Hell, hope and healing

A four-part series on the effects of child abuse and the myriad paths to recovery

By Mary Gail Frawley-O’Dea
Introduction

Since 2002, we rightly have been bombarded by stories about sexual abuse in the Catholic church. Many Catholics have felt the church has been singled out as a particularly heinous committer of crimes. There is truth to this, but it is also important to contextualize clergy abuse as a part of the wider phenomenon of serious child maltreatment that is still much too prevalent in the United States and in other countries.

The first article in this four-part series, therefore, will place clergy sexual abuse within the universe of child abuse and neglect and will describe the damage suffered by victims of early maltreatment.

We also have heard many times since the church crisis exploded into the public square that victims/survivors of clergy sexual abuse are damaged for life, that these horrible experiences never leave them and instead turn their lives into hell on earth forever. While this can occur, it does not have to. Survivors of adverse childhood experiences can heal and the second article in this series extends hope by describing what processes can help that happen.

In the third article, I extend the discussion beyond healing to discuss the possibility, now validated through research, that some trauma survivors actually experience post-traumatic growth. While never suggesting that somehow the survivor is better off because of the abuse, it is possible to derive meaning from those traumatic experiences and the healing processes addressed in Part 2 of this series. At that point, survivors often develop capabilities, interests and skills that add fullness to their lives. Part 3 also suggests that institutions and organizations affected by trauma can strive for growth by understanding the parts they are playing in healing or impeding their own and others’ recoveries.

Finally, in Part 4 of the series, I offer some practical suggestions for making empowered choices among healing resources.

Clergy sexual abuse in a broader context

[Mary Gail Frawley-O’Dea is author of Perversion of Power: Sexual Abuse in the Catholic Church and a psychologist who has been working with sexual abuse survivors for 30 years.]
Childhood abuse and neglect take their toll

Part 1

The past two decades have witnessed an interdisciplinary explosion of new information about the prevalence and aftermath of child abuse and neglect. From 1995 to 1997, the Centers for Disease Control and Prevention and Kaiser Permanente conducted a study of more than 17,000 Americans to determine how many had been subjected to adverse childhood experiences (ACEs) and what symptoms and disorders they suffered that differentiated them from those patients who did not have such histories. At the same time, researchers in clinical, developmental and neuropsychology, along with neurobiologists and trauma specialists, have increased our understanding of the potential impact of early abuse and neglect on virtually every aspect of a victim’s life.

So what do we know?

The CDC data indicates that only a little over one-third of subjects had no ACEs; 26 percent had one; 15.9 percent had two; 9.5 percent had three; and 12.5 percent had four or more. The study found that symptoms and disorders in ACE survivors were correlated with the number of ACEs experienced and with the frequency and/or intensity of each particular stressor: Let’s make this real.

The U.S. Census Bureau tells us that in 2014, there were about 245.2 million Americans over 18, meaning that more than 156 million adults have histories of ACEs, with more than 30 million Continuing from Page 1 having four or more. Over 50 million of us were sexually abused before the age of 18. Over 30 million watched our mothers get hit.

Think about these numbers when we get to the aftermath of adverse childhood experiences. Big numbers, but by now you may be wondering why you are being deluged with all this information. Isn’t the issue for Catholics “just” the sexual violations of kids by priests and the sometimes still-ongoing cover-up by bishops and provincial superiors?

I would say no. While clergy sexual abuse is the ACE most haunting the church right now, it is important that Catholics take in and feel that more than every other person in their pew has a history of ACEs and every eighth person has had four or more of these devastating childhood experiences, many of which are not single episodes, but ongoing incidences of abuse, neglect, watching Mom get beaten, or coming home to a drunk parent.

If churches are to be field hospitals, as Pope Francis so eloquently suggests, we should all understand who the patients really are and what they suffer.
If churches are to be field hospitals, as Pope Francis so eloquently suggests, we should all understand who the patients really are and what they suffer; even when they don’t look obviously injured. The abused and neglected are not “them”; they are us.

We now know that ACEs can have major effects on every aspect of human functioning. Symptoms and disorders increase commensurately with the more types of ACEs we have been subjected to and the more times those ACEs have occurred. Let’s quickly review what happens to ACE victims and survivors.

**Physical health:** It is now clear that early trauma is correlated with a plethora of symptoms and disorders potentially disrupting virtually every system of the human body. With such conditions as high blood pressure, chronic pain diseases, migraines, irritable bowel syndrome, obesity, and sleep disorders, ACE survivors have more medical problems, are on more medications, and use the health system more than other Americans do.

Scientists now believe that much of this stems from a surfeit of stress hormones coursing through the bloodstream and compromising the immune system. Stress hormones are great in an emergency, but they are supposed to go back to normal levels when the crisis is over. Kids who are being abused or neglected are in emergency mode so much of the time that their stress hormones are always high, stay high into adulthood, and do physical damage over time.

In addition to medical problems, many survivors are afraid of doctors, dentists and the invasive procedures that may ensue in the course of care and therefore avoid seeking help until they are sicker and conditions are further along.

**Cognition:** We also now know that ACE survivors often have disrupted cognition. Part of what ACEs overwhelm is the young person’s ability cognitively to contain, process and put into words the trauma they are facing.

The survivor often has attention deficits, memory problems and an inability to concentrate consistently. Contradictory thought processes ebb and flow with little predictability. One moment, we are speaking as an intelligent adult, capable of complex, flexible, abstract and self-decentered thinking. Under sufficient internal or external stress, however, or in situations somehow reminiscent of past abuse, our cognitive integrity shatters and becomes locked in rigidly inflexible, self-centered thought patterns, simplistic black-and-white opinions devoid of nuance and an immutable conviction that the future is destined to be both short and unalterably dim.

