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Pastoral Care with Addicted Persons

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Introduction

This article begins with an examination of addiction—behavioral addiction—and a brief history of when the American church began to get involved in helping persons with addictions. In my writing, I consider the painful memories shared by several counselees that

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endured traumatic experiences and whose addictions were instituted as their means of survival. I highlight cultural transference and cultural countertransference, as well as my approach of midwifing developed through research, group sessions, integrating self-psychology, narrative, and womanist theology. The integration of each provides the framework of my midwifing methodology. The information and resources utilized in the article are an accumulation of my ten years of experience and education working and providing care to a diverse population grappling with addiction.

As an ordained clergy, licensed Christian counselor and therapist, certified pastoral counselor, chaplain, and anger management specialist, I have provided care for a broad spectrum of persons—from the incarcerated and homeless, the poor and middle class, to the professional. The material presented in this article represents a technique of pastoral care that is focused on

1. Creating a safe and sacred space,
2. Power of telling and sharing one's narrative, and
3. Re-authoring one's narrative.

The technique affirms that each of the three parts helps to facilitate the opportunity for hope, wholeness, transformation, liberation, empowerment, re-authoring, and the development of a secured sense of self. Lastly, I illustrate the benefits of a midwifing approach when providing care to persons battling addiction due to the deeper issues of trauma.

For the counselees presented in this article, substance or behavior was developed in order to cope with harmful memories. The whole is intended for pastoral care professionals within a clinical and/or educational setting. The view represented is meant to shift attention from the addict to a focus on understanding the need for the substance or behavioral addiction. Further, the purpose is to explore the narrative of the person and the importance of journeying alongside the counselee as they unpack the reasoning of their addiction, explore self-love through self-care, and become whole and transformed by integrating negative and positive experiences. This will lead to liberation and empowerment, allowing the counselee self-acceptance through affirmation, re-authoring their narrative, and learning healthier ways of coping.

A. Exploring Addiction

The American Association of Addictive Medicine states,

> Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.[2]

In *Mental Health and Mental Disorders: An Encyclopedia of Conditions, Treatments, and Well-Beings*, edited by Len Sperry, addiction is also defined as,

> the compulsive use of a habit-forming substance or the irresistible urge to engage in a behavior despite harmful consequences and as a chronic disease of the brain which involves compulsive and uncontrolled pursuit of reward or relief with substance use or other compulsive behaviors.[3]

Behavioral addiction repeatedly engaging in behavior(s) that are destructive and result in harmful consequences.[4] When persons succumb to the control of substances or behaviors and become addicted, their judgment becomes impaired and their interpersonal relationships are affected, as are their emotional and spiritual internal self.

The practice of seeking to understand and help addicted persons began with the addiction to alcohol. In 1913 an assembly of religious leaders known as the Oxford Group gathered to create a space of healing for persons suffering from alcohol addiction. In 1935, their practices became more popular through Alcoholics Anonymous (AA), which adopted their model. The Oxford Group described itself as "a movement of vital personal religion working within the churches to make the principles of the N.T. practical a working force today."[5]

However, before 1913, the idea that human character can be changed can be traced back as early as the 1730s to Jonathan Edwards and John Wesley. Author and researcher Glenn F. Chesnut writes,

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[2] Len Sperry, *Mental Health and Mental Disorders: An Encyclopedia of Conditions, Treatments, and Well-Beings* (Santa Barbara: Greenwood, 2016), 17.

[3] Sperry, *Mental Health*.

[4] Sperry, *Mental Health*, 18.

[5] Dick B., *The Oxford Group and Alcohols Anonymous: A Design for Living That Works* (Kihei, Maui: Paradise Research Publications, Inc., 1998), 146–147.

> What Edwards and Wesley discovered was that human character could be changed. One could take the story of a person's life, and with the aid of God's grace, change the way the story ended.[6]

This concept of changing the way the story ends has been highlighted through narrative theology and narrative therapy.

