittent alternative episodes of mania and high energy, and also times of depression which often drain the patient’s energy and greatly diminishes the patient’s quality of life.

This patient had been admitted into the hospital after a very serious suicide attempt. When I went to visit Jim, he shared with me that his psychiatric treatment did not appear to be helping him. I mentioned to Jim that the health care professionals needed to get down to the underlying root cause of his illness. Jim did not believe that the psychiatrists were interested in finding the root cause of his illness. It was obvious to me that Jim wanted to talk to me. For the first time in his life, he shared an enormous secret of childhood trauma.

Jim’s trauma happened within the context of his family which included his mother, father and sister. The extent of the trauma included emotional, mental and sexual abuse. In the safety of the pastoral setting, Jim felt free to unburden his pain and shed his tears. He had carried his trauma inside for almost thirty years. I asked Jim if he would write down the negative beliefs and values that he held about himself as a result of his childhood trauma. He agreed that this would be helpful, and over the next few weeks, he came up with four or five of what I call, maladaptive core beliefs. In my view, maladaptive core beliefs are beliefs residing in the deep unconscious of a person that prevent an individual from reaching his or her potential. Potential develops within a person through self-awareness. Being self-aware a person is able to name his or her own gifts, talents and abilities and to devise a plan to reach one’s goals. In my view, inner motivation and determination to reach their own goals will bring the maximum meaning into a person’s life.

Conversely, maladaptive core beliefs can include failing to live up to one’s full
potential and can lead to self-destructive behavior patterns. In Jim’s case, his self-destructive behavior pattern was demonstrated by his inability to name or value his own potential and worth as a person. Bipolar disorder, childhood abuse and Jim’s ensuing lack of self-esteem caused him to feel and believe that his life was not worth living. He was compelled to end his life. This resulted in a serious suicide attempt that almost ended his life.

Eventually, Jim revised his destructive maladaptive core beliefs. He altered his beliefs so that they became a more positive statement of hope. The quality of Jim’s life continues to improve and he is now able to use his leadership skills to enhance the lives of other mental health patients. The other benefit of this spiritual care intervention is that Jim began to embrace a new spiritual dimension within his life. He writes daily prayers to God, and now attends church. Even without mentioning God explicitly, Jim’s healing allowed him to embrace concrete ways to celebrate his new-found spirituality. By getting in touch with and revising his core maladaptive beliefs, Jim became freer to experience God more as an unconditional loving presence.

b. Ministry Setting

Humber River Hospital is comprised of three different hospital sites that became one hospital. Geographically, the hospital covers a huge catchment area beginning at Jane and Finch, which reaches all the way to Jane and Church and extends to Keele and Lawrence Avenue. My ministry context is the psychiatric unit at the Keele site of Humber River Hospital. Our hospital is recognized as an acute care setting, which means that we are not funded by the government for long term care.

The nature of an acute care hospital is to effectively treat the patient on a short-term basis and to release them as quickly as possible. Spiritual caregivers are therefore challenged to meet with the patient in crisis and to establish a pastoral care relationship as quickly as
2. Statement of the Research Question

In the mental health setting at Humber River Hospital, I have met with a number of patients who disclosed that they have suffered from childhood trauma or abuse. Due to the pastoral care breakthrough with Jim (mentioned in the previous section), I would like to explore the hypothesis that a similar pastoral care intervention might help others who need to be healed of childhood trauma or abuse. My pastoral plan is to create a sacred place for wounded souls to feel safe enough to share their stories. If patients know that there is a place to come where they will be unconditionally accepted and loved just as they are, perhaps they will feel safe enough to let down their unconscious guards and also find a place to be healed.

In this study I want to discover the effects of my method of pastoral care interventions on the life and healing of the mental health patients at Humber River Hospital.

3. The Theoretical Framework and Assumptions Involved in the Study

a. Theological Framework

i. Spirituality and God’s Grace

Spirituality and God’s grace are present in the pastoral care interaction as the spiritual caregiver prays for spiritual direction throughout the whole pastoral care intervention. Grace is the free gift of God given by Jesus Christ to whosoever will receive it. The grace of God is
present to meet with people who are in need of encouragement, emotional or spiritual healing and a new perspective or revelation of the divine in their lives.

Key assumptions in this thesis are derived from a biblical perspective of God’s grace as recorded in the creation story. My assumption is that all people are created in the image and likeness of God. We all have the breath of God’s spirit within us. From the Christian perspective, we have a common creator, and are created to reflect God’s love and glory. My assumption is that all people are created with an implicit or intrinsic predisposition for spirituality. Basil Studer, in writing on second and third century theologians, maintains that Tertullian and Ireneaus affirm a belief in the innate spirituality of human beings. Studer writes:

Expound a vision of the order of salvation in which creation and the perfection of man occupy first position. Creation was aimed at man, God formed him with his hands: with the Word and Spirit. Thus man, made out of clay, was an image of Christ and with the breath of life through the Holy Spirit was granted likeness to God.\(^{372}\)

St. Augustine’s theology also embraces the belief that humankind is an integral part of God’s creation: “Lord, you have made us for yourself and our hearts are restless until we find our rest in you.”\(^{373}\) Karl Rahner also affirms an intrinsic spirituality through our common


humanity. He states: “The incarnation of Jesus Christ is an intrinsic moment in the whole historical process by which grace is communicated to all persons.”

All people experience adversity at one time or another in their lives, and often it is these experiences that lead people to a faith relationship with Christ. God’s compassionate presence helps us through our suffering and leads us to become more empathetic with others who suffer.

