A Catholic Guide to Understanding and Treating Clergy Sexual Abuse Survivors

Shasha Kleinsorge, Ph.D., OCDS
Karen Klein Villa, Ph.D.
Therese Cirner, LPC

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"*Nobody can use a person as a means to an end, no human being, nor yet God the Creator."*

(St. John Paul II, 1960, p. *27)*

Contact information:

drshashaklein@gmail.com
kkvphd@gmail.com
tcirner@gmail.com

Abstract

This analysis considers important variables for the understanding and treatment of clergy/religious sexual abuse survivors from the perspective of three Catholic psychotherapists. The journey of healing for most sexual abuse patients is long, complicated, nonlinear, and often terrifying. We review the pathology of clergy who abuse children and young adults—by misusing their power and by an insidious 'grooming' process which exploits the child's natural cravings for attention and love. We also describe the defenses which often emerge from early and traumatic experiences, especially Post Traumatic Stress Disorder and repetition compulsion, which is the victim surviver's unconscious repetition of the original abuse. Clinical and treatment strategies for addressing traumatic sexual abuse are presented, including the importance of a therapeutic frame, obstacles to talking about the abuse, and validation. In Christian circles, anger and forgiveness are often treated too superficially in the care of abuse victims. Some common and inevitable countertransference issues with these kind of patients are considered as well as the caregiver's need to be vigilant about secondary trauma. Because this type of betrayal affects the whole faith community, restorative justice is due to the faith community as well as individual victim survivors. Prayerful devotion to God, not merely the use of prayer as a tool, and Divine wisdom are needed for treatment providers who work with this population. Finally, a case study is provided.

The sexual exploitation and violence against children and young adults by men and women in positions of religious authority is a tragedy that creates far-reaching destruction in the victims' lives and in our faith communities. Clinical understanding of the dynamics particular to clergy/religious abuse is needed to help victims heal. It is important to first understand that in the treatment of sexual abuse victims, no two cases are exactly alike. (See Appendix: A Case Study as one example). Issues of severity, development, how attached the victim was to the abuser, previous losses, and resilience factors vary considerably from person to person and situation to situation. It is, therefore, ultimately helpful to be mindful to carefully listen to each unique person to understand who they are and how best to treat them. Secondly, there is a general misconception about the effective treatment of sexual abuse that is important to identify from the beginning. Namely, there is no easy or short-term means of treating traumatic sexual abuse. The journey of healing for most patients of sexual abuse is long, complicated, non-linear, and often terrifying. "As a general rule, the earlier, more severe, and more prolonged the trauma, the more negative and far reaching its effects" (Cozolino, 2016), and thereby, the more complicated and multifaceted is the treatment. While no analysis could fully cover the complexity and multifactorial nature of trauma and its treatment, we have organized the following according to the definition of trauma, factors contributing to the perpetration of clergy sexual abuse, defenses which emerge from early and traumatic experiences, and subsequent clinical and treatment strategies for addressing traumatic sexual abuse.

Trauma is defined as an overwhelming experience which reaches the breaking point with which a person can cope. We all have different breaking points, but everyone has one. Put another way, trauma creates stress which crosses into what is so painful/ evil that it defies all categories in the capacity of the human spirit to endure. According to van der Kolk (2015, 1989), a leader in trauma research, the victim of severe trauma henceforth lives in a different body and mind.

The subjective experience of victims speaks to the profound destructive effects of traumatic sexual abuse in particular. Victims report that they feel like "damaged goods" and they "will never be the same." One victim abused by a priest said, "He murdered something in me. Something died." And this from an alter boy molested by his priest: "Everything good in me was taken out and put into a blender. How do you exist after that?" Their suffering is intense. With deep hurt there is often depression, self-loathing, self-destruction, shame, suicidality, and often an inability to enjoy intimacy or give and receive love. Sustained, unresolved trauma more often than not results in symptoms of PTSD (which will be discussed below).

Important Factors in the Perpetration of Sexual Abuse by Clergy/Religious

Pathological Narcissism of Clerical Abuse

When St. John Paul II talked about the development of sexuality in what became his opus "Theology of the Body," he astutely indicated that the opposite of love was neither indifference nor hatred, but exploitation (Wojtyla, 1960). It is the misuse and abuse of the victim by the perpetrator that is at the center of clergy sexual abuse. More specifically, the abuser exploits the victim to receive admiration, 'narcissistic supplies' (i.e., interpersonal connections essential to their self esteem), and gratification of sexual impulses. Generally, abusers see their victims as an object for their own gratification and are unable to view the victim as a person with their own needs, thoughts, and feelings and as such, there is a gross lack of or inability to have empathy. Furthermore, offending clergy tend to display pathological levels of entitlement such that the abuser feels justified in being exploitive, hurtful, and free of regret. (One pedophile priest blithely defends himself: "It was like a game. I never used force...I had the strong impression he didn't object." And another tried to defend his actions with a 5 year old girl saying "She was flirting with me.") It is common among priest perpetrators that they will tell themselves that they were only "helping or educating" their victims and in this defensive manner will split off the wrongdoing in their actions. Many victims have even testified that the priest abuser suggested the abuse was divinely inspired. One Catholic nun who had sex with a young girl referred to the sexual activity as "God's love," hard as that may be to believe. This sense of entitlement and justification is one of the reasons that the minimal response of the church, bishops in particular, seems an extension of the original abuse.

The pathological narcissism of the abuser is reflective of the presence of a personality disorder. Priests, and many clergy perpetrators, can appear quite normal, competent, pious, and charming on the surface. However, in a duplicitous and split off way, they are operating from a very different set of moral and interpersonal rules. Because of this duplicitous and split-off self, many people have a difficult time comprehending how a priest could act in such a hurtful manner. If empathy is present, it is often used as a tool for grooming a vulnerable person (e.g., many victims come from homes of emotional neglect or physical abuse) or as a defense against understanding their own levels of aggression (e.g., priests who justify their abuse by believing they are caring for their victims rather than hurting them). This is not to say that certain perpetrators might not derive sado-masochistic pleasure from hurting a more vulnerable other.