Pastoral theologian Edward Wimberly ascribes to the power and the liberative means of a narrative approach to providing pastoral care, which he highlights in his teaching and writings. In *Recalling Our Own Stories,* Wimberly emphasizes that the use of narrative in scripture aides the counselee in drawing from problematic texts and journeying toward empowerment and deconstruction. His method explores the counselee's life and helps them to get at their presenting problem. This technique helps the counselee to define and/or get to the root of the problem and affirm space for a new narrative, deconstructing negative internal and external scripts. Wimberly's approach helps the counselee to see God at work in their life.

Michael White and Michael Epstein contend that "mapping the influence of persons" and "reorganizing their experience" encourages them to externalize the problem.[7] The narrative process helps the counselee to externalize themselves as the problem, and see the problem as the problem. It allows for the listener as well as the story teller to witness the story and create a new story through externalizing and re-authoring. I assert that the fundamental healing component in one's narrative is the *telling* and the *hearing*. This demonstrates the value and humanity of the person telling the story and asserts their value through the hearing of the story.

Reflecting on the change that began in the 1730s, and the later re-storying, provides insight today for pastoral care professionals who create an atmosphere of hope that will resonate with those who suffer with addiction, stirring within the counselees hopefulness. This hopefulness is critical. Receiving care and assistance in an environment hopeful of new possibilities of change allows counselees to gain confidence that they can overcome their addiction and begin again without the stronghold of addiction taking charge of their life.

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[6] Glenn F. Chesnut, *Changed By Grace: V. V. Kitchen, the Oxford Group, and A.A.* (Lincoln: Universe, 2006), xii.

[7] Michael White and Michael Epstein, *Narrative Means to Therapeutic End*, (New York: W. W. Norton, 1990), 17–18.

Sperry affirms that providing hope is a crucial dimension for addiction counselors as they offer themselves as "living proof" of hope. Most addiction counselors are individuals who overcame the control of their addiction and use their experiences to assist and care for persons who struggle with addiction.

Although most everyone who provides care to the addicted has been an addict themselves, the counselor must be able to demonstrate what Heinz Kohut terms "vicarious introspection."[8] For Kohut, vicarious introspection is the emphasis on empathy and introspection and should be used as tools in psychoanalysis to study the human experience and the core self of the counselee. This allows the pastoral counselor or pastoral care provider the opportunity to understand what the counselee has experienced through the lens of the counselee. In order to provide pastoral care and counseling, one must not focus on the addict, but on the addiction. The counselor must try to identify the underlying reasons or circumstances that led the counselee to seek to a resolution to a particular behavior (or substance abuse) in order for the counselee to cope or deal with problematic internal and external factors.

Empathy is valuable in counseling, even invaluable to providing care to persons who wrestle with addiction, because an empathic approach emphasizes contextual human understanding rather than technical competence. Thus, the pastoral counselor or pastoral care provider can "walk in the addict's shoes" and provide interpretation that coincides with their experience, rather than simply pathologizing their perspectives. Therefore, the goal of helping persons with addiction is not about beating them over the head with their addiction, but listening and practicing an empathetic understanding in order to gain insight into their pain, hurt, and into their internal/external unresolved self or shame; this will create a "cohesive self" and spiritual growth.

When persons suffer from addiction, they usually feel humiliated, shameful, and defeated. Therefore, one goal for pastoral care professionals should be to help the counselee give voice to their shame and provide a space for healing. Gershen Kaufman asserts that persons who suffer from addiction tend to hate themselves, have a

8 Heinz Kohut, *How Does Analysis Cure?* (Chicago: University of Chicago Press, 1984), p. 175.

lack of resolve and inner strength, and those result in failed relationships and unmet interpersonal needs.[9]

B. Transference and Countertransference and Uncovering the Root of Addiction

For a different lens in re-evaluating pastoral counseling to persons living with addiction, we explore the importance of self-awareness for the pastoral care provider. The role of discernment is important. We explore cultural transference and cultural countertransference in the therapeutic encounter to help the counselee as they find the courage to uncover what is beneath or at the root of their addiction.