Today, we can actually view this happening on PET scans that show different brain areas lightening and darkening when a trauma survivor’s stress level changes. This happens differently than in people with no adverse childhood experiences, indicating that trauma actually changes the neurobiology of the brain.

**Emotions/affect:** When a child is overwhelmed by ACEs, especially over time, the autonomic nervous system is overstimulated, creating anxiety and fear and releasing stress hormones. The young person’s brain tries to compensate for this hyperarousal by releasing endogenous opioids that calm the system down, often to the point of psychic numbing.

Over time, this results in the person’s inability to successfully modulate emotion so she or he may swing from states of intense affect to those marked by numbed passivity. Our ability to judge the true danger of a present-day situation is damaged; we may confuse people around us by overreacting or underreacting to current situations.

### Prevalence of adverse childhood experiences (ACEs) in the United States

<table>
<thead>
<tr>
<th>ACE type</th>
<th>Women (%)</th>
<th>Men (%)</th>
<th>Total U.S. population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional abuse</td>
<td>13.1%</td>
<td>7.6%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>27%</td>
<td>29.9%</td>
<td>28.3%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>24.7%</td>
<td>16%</td>
<td>20.7%</td>
</tr>
<tr>
<td>Emotional neglect</td>
<td>16.7%</td>
<td>12.4%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Physical neglect</td>
<td>9.2%</td>
<td>10.7%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Mother treated violently</td>
<td>13.7%</td>
<td>11.5%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Household substance abuse</td>
<td>29.5%</td>
<td>23.8%</td>
<td>26.9%</td>
</tr>
<tr>
<td>Household mental illness</td>
<td>23.3%</td>
<td>14.8%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Parental separation/divorce</td>
<td>24.5%</td>
<td>21.8%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Incarcerated household member</td>
<td>5.2%</td>
<td>4.1%</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

Source: CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study
Relationships/intimacy: ACE survivors’ expectations of others are forged in the fires of trauma. Often needy, but expecting rejection, neglect or worse from others, they may shift rapidly from dependent clinging to rage or cold aloofness.

Often the adult survivor’s history is littered with unsuccessful friendships, work relationships, and romances that confuse and hurt both them and those around them.

Especially where the ACEs have included sexual abuse, normal sexual functioning is elusive. Even sex with a beloved other can trigger flashbacks or terrifying emotional states that interrupt sexual encounters or lead us to avoid sex. Sexual abuse survivors may blame their bodies and sexual responsibilities for the abuse and can be too ashamed to be comfortably sexual.

Heterosexual boys abused by men may be tormented with doubts about their sexual orientation. On the other hand, homosexual boys who are sexually abused are robbed of the opportunity to grow gradually into their sexuality; instead, the perpetrator imposes it on them.

Sense of self: ACE survivors often have a fractured sense of self. One part of the traumatized child may be formed as a precocious individual who can learn, make friends, get a job later in life, and obtain an education. This may be the person two spaces away in the pew that seems to be just a regular Joe. Another aspect of the person, however, remains a frightened, grief-stricken child who emerges when conditions are reminiscent of the original trauma.

For victims of priest abuse, for example, a Roman collar, someone clicking rosary beads, or certain hymns can evoke this child. The survivor, no longer firmly rooted in the present, may experience the memories, fears and bodily states he or she felt back then.

Behaviors: Most survivors think they were somehow responsible for what happened to them or in their families. We impose standards on ourselves that we would never turn on another survivor — we should have stopped it; we could have prevented the domestic violence; if we spent more time with Dad, he would have stopped drinking. Depending on the nature of the adverse childhood experience, survivors feel dirty, ashamed, worthless and self-loathing.

Often they take their guilt, rage and self-hatred out on themselves through self-destructive behaviors like substance abuse (which also deadens psychic pain); promiscuous and unprotected sex; walking alone in dangerous areas at night; cutting legs, thighs, arms and public areas; tearing out eyebrows and hair; hustling or prostituting; or making suicidal gestures.

Sometimes they die. In fact, ACE survivors are almost three times as likely as other individuals to make at least one serious suicidal gesture in their lives.

Spirituality: Research indicates that many ACE survivors turn away from religion and even from God. We develop our image of God through the way we are parented early on and through religious experiences we may have.

Our capacity for awe, for experiencing wordless times of wonder and transcendence, depend in large measure on the nature of our early relationships. When these are betrayed through abuse, neglect, witnessing domestic violence, or serious dysfunction, our capacity to surrender to the ineffable that is God may be destroyed.

The especially heinous aspect of sexual abuse by priests and the depravity of the cover-up and unapologetic stance of bishops and provincial superiors often renders the young person’s ability to look to God for comfort and mercy. Instead, the priest as God to the child or adolescent has become a criminal transmitter of evil.

Author and clinician Richard Gartner quotes one patient who was sexually abused by a priest: “It taught me that there is a lie in the world. As I grew up and gave up on my piety, I grew to hate the smells, sounds, feelings of church. … My spirituality and ability to believe in a higher power were destroyed.”

So how does the man or woman a few spaces down in the pew seem so, well, normal? In the next piece in this series, I address the processes of healing and the resiliency that can transform the deepest of wounds into just noticeable scar tissue.
There is hope for survivors to heal

Research shows how resilience — inherent or learned — can moderate the impact of trauma on body, mind and spirit

Part 2

In the first article of this series, I discussed the commonality and damage of adverse childhood experiences (ACEs), including clergy sexual abuse. Here, I focus on the hope that most trauma survivors can heal because of inherent or learned resilience and/or through access to healing resources.

Resilience

Since the 1980s, when child abuse and domestic violence emerged from society’s skeleton closet, researchers and clinicians have rightly prioritized the tremendous wounds caused by adverse childhood experiences. Recently, however, researchers also have concluded that while about two-thirds of trauma survivors will experience at least some negative outcomes after trauma, almost another third will emerge into adults who seem not to have been deeply affected by earlier traumas.