**ii. Theology of Christian Healing**

Salvation is the greatest healing that Christ invites us all to receive. All people are invited to know God and to receive forgiveness and newness of life. God’s revelation of Christ is a work of the Holy Spirit which occurs as a result of Christ’s death and resurrection. Whether a person receives God’s grace as a revelation of Christ, either implicitly or explicitly, is contingent upon his or her free will and choice. All other healing happens by the grace of God through Christ. The act of following Christ is an invitation for us to experience an abundant life, “I have come that they might have life and have it to the full” (John 10:10b). Many times in the biblical texts we read that when Christ healed people, he was moved with compassion for their suffering (Mark 1:41). God knows our suffering, whether it is past hurts, a violation, abuse, mental or emotional anguish or physical malaise. He is touched with the feeling of our infirmities and moved with compassion to bring forgiveness, restoration of relationships, emotional, spiritual, physical or psychological

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375 Theologically, salvation is also known as redemption and is the free gift of God’s grace for all humanity which comes to us as a direct result of Christ’s death and resurrection. The work of the Holy Spirit due to Pentecost makes available this revelation of Christ through ordinary events of human life, through creation, through a healing or even through a tragic happening.
wholeness. Frequently, Jesus uses the terminology, “Go in peace, your faith has made you whole” (Luke 8:48).

From a theological perspective, transcendental Thomism best describes my operational theology which is shared by Thomas Aquinas, Karl Rahner and Julian of Norwich. A definition of transcendental Thomism is, “a twentieth century approach to theology which is rooted in the principle that God is already present to life as a principle that renders all life open to becoming something more than it is already.” Therefore, Aquinas, Rahner and Julian of Norwich all agree that: “The God who has made us and redeemed us not only can but also will, in Jesus, make all well that is not well….in the world and in our own lives.”

The statement that “all is well” does not mean that these great theologians denied the presence of suffering through loss, disappointment or death, but rather they believed that God providentially provides for the needs of the whole world, including all creatures and human beings as well (Romans 8:28). Christ’s redemption does not eliminate human suffering altogether. But Christ journeys with us through our suffering and transforms it into a redemptive process.

iii. **Theology of Redemptive Suffering: Sanctification**

My definition of sanctification is: A state of growing in divine grace; to be set apart for holy purposes; process of being made holy resulting in a changed lifestyle for the believer. Key assumptions in the biblical context of sanctification stem directly from the

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central truth of the paschal mystery of Christ’s life, death and resurrection. Christ’s birth unfolds with the reality of suffering as he had no place to lay his head, he went through the temptation in the wilderness, was hated, rejected, betrayed and crucified. This leaves us an example to follow (Matthew 4:4, Isaiah 53). Christ understands human suffering because of the incarnation, and therefore he is touched with the feelings of our infirmities. The Scripture states: “For we do not have a high priest who is unable to sympathize with our weaknesses, but we have one who has been tempted in every way as we are – yet without sin” (Hebrews 4:15).

Christ’s will for Christian believers is to follow his example, as affirmed in St. Paul’s theological perspective of baptism and sanctification. A biblical definition of baptism is to experience a complete identification with Christ’s death and resurrection, as a believer “dies to self” and “lives unto Christ” (Colossians 2:12). In Romans 5, suffering is seen as a redemptive process of sanctification which draws us closer to the Lord and builds the character of Christ within us. After we have suffered through a number of afflictions we will have some inner-woundedness that God wants to heal (Romans 5: 3-4).

iv. Dr. Edward Smith: Theophostic Prayer

Dr. Edward Smith is a Christian minister, counselor and the founder of Theophostic prayer ministry. For many years, Dr. Smith worked as a Christian Counselor with a group of incest victims, but over time he discovered that these patients did not receive any relief from their past trauma. As he studied the bible and prayed for divine guidance he came to understand his ministry as Theophostic Prayer Ministry. The meaning of the word “theophostic” comes from the Greek words “theo” which means God and “phos” which
means light. These two words describe God’s illumination in a previously darkened area of one’s mind and thoughts. Dr. Smith came to believe that traumatic events that happen in a person’s life tend to leave this person with a damaged belief system, which is lie-based thinking. In order to be a candidate for Theophostic Prayer Ministry, the person must be willing to re-visit any memory that holds the lie-based thinking.

Dr. Smith’s methodology is to pray out loud with the person and then wait for the person to access the memory that they need to re-visit. Prayerful pastoral sensitivity enables the counselor to listen, empathize and hear the patient’s emotional and spiritual pain, which validates their experience. After the traumatic experience has been shared, Smith will ask if there are any other memories that the person is thinking of, and he listens to the memories. Smith continues to pray out loud that God will give the person God’s perspective on this event, and he waits. Sometimes the person will start to smile and say that they understand or perceive their trauma in a completely different way. Smith then asks them to look through all the memories until everything is peaceful and calm.

This method has been effective with countless people who were released to live a normal life. One example was a patient, Sandra, with a mental health disorder and a fifteen year history of well-documented medical charts that she brought with her. Her medical charts had diagnosed her with chronic depression, obsessive-compulsive disorder, a pain diagnosed her with chronic depression, obsessive-compulsive disorder, a pain disorder and a number of phobias. Nothing had worked for her and she had nothing left to lose. Dr. Smith asked her several relevant questions: “Sandra, do you want to be free from your pain? Do you want the


Lord Jesus to release you? Are you willing to go to any memory that holds the source of pain? Are you willing to feel all the pain and identify the true reason for why you feel the way that you do?” She paused for a moment and answered “yes.”