Power Differential

This refers to the influence that certain roles in our society wield. For example, therapist/patient, clergy/parishioner, adult/child, employer/employee, and teacher/student are relationships that assume a significant power differential. In addition, one's financial status, age, gender, and job title may all be factors where a power differential is present. Clergy represent God, and people will give more credence to what they do and say than to others. Children are especially vulnerable to a priest-abuser because they are taught that he has tremendous power and authority, which induces reverential fear. Very often, children plainly see that their parents have reverential respect for priests. It is speculated that it is out of this reverential fear and/or respect that child victims freeze and become quite passive when they find themselves being molested by a sincerely trusted priest.

This power differential is why individuals in the care of a more powerful other are in a vulnerable position and why these types of relationships require a code of ethics that is specific to and recognizes the power discrepancy. Generally, it is considered that if someone is in a vulnerable position, they do not have the free will to give consent. Furthermore, given that we often refer to clergy in familial terms such as Father John or Sister Angelica, clergy are seen and experienced as extended members of our family, which infuses the power differential in a special way. That is, sexual abuse by clergy corrodes and ruptures a universal and biologically-based incest taboo (i.e., the prohibition against sexual relations between closely related persons) that inherently leads to a greater internal cognitive, emotional and relational disruption.

Knowledge may be power for the narcissistic predator. Priests, for example, will know intimate details of people's lives either through the confessional or at times of crisis when the family turns to them for spiritual guidance. Parents may become unwitting co-conspirators with the abuser/clergy. For instance, parents may tell their children that they are fortunate to have Father as a special family friend. This sets the stage for the next step of abuse—grooming.

Grooming

In the context of sexual abuse, grooming is defined as befriending or establishing an emotional connection with a child or young adult, and sometimes with the whole family, to lower the child's inhibitions with the objective of perpetrating sexual abuse and diminishing the capacity to resist it. Grooming most certainly occurs prior to the sexual abuse itself. For example, a predator may show special attention to the child in a classroom, present him/her with gifts, take him/her on trips, give hugs or other touching, or assign special tasks/responsibilities, all of which are

designed to break down normative and protective boundaries. Grooming is destructive because it exploits the natural tendencies of the child to attach to a good, nurturing, loving, and safe figure. Grooming leads the child or young adult to attach to someone they usually respect, admire, and trust to then exploit this attachment and insidiously cross a boundary into abuse, thereby using the child or young adult for selfish gratification. As Frawley-O'Dea (2007) puts it in her reflection on the treatment of childhood sexual abuse:

"Many children and teenagers do not disclose the sexual abuse secret because they care for the perpetrator. A central cruelty of sexual abuse, in fact, is the perpetrators trampling of the young persons generously and freely bestowed affection and respect. It is from this epicenter of betrayed trust that the mind splitting impact of sexual abuse ripples outward." (p. 76)

Furthermore, the attachment to the abuser who is also seemingly kind and affectionate and morally upstanding leads to grave moral confusion, and tragically, oftentimes to moral corruption. What is good? What is Holy if the abuser is a priest? Because of their affection or respect for the abuser, and the slow grooming process they may have very much enjoyed, the victim often feels that they were complicit in the sexual abuse which can lead to unremitting guilt and cycles of self-destruction and punishment to manage that overwhelming guilt. (See Repetition Compulsion section).

A further destruction of sexual abuse grooming is when there may have been an aspect of the sexual abuse that felt exciting or arousing. This often creates terrible guilt and shame, and also moral confusion. One teenager seduced by a priest said "The relationship and the sex with him were both pleasurable and shameful...I felt lucky...at the same time I knew our relationship was wrong and sinful." Another adult survivor of priest sexual abuse shares the deep ambivalent feelings toward his abuser. When he found out that the priest had been sexually involved with other children, he shared "I became enraged. I thought I was special to him." (Gartner, 2007, p. 96). What these two sentiments show is the complexity of sexual abuse when some (certainly not all) victims derive some form of pleasure from the relationship. As such, deep moral confusion and a 'split self' can occur when there is insidious grooming that exploits natural cravings to be loved and the body's natural response to sexual stimulation.

It may be many years into their adult development and treatment that victims can begin to see that they were subtly groomed into 'compliance' and that they were not responsible for the abuse. Treatment results in patients gradually trading in the image of themselves as bad, dirty, evil, disgusting, and shameful for one of a hungry, lonely, normal child/ young adult who had healthy impulses for attention and affection. Therefore, one central theme in the

healing of sexual abuse trauma is not that the adult survivor learns to have more self-esteem necessarily, but more importantly, they learn to have greater self compassion.

Symptoms and Defenses Which Emerge From the Trauma of Sexual Abuse

Post Traumatic Stress Disorder (PTSD)

PTSD is a constellation of symptoms that occurs following terrifying, psychological shock where subsequent symptoms can include flashbacks, sleep disturbances, nightmares, and severe anxiety such as becoming triggered by aspects of the event or recalling the trauma in a repetitive and vivid manner. Sexual abuse trauma, in particular, can also lead to significant symptoms in altered self concept, emotional dysregulation, and ruptures in interpersonal relatedness (i.e., considerable difficulties with closeness and trust). Childhood sexual abuse is also referred to as complex trauma or developmental trauma, to differentiate it from the adult onset or one time episodes of trauma such as a car accident, tragic loss of a loved one, or escaping a house fire. Complex / developmental trauma implicates a severe betrayal of trust and the violation of interpersonal/ physical boundaries. Examples include being exposed to sexual abuse, domestic violence, chronic/ explosive angry outbursts, and having or partaking in an abortion. These experiences, and others like them, exceed a person's cognitive capacity to deal with the overstimulation of the event as well as evoke overwhelming feelings of helplessness which require a number of defensive maneuvers to survive (e.g., dissociation, depersonalization, emotional numbing). There are four groups of symptoms found in PTSD: hyper- arousal, intrusions, avoidance, and social fragmentation (Cozolino, 2016; van der Kolk, 2015).

Hyper-arousal. This is a stress-induced hyper activation of the amygdala and autonomic nervous system, resulting in an exaggerated startle reflex as well as agitation, anxiety, and irritability. This defensive state of hyper-arousal changes the victim's perceptions whereby they become suspicious and hyper vigilant, guarded, expecting people to exploit them, and mistrustful of the intentions or motivations of others. Hyper-arousal states often alternate with emotional numbing.