Even more exciting are indications that resilience can be learned or expanded to moderate the long-term impact of traumatic stress on the body, mind and spirit.

The American Psychological Association defines resilience as “the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of threat.” Resilience researchers like Dennis Charney and Steven Southwick have investigated the genetic, biological, social and spiritual factors contributing to resilience. They and others have identified a number of factors that appear to endow an individual with resilience:

- Above average intelligence.
- An internal locus of control. A sense that the individual can determine his/her own fate, even when trauma occurs.
- An optimistic cognitive style. Resilient individuals tend to be able to find the silver lining in even the darkest, most thunderous clouds. They are able to imagine a time when life will be better.
- A close, safe relationship with at least one adult not involved in the trauma. This is an area in which abusive priests were often the most despicable and damaging. Children known by predator priests to be in difficult home situations, or kids who came to the priests for advice or comfort about other traumas, were often selected as victims. Instead of responding to an already hurting young person with kindness and mercy, abusing clergy too often became another trauma for the child or teen.
- A consistent faith and/or cultural traditions that provided hope and a steady belief system. Once again, we see the travesty of priests whose sexual violations robbed victims of a faith-based building block of resilience to life’s challenges.
- A good sense of humor, even when life is tough.

Further, resilience researcher Emmy Werner maintains that even the most resilient person has a breaking point. The trauma survivor’s breaking point may be lower than for those not coping with past ACEs and the sexual abuse survivor’s breaking point is likely to be lower still.

At the same time, the research and my 30 years of working clinically with sexual abuse survivors convince me that healing is possible even when wounds from sexual abuse are deep and suppurating. Part of trauma-focused psychotherapy, in fact, is increasing resilience, also known as strengthening ego functioning.

Trauma recovery

Psychotherapy with a well-trained trauma expert is often essential to healing from traumatic childhood experiences. There are a number of clinical approaches to trauma recovery, but the most comprehensive include the following factors:

Telling the narrative: It is important for a trauma survivor to tell their story to another who bears witness to it. Unlike the first time around, the survivor has control of the timing and pace of being “in” the ACE; the locus of control begins to be assumed by the patient.

Memories can be painful and sometimes are at first acted out as much as “remembered” in the way we usually think of that. It may be in therapy that survivors put some of their traumatic experiences into words for the first time. Doing so begins to structure the memories, gradually taking some of the affective heat out of them.

Building ego strength: Survivors often come to treatment feel-
and acting out of control. Part of trauma therapy is teaching grounding and relaxation techniques, and strategies to put time between impulse and action in order to reduce danger and instill a sense of control and mastery. Individuals with serious substance abuse problems must be in a recovery process in order to benefit from any therapy. Twelve-step program involvement is often a crucial adjunct to therapy.

**Differentiating between past and present:** With post-traumatic stress disorder, time is distorted. Something happening in 2016 that is sufficiently evocative of some aspect of the earlier ACE creates a kind of time travel. Survivors then experience themselves as if the ACE is happening right now. They feel and act in ways that confuse them and those around them.

In therapy, the survivor gradually is able to register and process a situation as it is now and to react accordingly. Often, this is accomplished within the therapeutic relationship as therapist and patient identify and work through perspectives on and feelings about one another and about the therapeutic process.

**Medication:** Because a survivor’s moods and affects are often out of kilter due the impact of trauma on the neurophysiology of the brain, she or he may need medication, sometimes even for life. Today, there is a wide range of psychopharmacological approaches to depression, anxiety, difficult mood shifts, sleep disorders and other PTSD symptoms.

There is no way around suffering in order to heal, but one does not have to suffer unnecessarily, and medications can make life more bearable as the survivor and therapist work together on the inherently unbearable.

**Integrating the personality:** One of the wonders of the human psyche is its ability to cope with the awful. When trauma has been especially severe, the mind may split experience into a variety of compartments representing elements of ACEs that would be too overwhelming to process, store or remember as a whole.

This dissociation allows some aspects of the personality to grow and even to thrive while other parts remain trapped in timeless terror, rage and helplessness. In therapy, survivor and clinician identify dissociated aspects of the personality and work with them to foster a more unified internal world for the patient.

**Re-entering the body:** Many survivors of abuse and/or neglect are alienated from their bodies. Some coped as children by leaving their bodies during traumatic times. Patients describe having been on the ceiling looking down at the child being abused or standing at the door with their hands over their ears as “he” was penetrated anally by a priest.

Somatic experiencing techniques like asking the patient to describe what they feel in their stomach as they describe some past or present experience can be helpful. The therapist who notices changes in posture, positioning in the treatment room, a movement or shift of the eyes can inquire about them, thus helping survivors to become acquainted with how
their bodies feel and what part of their trauma narratives their bodies hold and express.

Repairing the sense of self: I have never encountered a survivor patient who did not in some way blame her/himself for the early trauma. The viciousness of the patient’s self-loathing is often breathtaking. Putting guilt and shame where it belongs — on the shoulders of the adult who committed harm or enabled someone else to harm — loosens internalized attachment bonds to figures that once were loved and vitally important to the survivor.

The patient is in a predicament: Self-blame protects those attachments but requires cognitive and affective contortions that deplete resilience; relinquishing self-blame and self-hatred and putting the ACE in proper perspective with blame placed on the responsible adults is a loss of attachment bonds that is terribly painful.

It also can evoke long-held-at-bay rage that the survivor has usually turned against the self. Anger, rage and a demand for restitution often mark a period of trauma recovery that is important in restoring wholeness. This is a revitalizing phase of recovery, but it becomes problematic if the survivor cannot move beyond it. At some point, ranging must make way for mourning.