For three days, through prayerful re-visiting of the most horrific experiences imaginable, Sandra felt released from all her lie-based thinking. Four years later, she is no longer depressed, dissociated or obsessive. 380 Along with the theophostic prayer ministry I also incorporate Francis MacNutt’s theory of soaking prayer. 381

v. Theology of Christian Prayer

Prayer is the most important connection for a Christian and leads to an intimate relationship with God. John15:5 makes explicit a believer’s need for utter and complete dependence on the Lord. Christ said: “If you abide in me and my words abide in you, you will bear much fruit, for without me you can do nothing.” Effective ministry results as we stay in constant prayer with the Lord before a visit, during a visit and long after a visit. This realization is to take seriously John 15:5, believing that “without Jesus I can do nothing.” This revelation of intimacy with God inspires and challenges a Christian to continue to live out this sacred communion with Christ.

Christ’s teaching on prayer leaves Christians an example to follow: “But Jesus often withdrew to lonely places and prayed” (Luke 5:16). Jesus prayed when he was in the wilderness temptation, and prayed throughout his entire life and ministry. My theological

380 Ed Smith, Healing, 32-34.

understanding of prayer also embraces spiritual warfare,\textsuperscript{382} and the need for persistence in prayer: “Then Jesus told his disciples a parable to show them that they should always pray and not give up” (Luke 18:1, Luke 21:36).

\textit{vi. Francis MacNutt’s Theory: Soaking Prayer}

In 1974 Dr. Francis MacNutt, a former Roman Catholic priest, wrote a book entitled \textit{Healing}, which for over thirty years has been a primary source for spiritual caregivers. My pastoral care methodology incorporates MacNutt’s theory of soaking prayer as a key concept.\textsuperscript{383} MacNutt coined the phrase “soaking prayer” to mean that one often needs to cover one with many blankets of prayer, such as one would need to soak an injured foot many times or radiate a cancer many times before the good end result is achieved.\textsuperscript{384} He developed this practice based on his personal observations of the effectiveness of extended prayer with a patient. In many cases MacNutt realized that he needed to take a battle stance in prayer until the prayer was answered and healing took place.

I continue the practice of praying for the mental health patients whom I have offered counseled in the past, demonstrating my conviction that prayer in conjunction with psychiatric treatment continues to be effective as a means of spiritual care.

\textbf{b. Psychological Framework}

i. Object Relations Theory: Development of the Earliest Belief System

The reading I have done in the area of psychology and spirituality gives theoretical support for the relationship between early childhood development and mental and spiritual

\textsuperscript{382} Spiritual warfare is to pray against the schemes of the Evil One according to the context of Ephesians 6:18.

\textsuperscript{383} MacNutt, “Soaking Prayer,” 1.

\textsuperscript{384} This is a definition of Francis MacNutt’s theory on “soaking prayer” (accessed September 2008); available from www.christianhealingmin.org.
Ana Maria Rizzuto is a researcher and author who applies Freud’s theory of object representation to the development of children’s early identification and internalization in response to their interactions and relationships with their parents, a process which is generally complete by the age of six years.\(^{385}\) I will use a later development of the object relations theory to explain the earliest development of a person’s belief system. My incorporation of this model will be more explicit as I use what James and Melissa Griffith term the “God construct.”\(^{386}\) This theoretical model was developed by Laurel Burton and used by the Griffiths to describe the cycle of positive or negative relationships that children have with the parents.\(^{387}\) The Griffiths’ perspective is that:

Beliefs are intertwined with the relationships we have had, and now have with others whom we love and whose lives matter decisively. Internal representations of these significant others constitute some of our most important “object relations”, and holding on to certain beliefs is a way of maintaining those relations.\(^{388}\)

My own understanding of the meaning of internal representations runs parallel to the practice of choosing role models. Role models represent values, beliefs, attitudes or careers that we aspire to achieve in our own life. For example, Mother Teresa’s dedication to loving the poorest people in the world leads us to read and study her life in order to follow her example. A person’s first role models are very important as these relationships with a parent, relative, teacher or friend will help to inform a child’s earliest belief system and self-concept. Depending upon whether or not these relationships were positive or negative will determine

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\(^{386}\) See Appendix 1.


their feelings towards themselves, others and God. Transpersonal psychology re-visits the link between early childhood relationships and there impact on the development of a person’s self-concept.

ii. Transpersonal Psychology: Influence and Development of a Self-Concept

Fiona Tulk is an Australian researcher of inner child healing who uses transpersonal psychology to explain the impact and patterns that are formed as a result of emotional and spiritual trauma. Her research incorporates effective models of re-visiting memories. By re-visiting memories a person comes to realize that their own faulty judgments are at the root of all dis-ease, and this effects healing. Tulk uses transpersonal psychology to define her theoretical perspective, “which is the cognitive process of moving beyond the personality into the transpersonal self.”

Transpersonal psychology is about the consciousness which some call spirituality…… the seen and the unsee-able… the conscious, unconscious subconscious and supraconscious memories we carry which are the sources of programs, patterns and beliefs that govern our lives and thinking.

The process developed by Tulk invites people to explore areas that block their spirituality and healing so that they will love themselves. My research incorporates Tulk’s foundational concept of transpersonal psychology and childhood trauma to understand

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389 Inner child healing for Tulk requires that the adult survivor of abuse find their own voice and become liberated from the many layers of false beliefs that happened as a result of what others said or thought about them. Some of the layers are apparent, but most are not made explicit until a person is invited to re-visit their memories to discern how and what they were conditioned to believe as children.