Intrusions. Traumatic memories break into conscious awareness and are experienced as if they're happening in the present. Examples include nightmares, flashbacks, irrational reactions, and/or intrusive thoughts. These intrusions can be triggered by various external stimuli such as anniversary dates, people who look like the abuser, or touch, smells or sounds from the abusive incidents. While the trauma as an 'event' occurred in the past, the subjective experience of someone with PTSD is that, especially when triggered, the past is on-going largely because

the overwhelming memories and emotional pain of the event are repressed into the cognitive unconscious which does not differentiate between past and present.

Avoidance. An attempt to defend against dangers by limiting contact with the world, withdrawing from others, and narrowing the range of thoughts and feelings. Avoidance can take the form of denial, repression, dissociation, and amnesia. We see denial in patients who will question themselves, even as they are clearly remembering abuse, if it really happened. One victim of severe sex abuse said: "I don't know which was stronger in me, the denial or the shame" showing how the reality of such evil cannot be stably contained or integrated in awareness. The most apparent PTSD avoidant behavior is seen in people who cannot revisit any places connected to the abuse or even places in any way that remind them of the abuse. Many who have been abused by clergy cannot enter a church building, tolerate the smell of incense, listen to choir music, or cope with any other event associated with religious life. One man could not drive through the state in which his sister had years earlier committed suicide, but drove an extra 400 miles to avoid it on his way to another state. These dramatic avoidance maneuvers seem exceedingly irrational to others, which contributes to the victim's feelings of isolation. Dissociation is like running away in your head, spacing out, disconnecting from reality. It's very common for children to report themselves "going into the wallpaper" or being outside their bodies while being abused, a form of dissociation called depersonalization.

Social fragmentation. Can include difficulties with intimacy, emotional regulation and the cohesiveness of personal identity. Especially in cases of incest or clerical sexual abuse, the fragmenting effects of trauma can lead to severe moral confusion or corruption. Creation of provisional selves or leading a 'double life' can be a common consequence of sexual abuse. As one victim priest who lived a double life said "the seeds of secrecy and shame sewn into my vocational call by my priest abusers supported [my] splits." (Father M., 2007, p.117). Another man who was molested by clergy described it like this: "I grew up lying about sex… Lying about myself… to remain trusted and loved, I had to become someone other than who I was…I learned a malignant, enduring lesson: emotional survival required the creation of false selves" (Lewis, 2007, p. 125). Many sexual perversions, compulsions, and confused sexual identity issues seem to be related to insidiously groomed and perpetrated sexual abuse and the subsequent fragmentation that ensues.

Repetition Compulsion

Repetition compulsion is the unconscious tendency to relive some aspect of the abuse and is one of the most intractable consequences of trauma (although not limited to trauma). It is very difficult for victims to develop an

awareness of the many ways they may be repeating aspects of their original abuse. Freud's (1914) seminal insight was that patients are compelled to repeat in action what they cannot fully elaborate mentally. Van der Kolk (1989) reported, for instance, that "Many female prostitutes have a history of being sexually molested in childhood, incest victims are more likely to be raped in adulthood, and battered women are also often repeating a pattern of early childhood abuse." Additionally, research on priests who sexualize minors found that many sexually abusive priests "have themselves been subjected to premature sexual interactions with an adult as minors." (Kochansky & Cohen, 2007, p. 43).

Quite typically, victims have no conscious awareness they are engaged in repeating their trauma, even when it is blatantly clear to others around them. Perpetrators likewise have no awareness that they are repeating aspects of their past. Why do victims repeatedly put themselves in abusive situations or abuse others? Let's go through the 'usual suspects' of unconscious motives.

Turning passive into active. This is a common dynamic in which victims are compelled to repeat the abuse because they are attempting to master the victimization by "taking charge of the timing and execution of the harm" (van der Kolk, 2015). By turning passive into active, even as they play the victim role, they gain a sense of control and relief from the overwhelming helplessness in being victimized. Being in control and powerful is better than being helpless and afraid. In other words, it's like 'going on the offense' as a means of defense.

Identification with the aggressor. This is related to turning passive into active and is a mechanism whereby victims commonly identify with their abusers. That is, they become like them by sexually using or exploiting others in the same or different way. Why identify with the aggressor? Unconsciously, victims may model the very behaviors they saw just because we're prone to learn through modeling (Cicero: What society does to its children, it's children will do to society). Also, the victim may unconsciously try to reconcile with the abuser by showing that they are no better.

Self-medication of unbearable affective storms. Research reported by van der Kolk suggests that another motive for repeating abusive behavior is that unconscious states of hyper-arousal can trigger the release of brain opioids providing relief for anxiety (1989). More specifically, he states that "strong emotions can block pain" through the release of morphine-like substances in the brain and, in this way, re-exposure to stress can provide relief and in some cases, even pleasure. Sexual abuse victims who cut will often cite that converting their emotional pain, often triggered by nuances of their original abuse, to physical pain gives them considerable relief from

re-experiencing their abuse without recognizing that they are being self-abusive and engaged in a repetition compulsion. Self-medication of unbearable pain can lead to many paradoxical addictive patterns and behavior in the areas of drug use, cutting, eating disorders, and sexual addictions/perversions.

Abuse / pain is fused with love/ attention. In some cases, victims learn to receive attention and affection through an abusive relationship and can become locked in cycles of codependency. For example, emotionally abused children are often drawn to the same kind of negatively charged relationships in adulthood. Over and over again, through vociferous complaints of how awful or cruelly treated they are, they will relive their ambivalence, and may even express plainly that they are "bored" with those who are kind and gentle. "In fact, since people seek increased attachment in the face of danger, adults, as well as children, may develop strong emotional ties with people who intermittently harass, beat, and threaten them. The persistence of these attachment bonds can lead to and solidify the confusion of pain and love" (van der Kolk, 1989).

Self-blame and punishment to alleviate guilt for perceived complicity with the abuse. Self-abuse alleviates feelings of guilt for perceived badness resulting from the sexual abuse. Victims can master feelings of helplessness and implicitly rescue their perpetrators by unconsciously fantasizing that they can take responsibility for causing the abuser to lose control. For example, one often sees abused children who will deliberately provoke their parents into hitting them and in this manner, the child can derive a sense of control over the abuse itself and appease/punish their guilt for their perceived complicity in the abuse.