Educator, pastoral theologian, and counselor Archie Smith, Jr. uses the term "bleed through" as he explores and discovers something that is covered up.[10] Smith asserts that "pentimento" occurs when the past is not dealt with, but is forgotten or covered over.[11] Smith's framework provides an awareness of how one covers up (or over) that which one cannot deal or cope. Covering over one's traumatic and painful memories will eventually lead to "the bleeding" into their present, and that "bleeding" leads to addiction when they can no longer cope with the hurt from the past. For the pastoral care professional who wishes to help, assist, and journey alongside persons who request care, Smith's process emphasizes the creation of an atmosphere that allows the counselee to lament and to uncover what may have led to their addiction.

Pastoral counselors who create safe and sacred spaces for persons to cry out:

1. Assist the counselee to value their experience,
2. Acknowledge their pain,
3. Make space for healing to occur which promotes hope, and
4. Furthermore help them develop a healthy core self.

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[9] Gershen Kaufman, *The Psychology of Shame: Theory and Treatment of Shame-Based Syndromes*, 2nd ed. (New York: Springer, 1996), 122–23.

[10] Archie Smith, Jr., *The Relational Self: Ethics and Therapy from a Black Church Perspective* (Nashville: Abingdon, 1982), X.

[11] Pentimento is the technique of removing the top layer of paint to reveal a painting underneath. Smith uses the term as a means of "covering up a canvas previously painted," causing the experiences of their life to "bleed through."

A safe and sacred space allows the counselee to reflect on the strength of their faith and rebuild their trust in and relationship with God, inviting them to pursue healthier ways of coping and moving them from surviving to thriving. This framework allows the pastoral professional to disengage from a moral model in order to become aware of cultural transference and cultural countertransference.

Cultural awareness helps the pastoral care provider to avoid stumbling upon cultural boundary violations. That happens when the counselor or therapist imposes his/her values and notions regarding a wide range of social and cultural matters upon the analysis and counselee. According to Salman Akhtar, that occurs when the counselor ignores the counselee's cultural background, the counselor ignores his/her own cultural background, or the counselor ignores the effect of his/her own cultural background on the counselee. [12] Foremost, Akhtar asserts the counselor must take into consideration the cultural identity of the counselee. He writes, "Cultural identity is the core self-representation that is aligned and affiliated with the norms and attitudes, values, and communication idioms of a group of people." [13] Akhtar, expressing John Spiegel's definition, sees cultural transference and countertransference

> as [one's] respectively feelings, fantasies, and attitudes a patient [counselee] might have towards the analyst's [counselor] ethno-racial group or an analyst [counselor] may have towards the patient [counselee] ethno-racial group.[14]

Akhtar asserts one's perception of another's culture is transgenerationally conveyed as a result of one's historical relationship towards an ethno-racial group, consequently hindering interpretation during the therapeutic encounter. [15] Charles Gelso and Jeffrey Hayes write:

> Cultural countertransference (and transference) [are] culture-related distortions of the patient [counselee] or rigid interpersonal behaviors rooted in his or her [the therapist] direct or vicarious experience with members of the patient's

[12] Salman Akhtar, *Comprehensive Dictionary of Psychoanalysis* (London: Karnac Books, 2009), 64.

[13] Akhtar, *Dictionary of Psychoanalysis*.

[14] Akhtar.

[15] Akhtar.

> [counselee] group [occurring when the counselee holds onto perceptions that don't apply to the counselee]. [16]

Addictions: A Comprehensive Guidebook outlines the need for awareness of transference if operating under the moral model. Alleging that when working with persons who desire to overcome their addiction, the use of naming and blaming may stem from the counselor's cultural identity (religion, race, gender, etc.) and their attempt to avoid uncomfortable feelings.[17]

Clinicians Leslie C. Jackson and Beverly Greene expand the scope of cultural transference to encompass the

> emotional reactions of a client to the therapist based on the client's sense of who the therapist is, culturally, with respect to race, ethnicity, religion, gender, age, social class, and other factors ... cultural transference looks beyond race to acknowledge other obvious differences between the client and the therapist, and it allows for "cultural" reactions by a client to a therapist who is similar with respect to race and gender. [And] cultural countertransference as the therapist's emotional reactions to the client based on the client's race, ethnicity, religion, gender, age, social class, or the like ... [anything] that gets in the way of seeing the client more clearly.[18]

Jackson and Green go further, discussing the "real relationship" that occurs in the therapeutic space between the counselee and the pastoral counselor. The real relationship is the realistic relationship established between the counselee and the counselor, and not the one of fantasy.