390 Transpersonal psychology stands at the interface of psychology and the spiritual experience. The root of the term transpersonal means literally “beyond the mask,” and refers to self-transcendence or a sense of identity which is deeper or broader and more unified with the whole.


392 Fiona Tulk, “Transpersonal Psychology” (Tasmania, Australia: Transpersonal Lifestreams, 1998-2003), 1.

the progressive cycle of inner-woundedness which is reinforced over time. Tulk writes:

Behavior patterns may not necessarily come from a single incident which defines the wound that a child carries. A series of unrelated traumas can overlay one another in such a way that cripples the adult until the patterns of all related childhood incidents are accessed.  

The theory of object representation and internalization runs parallel to what Tulk says about our parental influences and role models from our early childhood. Tulk writes: “we were all born innocent to be who we are, but as time goes by our parents, teachers, peers influence our self-concept to the extent that we forget who we are.” If or when a person tries to incorporate everyone else’s values and principles into their life in order to find acceptance they might compromise their own beliefs, values and principles in order to fit in with the crowd.

Tulk believes that our own faulty self-judgment is at the root of our loss of identity. In order for a person to become aware of the negative impact that influenced the development of their self-concept, it is imperative for them to re-visit the memories that reinforced their beliefs about themselves. Often these memories happened during childhood and therefore the memories are not always readily available to the person.

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394 Fiona Tulk, “Hidden Trauma Patterns that Cripple a Wounded Child” (Tasmania, Australia: Transpersonal Lifestreams, 1998-2003), 1.

395 Tulk’s use of the word innocent does not deny a person’s sin nature but rather her use of innocent means that a child believes the words that their parents say concerning them as if they are true. At certain developmental stages a child does not have the full capacity to discern what they should or should not believe.


397 Tulk’s loss of identity is in reference to the many layers of conditioning or false beliefs that a person receives and tries to incorporate into their life. Their identity is lost or buried under the many layers of conditioning that they have received from parents, peers, and authority figures. They try to please everyone else until they forfeit their own free will and authentic self.
More often than not, people will only remember an incident or memory when another event acts as a catalyst which in turn triggers specific memories. For example, I know a person who was sexually assaulted by a janitor many years ago and recently her memory was triggered when another janitor played a joke and locked her in a closet. Although the second janitor did not sexually assault her, the memory of the original event was triggered and she reacted in a similar way with all the original emotions.

My research study will incorporate Tulk’s insight into the importance of how a person’s self-concept is developed as we listen and believe what other people say about us. In very early childhood a child tends to believe whatever parents or other adults say to them because they do not have the full capacity to discern what they should or should not believe. A child’s self-concept continues to be reinforced in a positive or negative way through other relationships with their peers and teachers. In the case of early childhood abuse, a child comes to believe that abuse is normal and that they are bad and deserve to be punished.

iii. Evolution of Inner-Woundedness: Concept of Soul Murder—Assessment Tool

Karen Ander Francis holds a Master’s Degree in transpersonal psychology and is a spiritual director who has worked with adult survivors of childhood abuse for over ten years. Francis is the author of the book, The Soul Friend: Spiritual Direction with Adults Abused as Children,398 which is based on her unique experiences as a spiritual director.

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My thesis incorporates Francis’ concept of soul murder. Her theory of soul murder explains in a profound way what I often hear during a pastoral care intervention with mental health patients who have suffered childhood trauma. Francis defines soul murder as: “a disconnection from self and others, or a total loss of identity in which a person does not feel that they have the right to exist.” My use of her theory of soul murder will be a key concept that I use to describe the impact and long term effects of childhood trauma and abuse. Childhood trauma or abuse impacts a person’s self-concept, emotions and beliefs about themselves. People who suffer “soul murder” have usually survived a number of serious suicide attempts as they act out of their false belief that they do not have the right to exist.

I also apply Francis’ theory as an assessment tool to discern if a patient is suicidal, and then I incorporate a system whereby the patients who are experiencing suicidal thoughts may contact me for extra help or support to avert the actual suicide attempt. In my experience, a number of patients have received the necessary pastoral or psychiatric intervention which prevented the actual suicide attempt.

iv. Childhood Abuse and Methods of Inner Healing—Robert Burney

Robert Burney is a spiritual teacher, codependence counselor, grief therapist and inner child healing pioneer who is also the author of a number of journals and two books, including audio tapes, “Codependence: Dance of Wounded Souls” and “Codependence: }

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399 Ibid, 47.
Burney explores the issue of child abuse and methods of inner healing. He believes that the purpose of inner child healing is to stop allowing experiences from the past to dictate how we respond to life today. Burney maintains that this cannot be done without re-visiting early childhood experiences. As a person shares their story, it is necessary for that person to own and honor the child within, so that they learn to love who they are right now. According to Burney, a person gains awareness of a dysfunctional self-image. He writes:

To become aware that we all have the power to change our relationship with ourselves. To become aware that we were programmed with false beliefs about the purpose and nature of life in early childhood and that we can change that programming. To become aware that we have emotional wounds from childhood and that it is possible to get in touch with and heal enough to stop them from dictating how we are living today. That is the purpose of inner child healing—to stop letting our experiences of the past dictate how we respond to life today. It cannot be done without re-visiting our childhood.

Kairos moment spiritual care invites people to name, own and express their emotional pain while the spiritual caregiver provides an atmosphere of acceptance and unconditional love.