Anger/ rage and aggression. Van der Kolk (2015) states anger directed against the self or others is always a central problem in the lives of people who have been violated and this is itself a repetitive re-enactment of real events from the past. Oftentimes, victims will feel and express more intense anger toward the person or people who failed to protect them from harm than directly toward the perpetrator. There seems to be a common dynamic to feel a greater betrayal in not being protected than with the abuse itself. This may account for the considerable backlash against the Church hierarchy for not protecting.

It is worth noting here that anger and aggression are not dealt with very well in Christian communities. There is unfortunately confusion in how we treat anger as a cardinal sin when the anger is selfish and unjustified versus the justified, unremitting anger that is the brain-compromised consequence of trauma survivors. For many Christians, anger can be a confusing source of shame and guilt. Oftentimes, the process of grieving can be halted due to the inability to accept the anger phase of grief. The result is then a greater propensity to symptoms such as depression

(anger turned against the self) and/or disowned anger in the form of acting out. As a result, the entire process of healing can be short-circuited. Furthermore, we as Christians can short-circuit the right of victims to process and make use of their natural anger or anger at God (we see such anger expressed in the Psalms). This can sometimes result in blaming victims (for failure to forgive and 'move on') or expressing the directive that they should heal faster and more fully than the complex nature of trauma allows.

Clinical and Treatment Strategies for Addressing Traumatic Sexual Abuse

While it can take years in treatment to reestablish a sense of safety for an individual in the treatment of sexual abuse, ultimately, grief and mourning is required. Beneath all the defenses, anger, shame, fragmentation, and acting out, there is a core pain that is excruciating to face: grief. In order to experience and achieve an imperfect healing, the grief of having lost their childhood and/or innocence, of not having been protected or cared for by important others, and of not having been nurtured in the way they both deserved and profoundly craved are central to recovery. This layer of processing in sexual abuse treatment is often understated, but is necessary for deeper healing.

Obstacles to Talking About Sexual Abuse

Sexual abuse victims/survivors can be quite hesitant and/or resistant to talking about their experiences due to blistering shame, guilt, and anger. They will often say they do not want to "go there" due to the affective storms that accompany the process of remembering and revisiting painful memories. If they speak up, survivors can feel as though they risk being humiliated, revictimized, or blamed. Victim blaming refers to others seeing the victim as the initiator of the sexual contact and/or somehow responsible for not stopping the abuse. Victim blaming may occur quite unconsciously because we just cannot tolerate the idea of horrible abuse happening and cannot accept the helplessness these stories evoke in us. Notice the crucial difference between acknowledging the child victim's hunger for affection from their perpetrator and concluding that the child was responsible for the sexual abuse. This nuance is impossible for the underdeveloped minds of children, but also for some adults.

Furthermore, there may be realistic fear of retribution for exposing the abuse and 'creating' scandal. Some are convinced the truth will hurt others. One woman abused by a priest starting at age 11 said she could never talk about it because she knew it would devastate her mother. When her mother died, she felt free to talk. Here are some of the manipulations used by perpetrators or those who become complicit in order to get a victim's cooperation or silence: The victim deserved it somehow, they were being initiated into something good, God will punish them or their

families if they tell, they will ruin the priest's reputation or life, and they need to protect the reputation of the Church.

Once a report is made, another wave of obstacles to talking about the abuse often ensues out of motives to protect the reputation of the priest and the Church herself. There may be strong desires expressed by church leaders and even family/ friends to silence the victim, to keep people from leaving the Church and withdrawing financial support. Victims also pick up on signals of being blamed for not recovering from the abuse, causing all these problems, and not getting on with their lives. The Church's defensive campaign to focus on various talking points (it's not happening here in our diocese, the scandal is mostly in the past, most priests are good men, etc.), when they are offered at the expense of acknowledging the level of damage to victims and failure to protect, creates a most inhospitable climate for clergy-abused individuals to open up.

Hence, there are many reasons for a survivor to believe that no benefit will come from talking about their past. Caregivers do well to assume that some or many of these obstacles may be present when dealing with sexual abuse. Given this context, the following are often important treatment variables.

Therapeutic Frame/ Alliance

The first principle of working with any patient is establishing a safe frame with predictable and professional boundaries. The therapeutic frame signifies trust and safety and in the spirit of Winnicott (1960) creates a "holding environment." The therapeutic holding environment provides the patient with a safe space to begin to recognize and meet previously neglected ego needs and facilitate the emergence/recovery of a true self. Survivors who have been severely violated need to know that the therapist has professional boundaries, and they will test those boundaries, usually unconsciously, to see if the therapist is safe. These patients will also unconsciously provoke or consciously request a therapist to violate boundaries in a predictable process of enactment that brings the repetition compulsion into the treatment (e.g., a patient who strongly wishes to be held or hugged during affective storms). A central unconscious question that becomes enacted is whether the therapist's caring will shift to grooming? Usually, all touching of patients should be strictly avoided, at least in the beginning of treatment and only if the patient initiates an appropriate touch like a hug. Touch, even simple social gestures, can have deep meaning for a sexual abuse survivor and can act as a trigger for symptoms. In fact, everything about the therapeutic frame should be intentional including what is written in the contract, confidentiality, rules about starting and stopping times, what fee will be charged, how extra-therapeutic contact is handled (e.g., including social media), and so on.

Generally speaking, when patients see that the therapist is serious-minded enough to handle their deep pain, they will be more likely to open up. In our view, being serious and professional is more important than being super-friendly and accommodating. Overall, a safe therapeutic alliance is the basis of healing. When patients feel safe, then they can learn to reoccupy their bodies, minds, and thoughts and subsequently visit themselves and their memories more deeply.