Womanist pastoral care author Markeva Hill writes,

> As counselors, we are trained to follow the transference thread that leads us through the labyrinth of the unconscious back to the scene of the crime(s). Once there, we assist in reconstructing the past in order to make sense of the present and create new meaning and options for the future [of the counselee].[19]

These are not easy to see and require a lot of clinical training.

Each explanation of cultural transference and cultural countertransference illustrates the need for cultural awareness when

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[16] Charles Gelso and Jeffrey Hayes, eds., *Countertransference and the Therapist Inner Experience: Perils and Possibilities* (Mahwah: Lawrence Erlbaum, 2007), 134.

[17] Barbara S. McCrady and Elizabeth E. Epstein, eds., *Addictions: A Comprehensive Guidebook*, (New York: Oxford University Press, 1999), 445.

[18] Leslie C. Jackson and Beverly Greene, eds., *Psychotherapy with African American Women: Innovations in Psychodynamic Perspective and Practice* (New York: The Gilford Press, 2000), 20, 24.

[19] MarKeva Gwendolyn Hill, *Womanism Against Socially-Constructed Matriarchal Images: A Theoretical Model Toward a Therapeutic Goal* (New York: Palgrave MacMillan, 2012), 70.

providing pastoral care and counseling to anyone. This awareness will not only allow for a therapeutic alliance to be developed, it also allows the counselee to open up and reflect on what purpose the addiction serves, leading them to develop a healthy core self. This, suggests Kohut, is the ultimate goal of therapy—the development of a healthy and balanced self or "cohesive self." Kohut speaks of the cohesive self as a psychic structure that becomes harmonious, vigorous, and energetic. In other words, it is an integrated self that is able to develop a structured/organized self. [20]

C. Midwifing: A Womanist Approach to Pastoral Counseling[21]

The term womanism was coined in 1982 by African American author and activist Alice Walker.[22] However, for this article, we draw on Delores Williams' definition of womanism, who declares that womanist theology is a

> prophetic voice concerned about the well-being of the entire African American community, male and female, adults and children ... attempts to ... affirm … challenge all oppressive forces.[23]

A womanist framework values the importance and uniqueness of the counselee, serving as a conduit to empower and journey with the counselee. It enables the counselee to cultivate their own true identity separate from what has been imposed on them via socialization, miseducation, and other external forces that may have led to their addiction. Hill asserts, "Womanism is able to empower pastoral counselors with the tools of healing and assist them in joining the counselee in a manner that would prove to be non-threatening for both counselor and counselee."[24]

Additionally, we assert that womanism seeks to create a safe space that allows the counselee to explore their defense mechanisms and current coping skills, eventually helping to un-armor defensive

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[20] Heinz Kohut, *How Does Analysis Cure?* (Chicago: University of Chicago, 1971), 99–100.

[21] Myrna Thurmond-Malone, "Midwifing: A Womanist Approach to Pastoral Counseling, Investigating the Fractured Self: Slavery, Violence, and the Black Woman" (ThD diss., Columbia Theological Seminary, 2015).

[22] Alice Walker, *In Search of Our Mothers' Gardens* (New York: Harcourt, 1983).

[23] Delores Williams, *Sisters in the Wilderness: The Challenge of Womanist God-Talk* (Maryknoll: Orbis Books, 1993), 67.

[24] Markeva Gwendolyn Hill, *Womanist against Socially-Constructed Matriarchal Images: A Theoretical Model toward a Therapeutic Goal* (New York: Palgrave Macmillan, 2012), 69.

and protective mechanisms by becoming aware of the root to their addiction. It seeks to dialogue with culture, socialization, and spiritual, religious, as well as with theological beliefs, as the counselee examines their story and the birth of their addiction.