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4. **Assumptions Operative in the Study**

   a. **Emotional and Spiritual Healing through Epiphanies in Pastoral Care**

   Dr. William Miller and Janet C’de Baca conducted research where they gained a longitudinal perspective on the ten year long impact of an epiphany experience in the lives of the people that were interviewed. Miller and C’de Baca describe the closest parallel definition and meaning of epiphanies as described by Dr. William Silkworth:

   Epiphanies appear to be in the nature of huge emotional displacements and rearrangements, ideas, emotions, and attitudes which were once the guiding forces of lives of these [people] are suddenly cast to one side. A completely new set of conceptions and motives begin to dominate them. \(^{404}\)

   My assumption is that epiphanies do take place within the context of people’s ordinary lives and also in the context of a pastoral care intervention. In my own experience, I received an epiphany through a pastoral care intervention as I disclosed the secret of my mother’s mental illness. This is a secret that I had kept to myself for twenty years, due to my fear and shame of the stigma that I felt was attached to mental illness. During the pastoral care intervention, I received a new perception of my mother’s mental illness and I was no longer fearful or ashamed of the stigma of mental illness. I was completely transformed as a result and healed so that today I am embracing this research in order to explore new ways of offering pastoral care to mental health patients who have suffered from childhood abuse. This research project is dedicated to my mother as my own experience has inspired me to understand more fully the impact of disclosure in relationship to epiphany and inner emotional and spiritual healing.

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b. **Healing: A Safe Place For Disclosure and Validation**

Unconditional love and acceptance of the patient just as they are provides an opportunity for them to feel safe enough to share their secrets. Trust, compassion and validation are essential qualities in a good pastoral relationship where an existing breach of trust has silenced the patient into years of shame. I use Abraham Maslow’s theory of “Hierarchy of Needs” and Carl Roger’s theory of “Positive Personal Regard” to create an atmosphere of safety and trust so that patients will feel a legitimate sense of safety.

Some trauma research shows evidence of a degree of emotional healing that takes place as people find a way to share or disclose their secret traumatic events. Trauma research conducted by J.W. Pennebake with students who were asked to anonymously write about upsetting or traumatic events, found that each participant was able to identify a secret trauma. The study concludes that carrying secrets may be hazardous to one’s physical health. From a positive perspective, the long-term effects of self-disclosure of traumatic events may help to reduce anxiety and depression.

5. **Action in Ministry Component**

I will review my data collection of pastoral documentations that I have collected over the last five years and choose thirty mental health patients who have a history of childhood abuse, had a positive response to my pastoral care at least one year ago. What I mean by the term “positive response” varies with each patient and it can mean that a patient who was very depressed and as a result they could not access their spiritual resources to pray, to voice or share their own opinion or smile. In some cases, I noted that after the pastoral care

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intervention that they were able to pray, voice their own opinion, smile or laugh. Or perhaps a patient was able to disclose a secret that they had carried for many years and this experience liberated their own perception, understanding and spirituality.

A letter will then be sent to each patient who fits the criteria as previously mentioned, and from these the first ten respondents will be selected as participants in this research project. The letter will outline the purpose for my research, which is to evaluate my pastoral care method and to learn from the patients what they found to be most helpful. Dignity and respect will be explicit as the letter will state that participation is completely voluntary. My research will be conducted in a printed questionnaire format in which the candidates may still participate even if they do not choose to answer all of the questions.

A consent form will also be included in the event that the candidate should choose to participate. Each participant will be asked the same nine open-ended questions by printing or typing their own answers to the question. This printed or typed format is just for accuracy and clarity of what the candidate wants to share of their own experience of my pastoral care. Confidentiality will be maintained as names will be disguised. A postage paid addressed envelop will be provided for each potential candidate. All questionnaires will be stored in a locked filing cabinet and destroyed after this research project is completed. A summary of the findings will be mailed to each candidate who participates in this research project.

The results will be documented in my thesis by using grounded theory and I will develop or modify my pastoral care methodology as a result of this research.

406 See Appendix 2.
407 See Appendix 3.
6. The Qualitative Research Methodology Operative in the Analysis of the Ministry In Action
   a. Grounded Theory

   As Strauss and Corbin write: “This is accomplished primarily through collecting interview data, making multiple visits to the field (theoretical sampling), attempting to develop and interrelate categories (constant comparison) of information, and writing a substantive or context-specific theory (Strauss & Corbin, 1990).”

   My use of grounded theory means that I have spent a substantial amount of time listening to patients’ own experience of childhood trauma through a pastoral care intervention. As shared earlier, I will use my field notes, which also include patients’ notes of my pastoral intervention with thirty patients. Gathered field notes also include pictures from art therapy, journal entries, letters and prayers written by the patients. Data is coded into relevant categories, which will evolve into major themes and patterns from patients’ stories and my own pastoral care intervention in order to develop a systematic theory-after pastoral care method.

   b. Coding

   Strauss and Corbin are really concerned with the process of describing and coding everything that is dynamic that is changing, moving, or occurring over time in the research setting. Therefore, I use the process of open-coding which is part of the analysis concerned with identifying, naming, categorizing and describing phenomena in the text. The next part of the process is axial coding, which identifies one as the central phenomenon. Then I will ask, (a) what caused the phenomenon to occur, (b) what strategies or actions actors employed in response to it, (c) what context and intervening conditions

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influenced strategies. The overall process is one of relating categories of information to the central phenomenon category.

Selective coding is the final phase of this process. I will then take the central phenomenon and systematically relate it to other categories, validating those relationships and filling in categories that need further refinement and development. Translated, my focus is to ask (a) what helped the patient to share their deeply personal painful experiences with this pastoral care giver? (b) what specific part of the pastoral interaction method did the patient respond to? (c) How did the patient feel during the pastoral care intervention? What phenomenon in the pastoral care intervention precipitated a degree of emotional or spiritual healing? If not, what does the patient feel might have been more helpful?

c. Memoing

This is the process in grounded theory research where the researcher writes down ideas about the evolving theory. This is a form of preliminary propositions (hypotheses), ideas about the emerging categories, or some aspects of the connection of categories as in axial coding. In general, these are written records of analysis that help with the formulation of the emerging theory.