Validation

Validation is the recognition or affirmation that a person‘s feelings, beliefs, or experiences are real. Validation is powerful because it’s akin to the most important ingredient towards socio-emotional development and healthy attachment: empathic attunement. To be shown empathy and to be validated means “I’m seen, therefore I exist. I’m seen, therefore I’m understood,” and ultimately “I’m understood, therefore I’m loved.” Validating statements are the building blocks of a therapeutic alliance. They reassure victims that their feelings / experiences are real and they matter. We are talking about their subjective reality, which doesn’t mean we have to agree with their beliefs. It is often very helpful to simply mirror a patient’s words and feelings back to them and offer basic sympathy and sorrow for their suffering. “I’m so sorry that happened to you. What an awful burden to keep such a secret...It’s too painful to even think about...You were absolutely terrified...How painful it must have been, how confusing...I can see why you would not want to believe it happened...I can see why you would want to numb yourself...I know this is very hard to talk about...Please don’t feel like you have to share more than you’re comfortable.”

It’s also validating and often welcomed with great relief to normalize a survivor’s experiences. For instance, “It’s very normal to feel like it was your fault,” or “Many victims of sexual abuse experience a lot of shame.” Patients will feel less crazy and isolated when they hear that it’s quite ‘normal’ to have certain feelings, thoughts, and physiological reactions after such a trauma.

As you know, it’s very invalidating to respond to survivors with cliché comments or superficial remarks about how they should cope. Comments like “you shouldn’t feel that way” or “you should forgive” all tend to be unhelpful because they are usually experienced as grossly invalidating of the deep pain and ravages of abuse. Examples from Dr. Langberg’s (1999) excellent counseling guide on what is usually a hindrance to treatment in Christian circles: “If you would only…read scripture more, believe more, stop thinking about yourself, put the past behind you,” “Why didn’t you tell someone?” “Couldn’t you have got up and just left?” Furthermore, those statements, when issued

hastily, may be asking a survivor to do the impossible, which tends to further isolate them from others and evoke more self blame and cycles of guilt and punishment.

Of course, therapists can gingerly encourage prayer, faith community involvement, tough theology questions, and forgiveness, as the patient leads and is ready; however, poorly timed or premature directives to "forgive" can, in our experience, short-circuit the healing process. Comments that suggest "blaming the victim" are among the most destructive. Words can truly hurt. One study demonstrated how simple, invalidating statements can increase anxiety and that validating statements actually soothe the nervous system (Shenk & Fruzzetti, 2011). In people who have problems regulating their emotions, invalidating statements increase aggressive behavior compared to validating statements (Herr, et. al., 2015).

In general, it can be a big hindrance to treatment when therapists demonstrate an over-eagerness for survivors to recover (see Countertransference section below). In particular, when therapists convey their desire for survivors of clergy abuse to return to the Church or make peace with God before they are ready, they become burdened with the therapist's agendas and their own emotional limits are ignored. Plus, those comments tend to be a dead give-away that the therapist cannot tolerate their pain. They may also reveal a mistrust of God as though He cannot reach these people unless they follow certain prescriptions.

What is most curative for trauma survivors is something they simply cannot believe will help: to be able to sit with their pain, to talk about what happened, feel it, own it, learn that it is transient and will not kill them, to learn how to adaptively cope with their sensitive nervous systems, and to receive God's love and love themselves. Dr. Langberg's summary of the three things needed for healing from sexual abuse trauma are: talking, tears, and time. This is psychotherapy (the 'talking cure'), or more technically, exposure.

Exposure

Exposure is the basic principle of how healing happens in PTSD. How does exposure therapy work? People want to know "How does talking about it make it better?! And not worse?" As van der Kolk (1989) summarizes "The only reason to uncover traumatic material is to gain conscious control over unbidden re-experiences or re-enactments." The principle of gradual exposure (also called gradual desensitization) works because as the patient talks more and more about the traumatic experiences, they gradually learn to tolerate the feelings and maintain experiences in conscious awareness. The neuroplasticity model of the brain stipulates that "as the person experiences anxiety

without harm, our brains learn to change how they respond to feared stimuli. This is the system that is built during successful psychotherapy" (Cozolino, p. 193-194).

If a survivor can revisit the trauma, then he/she can begin to process what was split off because it was unbearable, frightening, overwhelming. As material and memories become part of conscious awareness, they can be dealt with in more mature and mindful ways. Bringing into conscious awareness what has been split off and exiled into the unconscious is curative precisely because there is less need then for automatic ways of coping. What is unconscious controls the repetition compulsion and leads to symptoms. As patients are able to gain slow, incremental control over their painful memories, they begin to regain some control over their lives. To gain some control over their lives gives them vital dignity, which sexual abuse has destroyed. So even as they may have to accept great suffering through grieving, if dignity is restored, there is hope.

Furthermore, due to the fragmenting nature of overwhelming, traumatic experiences, patients need to develop a cohesive narrative regarding their experiences so they are less prone to symptoms or relationship templates which replicate early, albeit implicit memories of abusive relationships. Writing about experiences in diaries or journals supports a cohesive narrative and the reflective function to recall and integrate traumatic experiences as part of these top down methods of treatment. A survivor of early incest discovers: "In the process of writing, I found a safe harbor in which to objectify my past and try to make sense of it. As I watched my words, phrases, and paragraphs come together on the page, I could sometimes feel the weight of silence begin to lift, the burden of isolation begin to disintegrate." (Shannon, 2012). In fact, the research of Dr. James Pennebaker on expressive writing for healing has been documented empirically (1986). So writing about one's traumatic memories is another method of healing by exposure as it is believed "to stimulate prefrontal cortical areas that inhibit amygdala activation… [resulting] in a cascade of positive physiological, behavioral, and emotional effects" (Cozolino, p. 241).

Sometimes there are simply no words to convey the horrors of sexual abuse. Early, severe trauma 'lives' in the primitive part of the brain that is inaccessible and nonverbal. Nonverbal methods of treatment can be used to access memories and promote recovery through regulation of anxiety and bodily processes. The nonverbal tools used by child therapists can be effectively used for these very regressed patients. Beyond verbal and nonverbal paths to treatment, there are the "bottom up" interventions in healing of PTSD.