Finally, a womanist framework provides a holistic, healing approach as it creates space for the counselee to share, hear, and acknowledge their story; and, in turn, it helps them to affirm a stronger self-identity as they embrace their humanity and begin to integrate their experiences, moving from fractured selves to wholeness and taking control of their addiction. A womanist framework includes the pastoral functions of nurturing, empowering, liberating, and reconciling.[25]

The role of pastoral counselor as midwife is inclusive of these pastoral functions and provides support, meeting counselees where they are. This allows for the counselee to transition from a state of survivor mode to a thriving mode, thereby facilitating the creation of a safe and sacred space that allows the counselee to get through their challenging life experiences.

This framework also speaks of the power of language to transform and create healing. In some folklore writing, the midwife is referred to as "conjurer" or "sistah conjurer." Valerie Lee noted how sistah conjurer is a term that, rather than

> dismissing the women as superstitious or incompetent, gives them historical and personal agency [and] conjurer is a magical means of transforming reality.... It is a healing event ... taking healing as a metaphor for spiritual power ... emphasize[ing] the restorative potential ... locating in language a new curative domain. [26]

A recent study on the role of midwives illustrates how midwives empower women by meeting them where they are, which in turn allows them to "get through" the birthing process.[27] This perspective provides a construct to engage the pastoral counselor on the benefits of meeting the counselee "where she/he is" in order to facilitate

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[25] Carroll Watkins Ali, *Survival and Liberation: Pastoral Theology in African American Context* (St. Louis: Chalice Press, 1999), 8–9.

[26] Valerie Lee, *Granny Midwives and Black Women Writers: Double-Dutched Readings* (New York: Routledge, 1996), 14–17.

[27] Tracey Cooper and Dame Tina Lavender, "Women's Perceptions of a Midwife's Role: An Initial Investigation," *British Journal of Midwifery* 21, no. 4 (August 2013): 268.

empowerment, thus allowing the entire person to be present in the therapeutic encounter of good, bad, and uncomfortable issues that may need to be explored when getting to the root of addiction. The midwifing perspective suggests that the pastoral counselor must be in a position to hold, care for, and handle the issues that are part of the counselee's narrative.

We interpret the midwife as being able to create as a sacred and safe holding environment. This allows persons who are addicted to bring their entire being and life experiences into the therapeutic encounter, giving them the confidence by assuring them that their voices and stories will be honored and supported through the telling and sharing of difficult and traumatizing life experiences.

The narrative and midwifery experience of Margaret Charles Smith highlights the struggles of black women for whom she cared, and her ability to hold all that their "lived reality" represented as she cared for them and created a space to prepare for the birthing. Linda Holmes writes,

> Mrs. Smith's skills as a midwife stood up to many of the challenges she faced, allowing her, as black folks often say, to 'make a way out of no way.' ... Mrs. Smith met few problems that she couldn't solve.[28]

Womanist and women's healthcare provider Arisika Razak explains her experience of a midwife as someone who stands "as witness, companion, and helper.... My work [as a midwife] demonstrated the immense contradictions under which women live."[29] Razak goes on to share how her experience as a midwife created a holiness experience, whereby the face of God was able to be experienced in the birthing process.[30]

The counseling birth process in midwifing would be to journey alongside persons that struggle with addiction, allowing them to develop a functional process for externalizing—giving birth, if you will—to their life experiences that may have led them to become addicted. Therein, such allows them to encounter the face of God through the telling, thereby creating space for new life. A midwifing

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[28] Margaret Charles Smith and Linda Janet Holmes, *Listen To Me Good: The Life Story of an Alabama Midwife* (Columbus: Ohio State University Press, 1996), 88.

[29] Arisika Razak, "Embodying Womanism," in *Ain't I a Womanist Too: Third-Wave Womanist Religious Thought*, ed. Monica A. Coleman (Minneapolis: Fortress Press, 2013), 218.