Mourning: Perhaps the most soul-searing yet most necessary component in trauma therapy is the survivor’s mourning for the childhood that never was and never will be. Survivors almost universally feel cheated at some point in therapy. They have suffered, cried, raged, worked hard — sometimes for years — to heal and there is no restoration, no making it up, no justice.

As one patient cried out, “This is too much. I can’t stand it — I won’t — you can’t make me. I can deal with the abuse — maybe, perhaps. But the idea that I can’t go back, that my childhood is broken forever — I can’t live with that. I won’t know that I never was and never will be just a kid.”

That was then, this is now: When the survivor seems to have completed a mourning process and is functioning well on most days in most ways, the good trauma therapist begins almost to turn the tables on the survivor: Having spent perhaps years encouraging the patient to relate their narrative, feel the pain and loss, have empathy for the terrorized child they once were, and mourn the childhood that is gone forever, we guide the patient into considering what life can be now; reminding them (if it is true) that no one is traumatizing them now. It is here that the therapist can help the survivor build or expand on resilience

Resilience researcher Charny gives a “prescription” for enhancing resilience, and you do not need a therapist for all of it. He and others suggest:

- Fostering a positive attitude and optimism. In therapy, the therapist reality checks unproductive negativity. Was the argument with your wife really catastrophic? Did anything good come out of it? Could you help something positive emerge from it?

- Find a resilient role model. An Alcoholics Anonymous sponsor familiar with trauma, a martial arts teacher who mentors, or a next-door neighbor who becomes a friend may offer a model of resilience that increases the survivor’s own resilience, while also expanding his/her circle of relationships.

- Practice healthy coping skills. Take a walk instead of a drink; exercise instead of crawling into bed when feeling down; call a friend or read the paper at a busy Starbucks rather than isolating.

- Develop a supportive people network. A 12-step program, book club, exercise class, volunteer activity can get someone out of their head or down mood and into the dance of life again. Researchers stress that positive, high-quality social support enhances resilience, protects against trauma-related psychological problems, improves functioning in people who have life challenges associated with PTSD, and — especially hopeful — reduces the medical problems and early mortality experienced by some trauma survivors.

- Practice physical wellness. Regular exercise, good nutrition, keeping up with medical appointments, good sleep and hygiene all increase resilience to stress.

- Look at things in perspective. Especially early in treatment, survivors may use perspective as a defense against recognizing the depth of their own pain. Sayings like, “I know there are people who have it worse than me” or “Think of those Syrian refugees. Compared to them, I am blessed,” pronounced early on are often attempts to avoid the survivor’s own pain and suffering. Later, however, taking that kind of perspective helps all of us to place our own current stress on a useful scale and therefore enhances resilience.

- Engage in altruistic activities. Volunteering, caring for family in friends who are in distress, and other practices of generosity and altruism are linked to improvements in PTSD symptoms. Even having a pet to care for can be a source of relationship and meaning.

- Take some mindfulness training, learn to meditate or engage in centering prayer. Both meditation and mindfulness practices reduce stress, increase optimism and help keep perspective.

- Engage in a faith tradition or spiritual activity. Both correlate with increased resilience. It is another tragedy of the Catholic sexual abuse crisis that faith was often shattered along with body and mind boundaries. Sexual abuse has been called “soul murder” and sexual abuse by clergy is an icon of spiritual felony.

Many abuse survivors eventually do find a spiritual path in nature, neo-Paganism, connection with the Feminine Divine, or Native American prayer and rituals, and some return to a church. As therapists, we support any spirituality that provides soul succor to the survivor and that is not harmful to the survivor or to others.

The elements of trauma treatment described here are schematic and stereotypical. They do not play out linearly and they are more complicated and fraught than this outline may suggest. At the same time, they do represent key aspects of what trauma recovery therapy includes.
In the second article of this series, I focused on hope and healing for survivors of sexual abuse. Here, I extend the discussion beyond healing to discuss the possibility, now validated through research, that some trauma survivors actually experience post-traumatic growth.

If healing can occur from the truly devastating consequences of adverse childhood experiences — including sexual abuse by clergy — can survivors also experience meaningful growth through their confrontation with trauma? Can post-traumatic growth also occur in institutions that fostered abuse, as well as in the advocacy organizations that have worked on behalf of survivors?

Let me be very clear: No one ever is “better off” because they were abused or suffered other adverse childhood experiences (ACEs). Every child and adolescent is entitled to a “good enough” childhood where suffering is manageable and betrayal is minimal.

Unfortunately, too many children and teens are faced with soul-battering betrayals, abuse, neglect or terrifying family dynamics that send normal developmental pathways, including those related to the brain, off the rails.

At the same time, none of us gets from the cradle to the grave without a full measure of suffering in some way or another. Studies have shown that the meaning we derive from our suffering and how we carry the remnants of that suffering into the future determines to a great extent what kind of life we live and how fulfilled we are by it.

Post-traumatic growth

Over the last decade or so, researchers have begun to study post-traumatic growth, defined by Lawrence Calhoun and Richard Tedeschi, University of North Carolina, psychologists and post-traumatic growth experts, as “positive psychological change experienced as a result of the struggle with highly challenging life circumstances.”

Trauma survivors who achieve post-traumatic growth develop a perspective on life that is balanced and pragmatic. Through a tragic loss of innocence early on in life, these survivors accept that life is not fair and therefore demonstrate greater resilience when it is not.

They embrace the reality that there really is no justice for a survivor of ACEs because a shattered childhood can never be returned whole. Continued anger and resentment for them is, as the saying goes, like swallowing poison and hoping the other guy dies; these survivors do not want to give more of their soul space to the trauma or to those who caused it.