"Bottom up" (Autonomic Nervous System) Interventions

It is important to teach trauma survivors about brain changes due to traumatic experiences and how they automatically respond to and confuse real from perceived threat. Without this knowledge, patients are "more vulnerable to attributing their symptoms to character flaws or supernatural causes" (Cozolino, p. 202). Van der Kolk (2015) states:

> While we all want to move beyond trauma, the part of our brain that is devoted to ensuring our survival (deep below our rational brain) is not very good at denial. Long after a traumatic experience is over, it may be reactivated at the slightest hint of danger and mobilize disturbed brain circuits and secrete massive amounts of stress hormones. This precipitates unpleasant emotions, intense physical sensations and impulsive and aggressive actions…feeling out of control, survivors of trauma often begin to fear that they are damaged to the core and beyond redemption (p. 2).

Managing the anxiety of trauma that lives on in the body, getting to know body signals, and managing dysregulation are all aspects of bottom up recovery from abuse. Guided meditation, deep breathing, grounding techniques, music, exercise/yoga, for instance, all target the anxious nervous system of trauma survivors. Essentially, anything that decreases nervous system arousal will work to decrease anxiety and retrain the ANS.

Community and Therapist Care in the Treatment of Sexual Abuse

Restorative Justice

Restorative justice recognizes that as a community of believers, we are all bound to one another and that the "fate of all depends on the conduct of each." We all suffer when a priest abuses someone – we lose trust in our priests and our Church; we suffer when victims suffer – whole families and communities undergo trauma when one of their members is abused. Church leaders have the complex position of understanding that their response and action/inaction reverberates far beyond the original events, manifests slowly over time and has the potential to damage the fabric of our Catholic community leading to subsequent "collective trauma" or to "collective healing."

Many sexually abused survivors feel they can never find peace until there is justice. There is a deep restlessness and anguish about the grave wrong done to them somehow being made right. Some might suggest that for a Christian abuse survivor, there may not be a need to have to wait upon the abuser's apology or remorse, that healing can and does come about via relationship with Christ. While that may happen as the survivor grows emotionally and spiritually, it's a more typical consequence of deep betrayal to wrestle with the abuser, even interiorly, for a long

time. Oftentimes, sexual abuse survivors are tormented by fantasies of wanting to vengefully punish or kill their abusers. Some crave their sincere repentance and apology. The most anguished perhaps are those who vacillate between these two poles. One priest who had been molested by two priests during his young adult years and reported them to the Church said:

> It hurt to learn that only one of the priests admitted to the abuse. Perhaps unrealistically, I wanted to hear from them that they were sorry for betraying my trust and sexually exploiting me. I wanted them to have knowledge that they had some inkling of the pain they caused me. Instead, the bishop offered me a financial settlement. Although I am grateful for that form of restitution, it feels as if they are replacing with money the opportunity for restorative justice and reconciliation.
> (Father M., 2007, p. 119).

Unfortunately, rather than receiving justice, some survivors find that their hurt is compounded by evasive maneuvers of those in charge of the perpetrators. Cover-ups and the minimizing or denying of clergy sex abuse all wreak further damage to the survivor and the whole Church community. A type of institutional illness becomes apparent when priest-hosted town hall meetings or letters become public relations events to convey predetermined talking points about returning to idealizing clergy, not leaving the church, and looking away from the devastation and pain that was caused by clergy sexual abuse. Too swiftly focusing on the peripheral issues, even as they may be entirely true, is usually experienced as a colossal failure of love and understanding by those harmed by clergy—survivors and their family. Restoration of trust is at stake insofar as the laity can clearly see empathic responses of the church and are further ripped apart by empathic failures. Not moving beyond the collective dynamic of silencing around these spiritual and ethical violations leads to more repetition and illness within the community of the Church and the complicity of all in the next round of failure.

Many survivors believe that only acknowledgement of truth, holding perpetrators accountable, and ensuring the perpetrator will never have access to abusing others will serve justice. Restorative justice is the overt acknowledgement of the harm and the understanding that the harm caused carries particular obligations (e.g, punishing the perpetrator and compensating the victim; establishing procedures for ethics and oversight). Only honest group process between clergy and laity to achieve understanding and agreement can inoculate against recidivism and reestablish safety. Furthermore, through restorative justice, the community (i.e., the hierarchy and the laity) becomes better equipped to identify potential offenders (e.g., their techniques and offenses), reestablishes a

protective role with its members, and recovers from complicity in the abuse which occurs largely through idealization and silence.

It would be a simple act of kindness for those in charge of abusive priests and who deal with victims to ask the survivors "What would give you peace? What would justice look like to you?" Not that that would necessarily obligate Church leaders to fulfill all those wishes, but merely asking and taking time to listen would go a long way toward healing. We believe that if survivors of clergy sex felt seriously heard, seen, and tenderly valued by the Church, they may be less likely to act in harmful ways towards themselves and Church leaders.

In a counseling or therapy context, there are special ways that therapists can facilitate healing of broken relationships for these patients. Because there is a wide reaching ripple effect of sexual abuse, it may be important to include family members or religious leaders in therapy sessions. A patient may need the physical presence of his or her therapist in the room to provide a safe setting in which to share about the abuse with other people in their lives. These facilitated sessions can go a long way toward integrating the survivor back into their family or community where there was alienation, harmful secrecy, or bitter resentment.

Countertransference

Countertransference refers to the feelings and reactions the therapist experiences in response to the patient. As treatment providers, there can be vicarious or secondary trauma when working with survivors of sexual abuse. Subsequently, it is important to take care of ourselves if we are working with traumatized patients. It is difficult to listen to atrocities. We want to recoil from these stories; they can feel unbearable. Clerical abuse may impact our faith life or respect for the Church, or our very belief in a good, just God. And if we have trauma in our own histories that is not sufficiently resolved, these patients will certainly challenge us to seek treatment or return to treatment for the next installment.

Specific countertransference issues common to sexual abuse treatment include feelings of helplessness/ inadequacy, anger at the abusers, and the ever famous and tenacious "rescue fantasy" endemic to the batch of "wounded healers." Another important countertransference issue involves the patient bringing his/her repetition compulsion into the therapy relationship (transference). That is, the patient will misperceive and the therapist will in some way unconsciously, viscerally, represent their abuser. Or the patient will feel compelled to exploit the therapist, as their victim. With these inevitable enactments, therapists need to have a strong sense of themselves when they are turned into the "bad object." It can be challenging, and sometimes impossible, to not get pulled into these

enactments but to remain grounded in the reality of the present, to have established a safe foundation with the patient, and exercise the ability to guide them toward awareness and observation as opposed to reenactment. Bion (1962) discusses the importance of this "containment" function where a therapist receives the patient's overwhelming projections, processes them and returns them to the patient in a modified form that is more understandable and potentially less destructive. Furthermore, these issues can all be dealt with in the context of supervision or with other therapists who support and pray for one another and for each other's patients.