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d. Interpretation: Symbolic Interactionism

Symbolic Interactionism is the closest interpretative science that allows for the integration of a theological interpretation within the research project. I draw on Herbert Blumer’s theory of symbolic interactionism rests on three premises: first, human beings act toward physical objects and other beings in their environment on the basis of the meaning that these things have for them. Secondly, the meaning that these things derive from the language through social interaction, and I would add the meaning that people derive from their spirituality. Thirdly, meaning is established and modified through the power of human thought towards an interpretative process. Symbolic Interactionism requires that the inquirer actively enter the worlds of people being studied in order to see the situation as it is seen by the actor, observing what the actor takes into account, observing how they interprets what is taken into account.

e. Ethical Issues

First, due to the sensitive and vulnerable population involved in this research study, I have chosen to use a theory-after questionnaire methodology. Therefore, if a candidate feels comfortable to answer the questionnaire, they will have the complete power and control as to whether or not they want to participate or not. If not, they are free to discard the questionnaire without any negative consequences.

Secondly, a patient’s confidentiality will be maintained as I will not use any patient’s real name in my research and his or her participation in this research is

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completely voluntary. During the research project all confidential data will be stored in a locked cabinet, and after this research is completed all confidential data and questionnaires will be destroyed.

Thirdly, I will submit an ethics protocol to Humber River Hospital and the Ethics Review Board at the University of Toronto and will not proceed with my research until I have received approval of both ethics protocols.\footnote{See Appendix 3.}

7. Risks and Limitations of the Study

a. Risks

Participants in this study may have difficulty in articulating what aspects of my pastoral care were most helpful.

b. Limitations

My pastoral care methodology involves the practice of silent prayer for spiritual direction. Those who do not embrace a Christian understanding of healing or incorporate silent prayer in their practice may not find aspects of my method helpful.

8. The Contributions of the Study

Three contributions that might result from this research are: (a) deeper insight into the relationship between mental health issues and childhood abuse, (b) an understanding of the pastoral practices, with their focus on spiritual and emotional healing, which former patients found helpful, and (c) the development of a specific pastoral care model for adult survivors of childhood abuse. Other spiritual caregivers might find this method helpful.
9. **Timeline of the Study**

When I receive confirmation of acceptance of this Thesis Proposal I will begin the process of sending letters to each potential participant of which the first ten will be selected. The whole process including questionnaires, coding and analysis, and thesis writing should take approximately one year.

**Creating A Safe Place**

Creating a safe place in the spiritual care setting is a fundamental practice which is based on Maslow’s hierarchy of human needs with a focus on the safety level. An integration of the Rogerian method of spiritual care allows the patient to lead the spiritual caregiver to the traumatic events. Carl R. Rogers defines his non-directive theory as client-centered therapy. Rogers’ assumption is that:

> The client or subject is in the best position to resolve their own problems provided that the therapist can establish a warm, permissive atmosphere in which the client feels free to discuss their problems and to obtain insight into them.  

Using a Rogerian method of spiritual care invites the patient to share their story with the spiritual caregiver. As the spiritual caregiver prayerfully listens, the patient begins to access and remember their experiences because they now feel comfortable to share. Some patients have never had a sacred place in the context of the spiritual care setting where they have felt free to share their story. Patients have carried these stories for many years in the inner recesses of their soul. It is important for the spiritual caregiver to recognize that they are now on holy ground and may hear stories that have been buried deeply within them for many decades.

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Patients might begin with a current crisis and then lead the spiritual caregiver back to some of the most traumatic events. Most often they will disclose their own experience of childhood abuse as the spiritual caregiver empathizes with them and asks them some open-ended questions to draw them out. After the patient feels safe and begins to trust, they will re-visit specific incidences of abuse or trauma which often triggers the original feelings. At this time, the spiritual caregiver pinpoints words, phrases or metaphors that the patient has used to highlight their experience in order to affirm their courage, patience or inner strength. The spiritual caregiver does not impose their own agenda, but rather allows the patient to share their own memories.

Prayerful Active Listening and Question Asking

In addition to the Rogerian approach to spiritual care it is important to understand that much of what a patient needs to share indwells them unconsciously, in what Freud terms: “repressed memories, or the unconscious in which a person has no immediate access or insight to discern what is happening within them.” 413 People tend to repress traumatic experiences for many years because the memories are too painful to remember. However, during a spiritual care intervention when a patient feels a deep sense of safety and trust with the spiritual caregiver, they begin to access and re-visit their traumatic event. The spiritual caregiver will sense the fear in the patient’s voice or observe a change in the patient’s demeanour. Rogers and Freud both agree that the spiritual caregiver should ask an open-ended question, allowing the patient to re-visit their traumatic event. During this time, the

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spiritual caregiver listens to the patient as they re-visit their experience at a deeper level.

Freud recommended that therapists practicing psycho-analysis be profoundly in tune with the patient in question. James Strachey writes:

Freud recommended establishing rapport with the patient, to stay with the patients’ *imagoe*, and for therapists to turn our own unconsciousness like a receptive organ towards the transmitting unconscious of the patient in order to establish some open-ended questions.

Freud’s statement that we are to “turn our own unconsciousness like a receptive organ” captures the intensity of prayerfully moving with the patient through their own experience.