[30] Razak, "Embodying Womanism."

therapeutic approach is aware of the importance of creating a safe and sacred space that allows the pastoral counselor to build trust with the counselee in order to hear each story.

Valerie Lee highlights the trust aspect of midwifing throughout her book, *Granny, Midwives, and Black Women Writers: Double-Dutched Readings,* as she explores the perception of midwives from those for whom she provided care. About the midwife Miss Mary, Lee writes, "When patients saw the midwife coming, they thought they saw heaven! They thought the midwife could ease their burdens for them."[31] This suggests not only the perception of the midwife's healing aspect, but also her connection to God and a feeling of safety and trust engendered for women in her care. Engaging the voice of Holmes, who writes, "the ability to summon the Holy Ghost for support, guidance, and 'miracle working' ... midwives frequently assumed the meditative state of prayer in preparation of attending a birth." [32] Lee explores the "high and holy calling" of granny midwives who felt they received a "call from the Lord" to do midwifery, thereby relying upon the spiritual dimensions of God to use their gift of "catching the baby." [33]

For this pastoral counselor, "catching the baby" can be used as a metaphor for the pastoral counselor's ability to not only offer a container, but also to be able to hold the narratives of the counselee as the counselee themselves fill the container.[34] We believe that when we establish trust and safety, the counselee is more likely to permit their entire being into the counseling session and share their narrative. The pastoral counselor as midwife creates a therapeutic environment facilitating the counselee's undoing of the walls that may have been developed in the course of coping with a life that led to addiction. The pastoral counselor must have the fortitude to hold and engage the stories shared for the development of a counselee's healthy core self, allowing re-storying and healthier coping skills.

For that safe and sacred space to occur, the pastoral counselor must develop a position of empathy. Empathy allows for the

[31] Lee, *Granny Midwives and Black Women Writers*, 86.

[32] Smith and Holmes, *Listen To Me Good: The Life Story of an Alabama Midwife*, 88.

[33] Lee, *Granny Midwives and Black Women Writers*, 82–83.

[34] Lee, 84.

counselee to keep their walls down and be open to engage their story with the pastoral counselor, allowing the counselor and counselee to examine further the counselee's defense mechanisms. Lee's use of the metaphor "double-dutched readings" illustrates empathy as she places herself, as well as other folklore and literary writers, in the shoes of those who provide care. The desire was to tell the stories not from the writers' lens, but rather to tell the stories through the lens of those of the actually gave care in the folklore story—quite ingenious. Lee and other writers, such as Morrison, do not change the narrative to fit the experiences of today, but hold the story in the light in which the giver shared their experiences.

Thus, midwifing is an attempt at listening and understanding the stories and experiences through the lenses of those giving birth, that is, those who need to deliver and even get deliverance. When providing care to persons suffering from addiction the focus is not on the addiction, but on the story surrounding, behind, or beneath the addiction, as well as the thoughts, feelings, and perceptions that the counselee may have internalized as a result of their experience and/or addiction. This posture creates a sacred and safe space, allowing the counselee's narrative to be heard and defenses to let down, and this offers assurance that it is safe to tell their story, even *deliver* their story into the kind and gentle and empathic hands of an experienced pastoral care midwife—one the counselee trusts with their most intimate and painful experiences.

In other words, there is healing in the telling and the "delivery" of the story. It allows the pastoral counselor and counselee to reflect on the story. The *delivery* helps to free the addicted from the pain of the story and develop a healthier defense mechanism. The counselee can then inspect their defense mechanisms, which allows them to explore and get to the root of their armoring and the root of their addiction. This positions the counselee to gain insight into their inner self and how their armoring has played a role in their addiction, identity, and relationships. Exploring the "why" helps to externalize negative feelings and thoughts that may have prevented them from building a healthier self-image and relationships with others, creating hope and the willingness to replace the negative addiction with healthier ways of coping.