Sexual abuse treatment can be fraught with difficulty, mistakes, and enactments due to the original complex boundary violations, the abusive demand for secrecy, dissociation, and the isolated and repressive nature of the survivor's thought process and defenses. As therapists, we aim to be sensitive to these dynamics, but also aware that mistakes are inevitable. We need the willingness to forgive ourselves for not being perfect, not being all-knowing with these patients. We will certainly grow in humility, which is a great gift and important ingredient unto achieving holiness.

Prayer

Prayer is our most important gift to ourselves and these patients. While our interventions may be inadequate or imperfect or even harmful at times, our prayers will always be perfect as long as we pray God's love to heal these suffering souls. However, it's become almost platitudinous to say that we should pray for our patients. We note a caution about prayer that you all probably know already. Prayer cannot be used as a tool per se because God cannot be used as a tool. Christian prayer is more properly on outpouring of an intimate friendship with God. Focusing on using prayer merely as a wish-fulfillment tool becomes no more than manipulating spiritual energies, which is essentially New Age spirituality, repackaged Eastern mysticism. The difference is that the Holy Spirit is not a created energy, and cannot be manipulated as such. So in encouraging prayer to help in our work as Christian therapists, we bear in mind our need for intimacy with God, as collaborators with His will and purposes, in walking with Him as closely as we can. The goal of the whole Christian life aims at making all of our work, our play, our waking and sleeping hours a single movement of devotion to God.

The fact is that sexual abuse is amongst the most wicked and horrible things humans can do. And when the perpetrator is clergy/religious, men and women who represent God's presence and love on earth, we see the convergence of all three destructive forces of evil at play—the world, the flesh, and the devil. There are no

psychological defenses against supernatural evil. Hence, treatment providers must remain in intimate relationship with God and amongst a community of faith to combat these forces.

As therapists, we also need God because we need Divine Wisdom. We don't "treat sexual abuse" apart from the whole person. Therapy is more an art than a science. What we refer to as 'treatment' is essentially a relationship. Unlike heart surgery or building a bridge, for which there are concrete, clear cut solutions, we are dealing with delicate and complex relationships that involve body, mind, and eternal soul. Finally, we need God in order to see our patients and ourselves as God sees us, with beauty and dignity as His image bearers. We must see the patient as a dearly beloved child of God and know that His Love and Mercy will have the final word. Lord Jesus, you are the Good Shepherd who lovingly and tenderly carries your wounded ones. Give me your heart and the power of the Holy Spirit so I can be a source of healing for those harmed in any way by clerical sexual abuse.

"For the Lamb in the midst of the throne will be their shepherd,

and he will guide them to springs of living water,

and God will wipe away every tear from their eyes." (Rev. 7:17)

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Appendix: A Case Study

The case of Kathleen K. presented below is just one young woman's story of clerical abuse and clinical intervention. While every victim is unique in terms of gender, age, personality, ethnicity, the type of abuse, frequency and duration, they often share many factors in common. In Kathleen's story, the sexual abuse was significant, and lasted two years. No graphic details will be presented in this paper.

I (X.X..) first met Kathleen, a 22 year old caucasian female student majoring in Business, at the University counseling center. She was a new client to both the counseling center and to myself. She was not in the waiting room when I went to get her. I was returning to my office when I noticed a person in the back hall which the staff uses to exit the office area privately. It is an out of the way, little known exit from the counseling center. Curiosity drew me to discover who was there. I opened the door and said "May I help you?" A small smile appeared on the young woman's face saying "I'm Kathleen K. Are you Mrs. X?" We went to my office and she told me that she couldn't use the waiting room. She indicated that others might be able to see her shame. She asked me if she could meet me by the back door on time for our sessions and assured me that she wouldn't bother anyone. Kathleen said that she prayed that the Lord would tell me where to find her and come get her, hence the smile. So, each week she was there. At her last session with me 18 months later, she was in the waiting room when I looked for her. I made an exception for Kathleen to use the back door, recognizing that this was a compromise that may enable this young woman to get the help that she was looking for.

Presenting Problem

Kathleen wrote in very small letters on the Intake form that "depression" and "sleep problems" were the reasons she was seeking counseling services. Many requests for information on the Intake form were left blank. She did state that she had never sought help before.

Family History

Kathleen K. was the youngest of 5 children. Her parents, who were college educated Catholics, had sent all their children to Catholic schools. Mom stayed at home managing the 4 biological and 1 adopted child and her father, who traveled frequently for work, financially supported them. Kathleen was unaware of any mental health or substance abuse issues in her immediate family or of her extended family either. Since she was adamant that her parents were not to know of her counseling, she refused to ask them for that information.

Kathleen's Story

The pastor of the parish and Catholic grade school was a close family friend, highly regarded in her family as well as in the church, school and local community. The pastor arranged with the school principal for Kathleen, then in 7th grade, to bring him any mail that the school had for him to the rectory. He would have cookies waiting for her and indicated that she should stand next to him while he looked at the mail. At first she felt special; she was excited to leave class. She was honored to be requested by the pastor for an important job and felt very grown up since he wanted her to stay while he opened the mail.

Grooming began with the Pastor inserting himself into the family offering friendship to the parents. Then initiating this mail ruse. Perpetrators often start grooming the whole family in order to lower any guardedness of the future victims. His sexual agenda began with his hand on her shoulder and proceeded to increasingly more sexually abusive behaviors lasting two school years, 7th and 8th grades. Kathleen began to have stomach aches on mail days. When she complained to her mom about having to deliver mail, she was reminded that it was a privilege to do this small service for our pastor and our Lord.