**Give Time to Grieve their Losses**

Painful memories need to be listened to and heard at the deepest level. Prayerfully listen and remain comfortable as the patient sheds their tears and expresses their feelings and beliefs. Spiritual caregivers need to listen, hear and allow them full expression of their pain, praying that God will show them His own perspective of their circumstances. Often this is very difficult work for them to do, but it is a necessary process which opens the door for inner healing to take place.

**Point of Epiphany**

Often at this point, during our interaction the patient might experience an epiphany moment or say something like: “I now understand why I get very sick on this date every year.” The patient is enlightened as they name their connection back to their original traumatic event.

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*414* The term *imagoe* is a latin word meaning image and is associated with the following definition: a mental picture of something; conception; idea or impression.

Soaking Prayer

Daily pray for a patient continues for a period of time after the spiritual care intervention concludes. An integration of Francis MacNutt’s theory of soaking prayer continues until some transformation or positive change happens in the patient’s life.
Appendix B

Research Information Letter and Consent Form


Dear Madam / Sir,

I am a Doctor of Ministry student at Regis College, at the University of Toronto and The Toronto School of Theology working under the supervision of Professor David Reed. I am conducting a qualitative research study in order to evaluate the effectiveness of my own pastoral care methodology. The thesis component to this research study is as follows: I want to discover the effects of my method of pastoral care interventions on the life and healing of the mental health patients at Humber River Hospital. I am extending an invitation for your voluntary participation in the study, which I hope is going to generate a more in-depth understanding of the methodology and pastoral setting which invites a degree of emotional and spiritual healing.

Living and working as a Hospital in Mental Health for several years I have noticed that some patients have had a positive response to my pastoral care intervention. By positive response I mean that perhaps a patient was very sad or troubled before a pastoral care intervention and at the end of this pastoral care intervention the same patient was able to smile or felt more peaceful.

In this research project I sincerely invite positive or negative feedback as I am dedicated to modifying my pastoral methodology according for patients’ feedback. If you happened to have a positive response, did it last and how did it impact the quality of your life? This is why I am doing my research with patients who have received a pastoral care intervention from me while they were hospitalized in the General Psychiatric Unit of Humber River Hospital at least one year ago. By using a Questionnaire Format I am hoping that patients will voluntarily participate by answering the nine questions.

All data generated during this study will remain confidential. I will not use your real name anywhere in this study. I will be the only researcher who has access to this data and it will be stored in a locked filing cabinet and destroyed after this research project has been completed. You will be free to raise any questions or concerns with me or my colleague Laura Sutton who is not involved in this research project. If you feel uncomfortable with any of the questions, but want to participate in the study, do not answer that question. Please be assured that you are under no obligation to participate in this Questionnaire. Please feel free to discard the entire research project if you do not want to participate.

Although the findings of this study will not benefit you directly, by participating in this study you will be contributing new and potentially illuminating knowledge towards a more effective pastoral care methodology that will offer hope to other patients.

Thank you for your consideration. Please contact me at (416) 243-4546 with any concerns.
Appendix C

Research Questionnaire

1. What issue or situation made you ask for a visit from the Chaplain?

2. How were you feeling and what did you experience before your meeting with the Chaplain?

3. What helped or enabled you to share your experiences with the Chaplain?

4. What was life like for you before this pastoral care intervention?

5. How did you feel during this pastoral care intervention?

6. What was the turning point for you and how did it impact you at the time of this pastoral care intervention?

7. Did you experience any new emotional or spiritual awareness? If so, explain.

8. Did your life change as a result of this pastoral care intervention? If so, how?

9. What aspect of the pastoral care was most helpful? If not, what might have been more helpful?
Appendix D

University of Toronto Research Approval

From: Bridgette Murphy [bridgette.murphy@utoronto.ca]
Sent: Wednesday, November 26, 2008 10:34 AM
To: Blaksley, Mary-Ann
Cc: david.reed@utoronto.ca
Subject: Ethics Approval Letter

Dear Mary Ann,

I am writing to let you know that your recent ethics submission has been approved by the Social Sciences, Humanities & Education REB. A signed copy of your approval letter is attached to this email. The attached letter is your official documentation of ethics approval—please print and retain a copy for your files and make note of the expiry date of your approval. It is the responsibility of the researcher to maintain valid ethics approval for the duration of the project (see Continuing Review Requirements below).

AMENDMENTS AND ADVERSE/UNANTICIPATED EVENTS: Any changes to the approved protocol or consent materials must be reviewed and approved through the Amendment process prior to their implementation. Similarly, any Adverse/Unanticipated Events that arise during the course of your research should be reported to the Office of Research Ethics as soon as possible. Application forms can be found on the ORE website:

http://www.research.utoronto.ca/ethics/eh_forms.html

CONTINUING REVIEW REQUIREMENTS: The attached ethics approval is valid for a period of one year. In order to comply with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, you will need to complete either an Annual Renewal Form or a Study Completion Report in advance of the ethics approval expiry date listed on the attached letter. Additional information about continuing review can be found on the ORE website: http://www.research.utoronto.ca/ethics/eh_how.html#wha.