Post-traumatic growth thus engenders a greater appreciation of life and a changed sense of priorities that privilege living and loving and making life work.

Often these survivors are generous and want to help others who
Because every survivor heals differently, it seems inappropriate when SNAP criticizes meetings between victims and a pope.

suffer, which may be one reason survivors are overrepresented in the helping professions. This group of former victims tends to form warmer and more intimate relationships and have an enhanced sense of personal strength and a deepened spiritual development.

I was still practicing in New York on Sept. 11, 2001. Many trauma survivor patients with whom I worked were significantly less devastated and showed fewer acute stress responses to the horrible events of that day than nontraumatized individuals.

The trauma survivors already had accepted that life as they knew it could be catastrophically dismantled in an instant and forever. They were on a first-name basis with betrayal and evil violation.

They had a pragmatic perspective on 9/11, recognizing that life both would go on and that it would be altered in fundamental ways for a very long time. They did not rage about the unfairness and injustice of it all because they had already come to terms with and mourned the loss of innocent expectations that life can be fair; that betrayals never happen, or that justice inevitably prevails.

At the same time, these individuals were not cold or indifferent. Many of them volunteered for long hours to help victims and first responders, and they wept with friends and relatives who lost loved ones.

This combination of empathic outreach to their own and others’ suffering and pragmatic acceptance of the horror of 9/11, coupled with both hope that healing could occur and the knowledge that it would take a very long time, suggested that post-traumatic growth had emerged from the survivors’ deep working through of their own earlier traumas.

While trauma survivors who experience post-traumatic growth maintain a clear sense that really bad things can happen in life, they also feel that having survived the original trauma(s), there is not much else they cannot handle.

Again, that does not mean that they will not hurt — terribly sometimes — but they have a confidence forged in the fires of trauma recovery that they will also survive and even thrive through future losses, betrayals and traumas.

Can the church grow?

When ACEs are exposed, perpetrators, abusive or neglectful families, enabling institutions and others are often traumatized.

Here it is important to differentiate between “victimized” and “traumatized.” Victimization occurs when a person or group exerts destructive power over an innocent person or group. Trauma is a response to an experience, including but not limited to one that is victimizing.

Even a perpetrator can be traumatized when she/he is exposed for victimizing another. Life is changed forever. Shock, anger, fear and other post-traumatic symptoms may ensue, including minimization, denial and dissociation.

A central issue here is whether individuals or groups can engage with a traumatic experience in a way that promotes growth. Or do they harden defenses and avoid the kind of self-examination, pain and mourning that a victim has to endure in order to heal, become resilient and grow? Post-traumatic growth here emerges primarily from rigorous self-examination and a painful mourning process.

The Catholic church is an institution traumatized by the sexual abuse crisis. The earliest response of the institution was to preserve its long-held identity as a source of goodness and godliness.

Yes, its leaders acknowledged in a vague way that of course there is sin within the church, but the sense was always that sin was somehow a general thing and not assigned to specified actors in the church drama. I sin, you sin, we all sin was an implied mantra that attempted to diminish the criminality and evil of priests who sexually violated kids, and of bishops who protected perpetrators and covered up abuse.

Church officials lied, denied and projected blame on victims, parents of victims, a sexually liberated and sexualized culture, bad apple priests, the ‘60s, the media.

They had seen the enemy and it was not them.

It is still happening today as when Germany’s Cardinal Gerhard Müller recently excoriated the Oscar-winning movie “Spotlight.” In his mind, the movie led to the generalization of blame for sexual abuse by some priests onto the shoulders all priests, and it was too hard on bishops who did not respond appropriately to reports of abuse.

To be fair, another former prelate, Malta Archbishop Charles Scicluna, once the Vatican’s chief prosecutor and deeply involved in investigation of the sex abuse crisis, said that all bishops and cardinals should see the movie to understand that reporting the crimes, not silence, “will save the church.”

Here and in older cases, arrogance and clericalism abounded as a church official worked hard to restore power; control and an idealized view of the church and its clergy; The 2,000-year-old monarchy refused for a very long time and, in some places, still refuses to embrace self-examination and mourning, and it hoped that this, like so many past scandals, would just blow over. It didn’t and it hasn’t, and that’s a good thing.

There is also now a papal commission mandated to develop policies and procedures on sexual abuse. Victims, experts and clergy on that commission are talking with each other and are listen-
ing to each other. They are getting to know each other as people and not as straw figures. They are determined and most are hanging in even when the going gets discouraging.

Many are justifiably doubtful about the ultimate success of this commission, but its members deserve suspension of judgment about the outcome until there is one, and they deserve support for their mission.

Still, it is too early to determine if or when the church will do enough self-examination, engage in enough honest investigation of all the root causes of sexual abuse, and submit to a thorough enough mourning for the church that never was and can never be again. It is too soon to tell whether the hierarchy can or will grieve and repent enough for the destruction visited upon all of the people of God through sexual abuse of its youth.

It would be indicative, for example, of real post-traumatic growth and institutional change if bishops and provincial superiors were clearly instructed to report all known or suspected abusers to secular authorities like the police and child protective services. Further, if church officials who cover up abuse lost their jobs, it would reassure Catholics that the church is convinced that covering up abuse is just as sinful and criminal as committing it.

Perhaps the most hopeful sign of potential change is the election of Pope Francis. The cardinals knew who he was when they elected him. And he has not stopped surprising. Although he has been imperfect, contradictory and even at times infuriating when it comes to sexual abuse, he also has attacked the kind of clericalism and ecclesiastical arrogance that fueled decades, even centuries, of the vilest sexual violations of the young. Welcoming the homeless into the Vatican; washing the feet of women; caring for the incarcerated; taking a relatively passive position on homosexuality; embracing other religions and even atheists as fellow travelers; rehabilitating previously excoriated “dissenters”; chastising bishops to get out on the street and pastor; modeling humility, humor, joy and mercy; reminiscing with the press about once having been in love — all are death by a thousand cuts to the hierarchical hubris that enabled priests to soul-murder the young, with bishops and provincial superiors serving as accessories.