She told me of her humiliation in having to wash her underpants at night and have them dry by morning to put in her drawer to avoid alerting her mother to what was going on. She experienced a reprieve during the school holidays followed by worsening stomach aches and headaches when school resumed. One of the unintended consequences of the sexual abuse was that Kathleen became a stoic, tough young woman who used humor as a defense mechanism and belittled people who she thought were 'cry babies.' She made me work every minute when we met. She often evaded answering questions directly, and sometimes accused me of being "nosey." I patiently waited and tried another avenue to access her. Eventually the story came out. Essential is to note the ways Jesus related to people. He attended to each one He encountered with his undivided attention and desired for them to be healed. He provided them a safe place to unburden themselves. He validated their life experiences, but some he challenged such as the woman at the well, who did not tell Him the whole truth. Jesus wants to set the standard for us as therapists and offer us the Holy Spirit to gift us to do so.

Interventions

During the course of my work with Kathleen, I found the following therapeutic considerations to be important. We worked together over the course of 3 ½ semesters and the progress and healing that occurred was definitely not linear but very complex and painful. All of the protective defense mechanisms which guarded her pain were loath to go quietly.

My experience of engaging Kathleen in therapy felt, at times, adversarial. For every careful step I would initiate or encourage, there would be some type of push back. When the concept of transference was introduced, she would find something to mock in it. I would gently engage in this dance, with patience, understanding that the wound must be significant if it was being so staunchly defended and with such vigor. Yet, she showed up each week at the back door on time, not bothering anyone.

Education was a means of increasing her sense of safety. Kathleen viewed the abuse and resulting trauma as a deep dark pit of pain and chaos - who would want to go there? Over time, she grew to understand what trauma is and how it occurs. At appropriate times I would interject what type of symptoms someone suffering from trauma might have. We then paired what Kathleen had experienced with those symptoms. We were able to discuss the power differential between herself as a 7th grader and the Pastor of her known universe. It was a shock for Kathleen to clearly look at that the priest who prepared her for Confirmation had also planned her abuse.

I attempted to engage her more actively in treatment by inviting her to reach more deeply into her experience and to journal about therapy, her thoughts and feelings after a session as well as nighttime obsessions which prevented her from sleeping. Kathleen had a minimal amount of emotional vocabulary. We worked on a worksheet where feeling words were organized and listed. PTSD clients fear remembering, feeling the terror, and the confusion of the trauma and Kathleen was no different. Control is highly valued for the survivor and reexperiencing is to be avoided. The shame and internal injury she had experienced were revealed after a number of months of working with these words. Kathleen knew that she hurt and was lonely but didn't know that she felt rage or abandonment or fear. That self assessment only came later. Education regarding trauma and treatment, journaling between sessions, feeling words to assist her in communicating her emotional / experiential vocabulary were all preliminary interventions to build a narrative. The narrative is her story about her missing years that were stored in a vault protected by defense mechanisms. She had always known what happened to her, but she tried to never look at it or allow it to reach true consciousness. She promised herself never to get near to anyone again.

Telling the story helped strengthen Kathleen's confidence that perhaps she can remember and feel and verbalize the experience without becoming overwhelmed by the physical, psychological and spiritual pain of the abuse. Desensitization occurred in the process. Insight into her abuser, herself and her defense mechanisms increased. The quality of the therapeutic alliance changed for the better after she was able to develop a narrative. We looked to the future as well as problem solving for the present. Kathleen was very intuitive and intelligent. She utilized the

education, and coping tools to maneuver through the feelings and narrative she was able to construct. She managed to finally cry since being tough on 'cry babies' was one of the last defenses to crumble.

Medication evaluation and management. Kathleen was referred to our University physician who shared our part of the building. This physician was willing to evaluate some of our clients whom staff suspected of being appropriate for a SSRI. Kathleen was ending her junior year and would be facing an Internship in a few months followed by her senior year and all that entails. She eventually agreed to a trial of a SSRI to help manage anxiety and stabilize mood. This addition of an SSRI was a very important part of treatment during the last year of school and treatment.

Restorative Justice. Kathleen, in response to her pain and embarrassment, had closed off everyone, guarding her guilty secret, and so had become very emotionally distant from the parents whom she loved. The clerical abuse effectively denied Kathleen the loving support and parental guidance that teenage girls so deeply need. Through the process of therapy, Kathleen reached out to bridge the chasm and restore the parent-child bond. One day she asked if she could invite her parents to a session. She wanted to tell them about the sexual abuse now that the pastor was dead (she cheered), and she was ready to graduate in a few months. Since her parents needed to travel from New England, it took a week just to find a common time for the four of us to meet. The day arrived. Everyone was nervous. I wondered "What if the parents responded in some negative way?" Kathleen worried "How would they take it, would they blame me?" And the parents were nervous since they didn't know why they were coming, invited by their distant and aloof daughter. Since all were believers, we opened with a prayer. Kathleen managed to tell her story to her parents. I provided education to them regarding the effect this has had on her. I also fielded some questions they had as parents and told the mom that she had no way of knowing why Kathleen was reluctant to deliver the mail. I left the room after an hour, they hardly noticed I left as they held each other and cried for the lost years of love. Graduation day arrived and she had such a big grin on her face as she hugged friends and family. I didn't remember her calling anyone a cry-baby in quite a while.

Afterwords

Just a few months ago, Kathleen reached out to contact me after many years. As with many survivors, the Pennsylvania Report in August 2018 was jarring to Kathleen. What was so private had become front page news and shook her emotionally. Her strategy in coping with this distressing turn of events has been to chose not to read nor to discuss this news release—to minimize her exposure to it. She was looking for validation from me that this was a healthy strategy and I supported that decision. I did ask her what brought her to counseling in the first place

when she was in college. The now married mother of two, who once wrote in small letters “depression and sleep” wrote the following:

“I was miserable, I was exhausted. I was ashamed. I was confused. I was angry. I was so tired of the flashbacks and the nightmares and the voices in my head telling me I wanted it, or it was my fault. I spent years telling myself not to feel so I wouldn’t get hurt again and I found myself in a place where I was incredibly lonely. I knew this wall I had built to protect myself was the very thing causing my loneliness. I figured at that point life could not get any lonelier and if there was even a slight chance someone could hear my story and still tell me it wasn’t my fault I was gonna go for it. And You? You set up the perfect setting for me to let it all out. Most importantly I heard what I was searching for. I heard it really wasn’t my fault !” —Kathleen