Bridgette________________________________
Bridgette Murphy
Research Ethics Coordinator Social Sciences, Humanities & Education
Tel: 416-946-5606 Fax: 416-946-5763
Office of Research Ethics

3rd Floor, McMurrich Building

12 Queen’s Park Crescent West

University of Toronto

Toronto ON M5S 1A8

www.research.utoronto.ca/ethics/index.html
UNIVERSITY OF TORONTO
Office of the Vice-President, Research and Associate Provost

Ethics Review Office

STUDY COMPLETION REPORT

1. TITLE OF RESEARCH PROJECT

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<td>Renewal Date: Nov. 25/09 expiry date</td>
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<td>Completion/Closure date: May 7/09</td>
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2. INVESTIGATOR INFORMATION

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<tbody>
<tr>
<td>Title: Chaplain</td>
<td>Name: Mary Ann Blaksley</td>
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<tr>
<td>Department: Humber River Hospital - Chaplaincy</td>
<td></td>
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<tr>
<td>Mailing address: 200 Church St.</td>
<td></td>
</tr>
<tr>
<td>Phone: (416) 243-4546</td>
<td>Fax:</td>
</tr>
<tr>
<td>Email: <a href="mailto:mblaksley@hrrh.on.ca">mblaksley@hrrh.on.ca</a></td>
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<tbody>
<tr>
<td>Title: Professor</td>
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<tr>
<td>Department: Wycliffe College</td>
</tr>
<tr>
<td>Mailing address: 5 Hoskin Ave. Toronto, Ontario M5S 1 H7</td>
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<tr>
<td>Phone: 905-513-6122</td>
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<tr>
<td>Email: <a href="mailto:david.reed@utoronto.on.ca">david.reed@utoronto.on.ca</a></td>
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</tbody>
</table>
3. PROJECT INFORMATION

a) How many research participants were proposed for the study? 30 Questionnaire sent out
b) How many research participants were involved in this study? Seven participated. Two other consents were signed as they wanted to submit certain aspects within the study but not the Questionnaire.
c) Did any research participants actively withdraw from the study?
   Yes ☐   No X ☐   If Yes, how many?
   Please describe circumstances.

d) How many research participants completed the study? seven
e) Since receiving original ethics approval, have there been any adverse or unanticipated events?
   Yes ☐   No X ☐ (If Yes, please submit an Adverse/Unanticipated Event Report Form)
f) Please give the reason for closing the study (i.e. end of study, accrual met, etc.):

My signature certifies that the above information is correct and that no additional procedures will be conducted without ethics approval. Proper safeguards to confidentiality and security of data will be maintained until all data are destroyed.

Signature of Principal Investigator: Mary Ann Blaksley  Date: September 30, 2009
Appendix E

Humber River Hospital: Research Ethic’s Board Approval

May 12, 2008

Ms Mary Ann Blakley
Humber River Regional Hospital
200 Church Street
Weston, Ontario
M9N 1N8

Dear Ms. Blakley:

Re:  REB File Number: 2008-066-III
    Protocol Title: A Sacred Place for Wounded Souls
    Approvals: Informed Consent(s) for Use:
    Participant Information & Consent Version 1 dated 28 April 2008

The above named protocol was reviewed and received expedited approval on 07 May, 2008 by the Humber River Regional Hospital Research Ethics Board.

The following is approved from an ethical standpoint for 12 months:

- Application Form -
- Protocol dated 4 February 2008
- Questionnaire
- Participant Information & Consent Form Version 1 dated 28 April 2008

Should your study continue beyond 07 May, 2008 you are responsible for ensuring the study receives continuing REB review and re-approval. Please ensure that your Continued Review Submission is forwarded to the REB in sufficient time for review to avoid a lapse in REB approval.
3. PROJECT INFORMATION

a) How many research participants were proposed for the study? 30 Questionnaire sent out
b) How many research participants were involved in this study? Seven participated. Two other
consents were signed as they wanted to submit certain aspects within the study but not the
Questionnaire.
c) Did any research participants actively withdraw from the study?
   Yes ☐ No ☑ If Yes, how many?
   Please describe circumstances.
   
   d) How many research participants completed the study? seven
   e) Since receiving original ethics approval, have there been any adverse or unanticipated
      events?
      Yes ☐ No ☑ (If Yes, please submit an Adverse/Unanticipated Event Report Form)
f) Please give the reason for closing the study (i.e. end of study, accrual met, etc.):

My signature certifies that the above information is correct and that no additional procedures will be
conduct without ethics approval. Proper safeguards to confidentiality and security of data will be
maintained until all data are destroyed.

Signature of Principal Investigator: Mary Ann Blakesley       Date: September 30, 2009
Bibliography


Depression Research at the National Institute of Mental Health Office of Communication and Public Liaison. Bethesda, MD: NIH Publication no. 00-4501, 2002.


Fox, G. *A journal or historical account of the life, travels, sufferings, Christian experiences, and labour of love in the work of the ministry of that ancient, eminent and faithful servant of Jesus Christ, George Fox.* Vol.1 (1839): 66.

Fox, G. *The work of George Fox.* Vol. 1, 1831.


Freyd, P. “How do we know we are not representing pedophiles?” *False Memory Syndrome Newsletter* 2 (March 1993), 2-3.


Hufford, D.J. “Sleep paralysis as spiritual experience.” *Transcultural Psychiatry* 42/1 (2005): 11-45.


Matson, Todd. “All Diagnoses and Degrees Aside.” Journal of Methodist Counselling and Consultation Services 2/3 (Fall 2008): 8.


Means, Jeffrey J. “Mighty Prophet and Wounded Healer.” The Journal of Spiritual Care and Counselling 56/1 (Spring 2002): 42.


Starman’s Abuse Recovery U.K. (March , 1997): 1-2. (This quote comes is from an adult survivor who experiences nightmares as a direct result of their own abuse experience.)


“The Role of Religion and Depression.”


“My Whole Life has been a Non-Event.” Australia: Transpersonal Lifestreams 1998-2003.