There are reasons to hope and reasons to remain doubtful that the church is capable of post-traumatic growth. It is understandable that many victims and activists judge change to be too slow and too circumspect. While we wait to see how far change will go, advocacy organizations like the Survivors Network of those Abused by Priests (SNAP) keep the pressure on. But would post-traumatic growth advance their effectiveness as well?

SNAP and healing trauma

The major advocacy group for Catholic sexual abuse victims is SNAP. It is unquestionable that SNAP courageously and tirelessly has kept sexual abuse by clergy in the consciousness of people across the world. Its members dragged the whole issue into the public square and have insisted that it stay there for more than three decades. They have spoken truth to power and have been clobbered by those powers; they have gotten up, bruised and scorned, to speak again.

Those efforts have enabled thousands of victims who had been trapped in silence to come forward and to speak their stories. That alone represents a priceless gift to victims, to their families and to those whose hearts and minds have been changed by listening and taking in the destruction caused by sexual abuse.

Is it time, however, to ask if SNAP can grow beyond its work of confrontation? Twenty-seven years is a long time to be battling such a formidable institution as the Catholic church. To do so has required a herculean degree of dedication, as well as a high level of agreement about what needs to be done.

Over time, understandably, SNAP has developed its own program of orthodoxy, a view upon which it relies so that it isn’t distracted from its primary work. A paradigm of hierarchy, what appears to be automatic reactions to anything the church does, and a rigid approach to the right ways to advocate and support, however, can be viewed as coming close to a mirror image of some aspects of the church.

One of the most frustrating outcomes of SNAP’s current approach to advocacy is that SNAP talks at
the church and the church resolutely ignores SNAP’s voice. It may be too late for that to change.

It is so unfortunate, however, that each has been so closed to the possibilities offered by the other that productive encounter; honest exchange of information and expertise, and openness cannot be negotiated. The church has much to learn from SNAP. On the other hand, SNAP might be even more effective were its leaders to listen in a nuanced way to all the contradictory; confusing and sometimes vague messages coming from chanceries, provincial offices and the Vatican, searching for those that might offer common ground.

Healing requires a very different program than advocacy. SNAP has never taken an organized approach to that part of the process. For example, SNAP is ideally situated to develop a sister organization, one headed by researchers, academicians, clinicians and victims, completely dedicated to addressing the healing needs of survivors and separate from advocacy activities.

Sometimes, it is a really bad idea for a survivor to join a lawsuit, protest outside a church, hear again how uncaring the church is, or even get emails and notices of those activities. It may be harmful for a victim to attend a SNAP conference in any given year or at all.

Because of these sometimes antithetical tasks of healing and advocacy, an arm of SNAP dedicated wholly to healing and cordoned off from accountability to the advocacy arm could strengthen the good SNAP already does for victims while preventing unintended potential harm.

It was instructive for me to hear a SNAP advocate once report at a meeting that SNAP told “our” victims that their moment of victory occurred the day their lawsuit was filed. To me, it was inappropriately possessive and patronizing to characterize survivors seeking help from SNAP as “our[s],” and I wondered how a survivor might feel about being referred to that way.

Further, it is unsound from a healing perspective to tell any survivor when their moment of victory will be or even to predict that there will be one. Survivor suicides have occurred the day a lawsuit was filed, during litigation, and after the settlement was completed and the money deposited in the survivor’s account.

In 30 years of practice, I have never encountered two survivors whose healing proceeded in exactly the same way. I know a lot about a lot of healing approaches that work for a lot of survivors, but I know nothing about what healing will be like for the survivor with whom I am meeting for the first time. Their journey of recovery will be unique and surprising in ways I cannot anticipate.

It is crucial for everyone involved with survivors to maintain a dialectic tension between what we “know” and the willingness not to know anything about a particular survivor until we have spent a long time being invited into their experiences.

Rather than predicting what may nor may not ever feel like a victory, one might extend hope to survivors by saying, “I believe that if we do our work well, you will grow from being a survivor who happens to be a person, to a person who happens to be a survivor.” That is the ultimate victory, but how or when or if it will happen is the mystery of every journey.

Because every survivor heals differently, it seems inappropriate when SNAP criticizes meetings between victims and a pope. Last fall, David Clohessy, SNAP’s director, dismissed the pope’s meeting with victims as a “smart public relations move,” asking, “Is a child anywhere on Earth safer now that a pope, for maybe the seventh or eighth time or ninth time, has briefly chatted with abuse victims? No.”

SNAP’s president, Barbara Blaine, meanwhile, wanted the pope to meet with victims in public, not private, and devalued the invited survivors as apparently not the right ones.

“He won’t publicly meet with victims who would potentially question him on his record, question what he’s doing to actually protect the children,” she said. “If you notice, they are always devout and the response is carefully scripted.”

Few others characterized these meetings as intended to address policies and procedures, although one can argue that any time a cleric, including a pope, hears the stories and sees the faces of actual victims, change can happen. These were to be pastoral encounters, however, between victims and the pope.

Further, it is a bit ironic to chas- tise the pope for staging a moment only for its public relations value while simultaneously suggesting that he conduct it in public.

Finally, it is certainly not supportive of healing to assume that a given survivor might not experience something affirmative in that setting and it is antithetical to supporting someone to shame a victim for desiring or acquiescing to a moment like that. Such judgments raise a question about who is using whom for public relations value.

Both the church and SNAP have some self-examination and painful mourning to do.