Midwifing allows counselees to explore their need to escape negative memories such as sedative scripts of shame. A sedative script looks at a scene while paying attention to the negative and while disregarding other parts of the scene.[35] The telling of their story authorizes counselees to honor their voice, story, and identity, thus allowing them to become empowered and deconstruct negative sedative scripts. Through listening and affirming, pastoral counselors have the ability to journey with the counselee to un-armor—again, to "deliver"—and to thereby re-story a new beginning. This allows the counselee to not only uncover painful memories, but to move past the old negative behaviors that create feelings of inadequacy.

This Midwifing Pastoral Care helps to empower the counselee to recognize their humanity. When this occurs, they are able to become empowered and thereby liberated from negative experiences and from the stronghold of their addiction.

D. Four Verbatims in the Midwifing Model of Pastoral Care

The following four statements come from real-life sessions with hurting people and reflect the benefits of the midwifing approach, the names changed to preserve anonymity. Coming from a variety of backgrounds and ethnicities, educated and non-educated, poor and middle class, they all confess to be spiritual or Christian. Each shared their reluctance of counseling, being afraid that they might be judged; they wanted to forget bad memories and did not want to be typed as crazy. Lastly, each shared that there was not adequate space in which they could openly share their experiences and feelings.

> **Jessica:** I struggle with identity. It's hard to look in the mirror because of what happened to me during my childhood. I use sex so I could have control because I didn't have it growing up. I questioned God and how could He allow this to happen to me. Where was he? I didn't think of me having a lot of sex as an addition I just wanted to be numb. But counseling is helping. I feel safe and I'm learning how to define me even though I was molested.
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> **Jeff:** I was pretty excited about counseling after our first session. You seemed sincere, and that made me feel safe. It feels good to talk about my dreams and not live in the past. I have been able to recognize triggers that lead me to drink or be mean to others. I'm learning to love myself.

[35] E. Virginia Demos, ed., *Exploring Affect: The Selected Writings of Silvan S. Tomkin* (New York: Cambridge University Press, 1995), 389.

Samantha: You know I took what you said to me last session and I wrote a letter to my father and shared how he hurt me. Even though he is dead, it helped me to get it out of me. I realize that I used food to replace what I didn't get from my dad and this week instead of turning to food I wrote the letter. It made me feel like I'm finally getting control.

Keisha: Growing up in Mississippi during segregation was hard. I hated being black. When I left for college I didn't know it could be worse, but it was. When I was at a frat party I was raped. I have been holding that in for so long. I felt dirty and ugly and was ashamed. I couldn't go to church or tell my parents, so I started getting high and drinking.

The relevance of the midwifing approach in a modern world focuses on how healing and wholeness can occur as persons who struggle with addiction receive adequate care through a culturally empathic therapeutic encounter. The pastoral counselor willingly hears the stories through the counselee's own lenses, affirming their narratives, and facilitating deconstruction of their negative and harmful life experiences. In so doing, a safe and sacred space for addicted persons helps "deliver" them from negative coping and "embraces" a re-authoring of their narrative.

Conclusion on the Midwifing Model of Pastoral Care

In conclusion, midwifing is a concept that provides guidance, affirmation, compassionate care and support for those who seek care. It fosters empowerment and liberation, allowing persons to connect with self, community, and God. Midwifing is aware of the impact that one's culture and socialization have on the development of the structure of one's self. Midwifing is an effective method as it

1. Establishes a safe therapeutic space that allows the counselee to construct a therapeutic alliance,
2. Postulates a position of empathy allowing the counselee to feel free to open up and explore their defense mechanisms,
3. Allows the counselee to experience the therapist as affirming, understanding, and non-threatening,
4. Recognizes their humanity,
5. Enables the counselee to become empowered and liberated in order to deconstruct negative identification, strongholds, and/or behaviors, and
6. Develops a healthy core self and relationship with the community, allowing the counselee to see themselves in the

image of God as they develop a mature self through repairing self-deficits.

Lastly, wholeness become possible as the pastoral counselor creates the space for the thickexperiences of the counselee to be heard.[36] With hope all along the way, the addicted move from a fractured self to a whole self that embraces their humanity and their self-worth, allowing them ultimately to see themselves in the image created by God—even truly loved and fearfully and wonderfully made.

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