Pastoral Perils in the Care of Trauma Based Personality Disorders

Pastoral Perils in the Care of Trauma-Based Personality Disorders.

- Traditionally "softer" therapeutic frame
- More available than fee for service providers
- Ambiguity and confusion of the pastoral role
- Strong "parenting" strain in pastoral care providers
- Pastoral care is frequently a solo enterprise
- Own personal issues

Pastoral Perils in the Care of Trauma-Based Personality Disorders.

- An understanding of the perils does not prevent them from being present
- In fact, the very presence of the peril is witness to the significance of the relationship
- However, understanding can save the pastor from enmeshment, thereby:
  - Tolerating the perilous relationship with less anxiety
  - Be a better steward of the sacred encounter
  - Model right relationship and prevent re-enactments of the abuse.

Peril #1: Increased Transference & Counter-transference (a)

- Transference: Displaced though and feeling dynamics (typically from the past) and projected onto the pastor.
- Counter-transference: Thought and feeling dynamics in response to the pt's transference– and in combination with the pastor's own character structure– which are projected back into the relationship with the pt.

Peril #1: Increased Transference & Counter-transference (b)

- Affective awareness is the most effective indicator, *e.g.*,

Pastor feels…	Possible dynamic in the pt…
Nurturing, protective, sexually aroused	Histrionic, dependent, borderline
Used or manipulated	Narcissistic
Guilty	Dependent, passive
Annoyed, frustrated, angry	Obsessive/compulsive; passive aggressive; borderline
Afraid of patient	Borderline, anti-social, schizoid
Afraid for patient (or of environment)	Paranoid, schizotypal

Peril #1: Increased Transference & Counter-transference (c)

- Some Early Signs
  - Inconsistent or inappropriate self disclosure
  - Rescue fantasies about patient
    - All pt needs is proper re-parenting, etc
    - If only we had meet differently; agreement to meet later
  - Between meetings with patient:
    - Inconsistent concern about dress and appearance
    - Sexualized daydreams or fantasies about patient
    - Dreams about the particular patient
  - Feeling of being overwhelmed in the face of attraction, anger, ineffectiveness, guilt, fear, envy.

Peril #2: Defining meets and Bounds in the Relationship

- Trust issues
- Defensive distancing
- Personal boundaries
- Secondary PTSD
  - Projective identification
  - Affective contagion
  - Nightmares
  - Altered perception
  - Pt's abusers become your own

Peril #3: Roles and Responsibility in the Relationship

- Idealization
  - Both positive and negative
  - Be aware of your own need for gratification
- Control
  - Collaboration
  - Standing orders
- Motivation
  - Not everyone is interested in growth and change
  - Need to be cared about, protected, or parented
  - Behavior is more reliable than verbalization.

Peril #4: Trance States and Dissociation

- Depersonalization
- High suggestibility
  - Constantly moving in and out of autohypnosis
  - Use caution with meditation and prayer
- Dissociative disorders
  - Do you really want to go there?
    - See publication: *A Pastoral Commentary on Dissociative Disorders: A primer for pastors*
- Enmeshment in pt's hypnotic reality
- Grounding in the here and now.

Peril #5: Suicide and Self-Injurious Behaviors

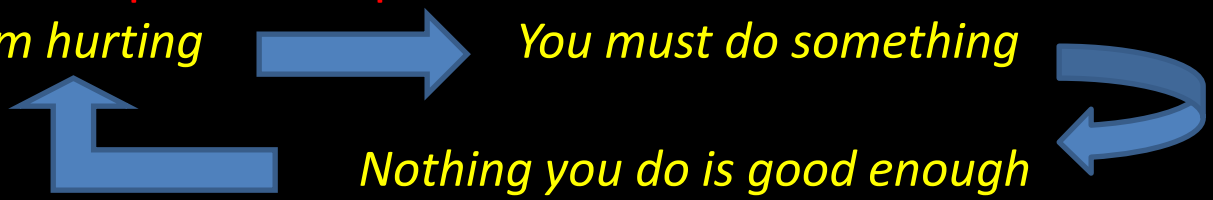
- **Safety is ultimately the patient's responsibility**
  - Process rather than content
  - "If you are going to hurt yourself, could I stop you?"
  - SIB as a control issue
- Hypothesis of rational for SIB
  - Manipulation of brain chemistry: altered cognitive processing, relief from imagery and associations,
  - Public significance and response: show of anger or protest, approval or rejection, diversion
  - Psychodynamics: expiation of guilt, identification with the abuser, punishment or control of other behavior
  - All = attempt to "make meaning" or "do theology"

Peril #5: Suicide and Self-Injurious Behaviors [2]

Peril #6: Cognitive Entrapments, Distortions and Double-binds

- Test statements for cognitive and perceptual errors
  - Reframe, reduce, restate examine statements, *even nonverbal*
  - Watch for generalizations and catastrophizing
  - Pt will make up an interpretation to fit the facts; check it out

- Avoid entrapment loops:
  - *I am hurting* → *You must do something* → *Nothing you do is good enough* → *I am hurting*



- Avoid double binds
  - *e.g.,* "if I don't forgive my abuser, God will not forgive me" "…if I leave my husband, the beatings will stop, but then I'll be all alone and hurt myself."
  - Avoid getting caught inside the binding system, least you end up owning the problem, which (by the way) prevents it from having a solution.

Peril #7: Religious Themes

- The Faustian Deal
  - Dependent patients may invoke religious issues in order to make themselves interesting and stay in relationship.
  - Pastoral clinicians are then delighted and prone to over-function in order to make themselves helpful, stay in relationship, and justify a place in the treatment plan.
- Typical Issues:
  - Good and evil (which am I?); abuse in a religious context, or by clergy/religious persons; ritual observance; confession; forgiving abusers; sacrifice; why did god let this happen; prayer; why am I being punished; how do I make it stop?; guilt; truth; justice; sexual ethics; moral agency; possession states; safety in relationship.

Peril #8: Staying on the Treatment Team

- Are you part of the team?
  - Do you chart properly (DAP, SOAP)?
  - Do you go to treatment team meetings?
- What is your treatment goal?
  - Is it an element of– or at least support– that of the treatment team?
  - Does the patient articulate the issue in religious language?
- Can you articulate the issue on the treatment plan using
  - V-code [v62.89] + a 10 word statement?
  - A plan of intervention?
  - A simple, achievable, and measurable outcome?

Using Religious or Spiritual Problem V-code: v62.89

- This can be used in conjunction with a DSM-IV Axis I or II diagnosis on a treatment plan to designate an religious or spiritual problem that may be the focus of clinical attention.
- Examples:
  - Axis I: 309.81 Post-traumatic Stress Disorder

    v62.89 related to fears of eternal punishment following church camp experience.
  - Axis I: 296.2 Major Depressive Disorder, single episode, severe;

    v62.89 Acute grief: patient hears recently deceased spouse calling for her to "join him now with Jesus."
  - Axis I: 295.70 Schizoaffective Disorder.

    v62.89 patient cuts self during school chapel services to achieve ecstatic state and be "closer to God."