It might indicate growth, for example, if SNAP were able to acknowledge positive steps taken by the church even while keeping the pressure on for more. The church cannot and should not be a single-issue institution. We all can celebrate the good it brings to the world while holding its hierarchical feet to flames of accountability and transparency — both operationally negotiable terms — in protecting kids and supporting survivors.

It would be indicative of church growth, on the other hand, if it could genuinely express gratitude to SNAP for the gift it has bestowed in forcing the church to recognize the scourge it visited on hundreds of thousands of kids worldwide, and in compelling the church to do penance and to make real, lasting change in policies and procedures that will keep kids safe.

ACEs, especially sexual abuse, create deep and long-lasting wounds. Healing, however, is possible, as are strengthening resilience and attaining post-traumatic growth.
Resources for recovery

Whether for you or a loved one, here are ways a survivor can find healing support

Part 4

When someone decides to embark on healing from adverse childhood experiences (ACEs), and/or when concerned loved ones of a survivor want to help that person begin to heal, it can be confusing to know how to start. This last article in the series focuses on finding the best healing resources.

It is a slice of all the resources available to someone and does not represent either endorsement or rejection of any particular source. Many of the resources listed here provide links to still other sources of information or help.

Best first responders

The sad truth is that abusive families or institutions are unlikely ever to consistently put the interests of children before their own, no matter how many laws are passed or promises made. We are the best hope of preventing child abuse and responding to it quickly when it occurs.

If enough of us believe that every child is our child, that we are responsible for the safety of every child we know, we can be the most effective instruments of change.

If we believe, with Pope Francis, that churches are field hospitals, then we are the nurses, paramedics, doctors and, of course, the patients in our own communities. Any one of us can pick up the phone at any time if we know or suspect a child is being abused or neglected. It’s anonymous and it is the right thing to do. Here’s how to do it:

Childhelp National Child Abuse Hotline (1-800-4-A-Child). This is a number every one of us should memorize. Although each state has its own laws regarding child abuse reporting, any person can anonymously report known or suspected child abuse to the hotline and they will contact appropriate local investigative authorities within 24 hours. It is easy. Use it. Use it if you know or suspect that a priest, a teacher, a bus driver, your best friend’s husband, your next-door neighbor or, yes, your own Uncle Louie is abusing or neglecting a child.

There are no good excuses not to call. You can save a life and even a soul.

Choosing a therapist

It can be a daunting task to begin looking for a therapist to assist in the journey of recovery from sexual abuse or other ACEs. It may be difficult to know what to ask, what not to ask, what are generally appropriate treatment parameters, etc. Since it is important to work with someone you trust, as well as someone you “click” with, these guidelines may be helpful. (These were originally published on the website of the Survivors Network of those Abused by Priests.)

Consultations: You are looking for another human being whom you can trust to guide you through the sometimes treacherous shoals of recovery from ACEs. You have both the right and the responsibility to gather data to help you make a good decision. It is not unusual for someone to have one consultation session with at least three therapists before choosing someone with whom to work. Most therapists will charge for a consultation, and it is money well spent to
When someone decides to embark on healing from adverse childhood experiences, it can be confusing to know how to start.

ON THE WEB
Adverse childhood experiences (ACEs) have been referred to throughout this series. Details are available online at www.cdc.gov/violenceprevention/acestudy/index.html.

be sure you make a choice that is healthy for you.

What to ask at a consultation: In addition to being a person in need, you are a consumer. Again, you have the right and the responsibility to ask a potential therapist enough questions to get a sense of the way he/she works and how comfortable you are talking with him/her.

Ask about the therapist’s years of experience. How many years has this person practiced as a psychiatrist, psychologist, clinical social worker or other kind of mental health professional? Are they licensed in the state in which they practice?

Ask about the therapist’s trauma training. What specific training and/or supervision has the therapist had in working clinically with abuse survivors? Until the 1980s, there was little formal training available in trauma. Since then, many academic programs and postgraduate institutes have added trauma courses. Other therapists have sought out seminars, conferences and supervision with clinicians more experienced with sexual abuse survivors.

Look at the bookshelf: If the therapist displays a collection of books, look for titles on psychological trauma. It gives you a sense of the person’s interest in this field. Some people keep their books at home, though, so don’t leap to conclusions.

Personal therapy: Most clinicians feel it is imperative to have gone through their own therapy before or during their professional careers. Some postgraduate programs require that the therapist be in treatment during training. Some people disagree with me, but I think it is a fair question to ask a potential therapist if they themselves ever have been in treatment.

It is not fair to expect the therapist to talk about how long they were in therapy or for what reasons. Most therapists also will not say if they themselves were abused, at least until well into treatment, if at all, and this is appropriate boundary setting.

Approach to therapy: This can be a little tough to answer, but you can ask a therapist how they generally work. What do they think is important in therapy: changing behaviors, changing beliefs, identifying how past relationships continue to be played out unconsciously in the present? Are they active therapists who engage in a “conversation” or are they quieter, speaking mostly to make interpretations?

There are no right or wrong answers here, but the responses help you get a feel for what it might be like to work with this person.

Therapeutic frame: What is the therapist’s cancellation policy? It is not unusual for a therapist to charge for missed sessions depending on the circumstances, and insurance cannot be billed for those sessions.

What is the person’s policy regarding between-session contact if you are having a difficult time? Is the therapist available for more than one session per week if you need it?

What is the fee, and how does the therapist expect to be paid? For instance, some therapists collect only the copay from insured patients and wait for insurance to pay them the rest. Others want to be paid in full and let you collect the insured portion of the fee. Again, there is no right or wrong, but it’s good to know ahead of time.

Psychiatric referrals: Does the therapist work with a psychiatrist who is also knowledgeable about trauma and to whom the therapist can refer you if medication is needed? Don’t be surprised if it is needed. Many survivors of sexual abuse greatly profit from antidepressants, anti-anxiety agents or mood stabilizers for various periods. One has to suffer to recover but not beyond what is necessary to do the work of therapy. Medication often allows someone to make better use of treatment and recover more quickly. We know now that trauma affects the brain, not just the psyche. The new medications help a lot.

Limits of confidentiality: Review the limits of confidentiality with your potential therapist. All therapists will break confidentiality if you are a lethal threat to yourself or someone else. In those cases, the therapist must do everything possible to protect your life and/or the life of another person. If you tell the therapist that a child is being abused, by you or by anyone else, he/she must report it.

If you are in litigation, you should know that your therapist’s records and/or sworn testimony legally can be subpoenaed. The therapist can argue client privilege, but if ordered by a judge to comply with the subpoena, she/he can be held in contempt of court for not going along.

Beyond those limitations, the contents of your sessions and any other information about you should be held in confidentiality by therapist. In no cases, beyond these mentioned, should a therapist share information about you or your treatment without your written and very specific permission.

Therapist’s expectations: What does the therapist expect of you? What is his/her view of the ther-
apeutic alliance and each party’s role in it?

**Contract:** It is often helpful for you and the therapist you choose to contract for six sessions in order to come to a final decision about working together. At the end of six sessions, you both can review how you think it is going and whether or not it is a good match for you. This kind of beginning allows both of you a fixed time to decide to go further or to part company.

When you have begun to work steadily with a therapist, you may develop doubts about how things are going. Since therapy for an ACE often is rocky, it is important not to bolt without carefully considering with the therapist the reasons for leaving. If you don’t hate your therapist at some point, the work probably is not getting done.

On the other hand, it is also important to feel that you can terminate a treatment if it really is not working for you. Since recovery from sexual abuse often involves a volatile therapy, it is a good practice to set the same kind of six-week contract before leaving that you did when you began.

Once you feel that you want to leave, talk to the therapist and see if you can contract for a six-week mutual discussion of the issues before reaching a final decision.

Many therapeutic partnerships that seem to be foundering have found it tremendously helpful to consult another therapist skilled in the area. Whether the therapy is then rescued or ends, both the therapist and the patient may feel validated and affirmed by having a consultation with a third party.

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**Support organizations**

**Alcoholism:** Alcoholics Anonymous meetings exist throughout the world and the doors are always open to newcomers. Start here to find a meeting in your area: [www.aa.org/pages/en_US/find-local-aa](http://www.aa.org/pages/en_US/find-local-aa). Once you get comfortable, look for a sponsor who honors your trauma background.

If you are the loved one of an alcoholic, start here to find local Al-Anon or Alateen meetings: [al-anon.org/find-a-meeting](http://al-anon.org/find-a-meeting).

**Other substance abuse:** Narcotics Anonymous meetings also are held in many places. Start here to find a meeting: [www.na.org/meetingsearch](http://www.na.org/meetingsearch).

**Childhelp:** A resource about child abuse and neglect for kids, parents and teachers is at [www.childhelp.org](http://www.childhelp.org).

**International Society for the Study of Trauma and Dissociation:** a resource for professionals and the public. Its website includes a “find a therapist” link here: [www.isst-d.org/default.asp?contentID=18](http://www.isst-d.org/default.asp?contentID=18).

**International Society for Traumatic Stress Studies:** Though primarily a resource for professionals, it does offer a “Find a Clinician” link at [www.istss.org/find-a-clinician.aspx](http://www.istss.org/find-a-clinician.aspx).

**MaleSurvivor.org:** This is, in my opinion, the best resource available for male sexual abuse survivors. It is directed by clinicians,
survivors, academics, researchers and advocates who serve for limited terms. MaleSurvivor.org offers recovery weekends, a great reading list, resources for finding a therapist, safe chat rooms for survivors, and more.

Mental Health America: an advocacy and support agency with local affiliates all over the country (www.mentalhealthamerica.net). It offers a wealth of information about mental health issues and can help you find local affiliates and other mental health resources. They also have online mental health screenings that help individuals and loved ones get a sense of what mental health issue they may be confronting.

National Center on Elder Abuse: As more people are living longer, elder abuse is becoming a greater national problem. This group (www.ncea.aoa.gov) has online resources about elder abuse. Their elder care locator will help you find the local agency to whom to report elder abuse: eldercare.gov/ElderCare.NET/Public/Index.aspx or 800-677-1116.


National Suicide Prevention Lifeline: A 24/7 resource for anyone thinking about suicide and for friends and relatives concerned about a loved one: 800-273-TALK, or www.suicidepreventionlifeline.org.

RAINN (Rape, Abuse, and Incest National Network): RAINN is a good resource for those who have been sexually assaulted as adults or as young people: rainn.org/get-information.

Sidran Traumatic Stress Institute: Sidran’s website offers a host of information for survivors and for loved ones (www.sidran.org/resources/for-survivors-and-loved-ones), an extensive reading list (www.sidran.org/resources/essential-readings-in-trauma) and links to many other resources (www.sidran.org/resources/links).

Survivors Network of those Abused by Priests: SNAP (www.snapnetwork.org) is an effective social justice advocacy organization that works to prevent child sexual abuse, especially by clergy.

**Opening doors**

I am grateful to the National Catholic Reporter for publishing this series. By doing so, it has opened doors to the field hospitals that Francis wants us to staff in our churches and has hung a red cross on the doors of NCR.

For me, it is tremendously rewarding to offer a psycho-educational series on ACEs that may raise consciousness and that provides resources for the many readers who have experienced ACEs or who know others who have.

I have been so privileged to accompany ACE survivors on healing journeys. My work has changed my life, imbuing with it grace, hope and awe for the resilience of the human spirit.