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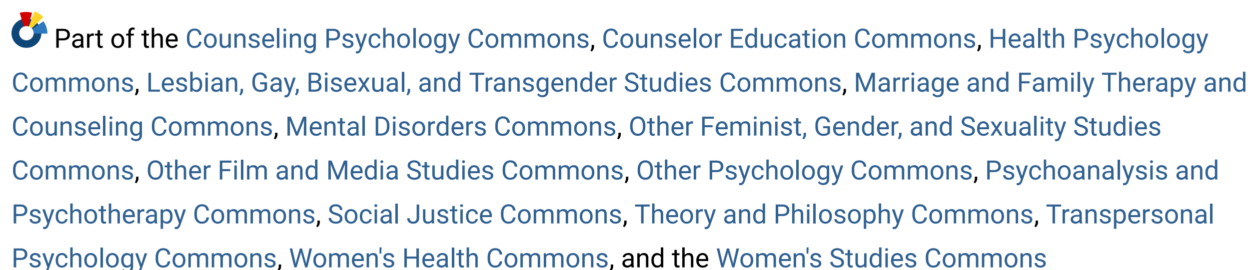

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Womanism and Well-being:

A Manuscript Dissertation Exploring the Effects of Shame, Loss and Gender Issues

By

CHRISTY ANGELLE-VIDRINE BAUMAN

A dissertation submitted in partial fulfillment

Of the requirements for the degree of

Doctor of Education

Seattle Pacific University

2020

Seattle Pacific University

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Approved by Dr. Cher Edwards

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Dr. Katherine Douglass

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Dr. Tina Schermer Seller

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Program Authorized to Offer Degree

Date

Department of Education

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Date ______________________________

To my husband Andrew, thank you for your support and work to "hold up my arms".

To Cher, thank you, this is a product of your commitment and care in my career and my future.

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Abstract

The purpose of this study is to contribute to the research on gender issues and psychological well-being across the adult lifespan utilizing qualitative research examining factors (e.g., societal influences, sexual objectification, shame, loss, meaning-making, and internal identity) in developing resilience and mitigating mental health issues. This paper discusses the importance of addressing well-being through expression of loss, meaning-making, and social impact. This manuscript style dissertation will review publications in such areas as sexuality, spirituality, grief, shame, intimacy, social, and interpersonal relationships. The exploration of biopsychosocial impacts as it relates to meaning-making, resilience, and communal involvement. The three publications will be analyzed through qualitative research applying a case study approach. Findings suggest, women, regardless of sexual orientation, report negative mental health and body image dissatisfaction after internalized experiences of objectification, prolonged losses, and environments of shame. Research will seek to note any factors that affect well-being and gender issues, such as meaning-making rituals, societal connection, and internal psychological awareness. This paper should be viewed as both an invitation for further research into the effects on women within a discriminatory sociocultural context, such as racism, sexism, heterosexism, and other gender discrimination. It should also summon mental health professionals to incorporate more aspects of advocacy, social support, self-care, coping mechanisms pertaining to gender issues within individual treatment plans, overall mental health programs, and church congregations for women recovering from oppressive environments of sexual and spiritual shame.

Keywords: womanism, feminism, mental health, gender issues, LGBTQ+, womanist theology, feminist theory, grief, spirituality, resilience, sexuality, self-regulation, objectification, meaning-making, self-awareness, social connection.

LIST OF ABBREVIATIONS

1. WT -Womanist Theology
2. SRT - Shame Resilience Theory
3. OT - Objectification Theory
4. SOT - Sexual Objectification Theory
5. MMM - Meaning Making Model
6. LST - Lifespan Theory
7. FT - Feminist Theory
8. LGBTQ+ - Lesbian, Gay, Bisexual, Transgender, and Questioning
9. TOTW - Theology of the Womb
10. ABL - A Brave Lament

Chapter One: Introduction

Women's mental health and well-being regardless of their sexual orientation has been an under-researched topic until recently (Lightsey, 2015; Watson et al., 2018; WHO, 2014). The purpose of this case study is to discover what aspects impede or facilitate well-being in women through exploring three personal publications. The three publications were co-authored or authored by the researcher and discuss gender issues and well-being as they apply to women's sexuality and spirituality over their lifespans. At the time of this writing, mental health is defined by the World Health Organization (WHO, 2014) as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (para. 2). Womanist Theology (Walker, 1983) and Feminist Theory (Young, 2000) research has analyzed gender inequality, discrimination, sexual objectification, oppression, and patriarchy (Hoffman, 2006; Watson, et al., 2008). Each manuscript studied here will address different aspects of feminism: particularly, gender issues, shame, and loss in womanhood. The initial manuscript, *Persons Who Identify as LGBTQ*, identifies areas of research that show mental health risks are an outcome of shame, discrimination, sexism, and societal prejudices. The second publication, *Theology of the Womb*, explores issues of feminist theology through body image, birth, and death. The final manuscript, *A Brave Lament*, is a documentary about mental health, loss, stillbirth, womanhood, and communal grief. These three publications were chosen due to my interest in the research of women's well-being and because of their interaction with common aspects that affect a woman's wellbeing; sexuality, discrimination, shame, birth, loss, grief, and community. The

manuscripts will be examined through the lens of gender theories, particularly Feminist Theory (Hooks, 2000) and Womanist Theology (Williams, 2006).

Womanist Theology (Williams, 2006) is a theory and practice of inclusivity, gender (including sex, sexism, sexuality, and sexual exploitation), race, class, sexual orientation, and ecology seen through a theological lens (Hoffman, 2006; Thomas, 1998). This theory was chosen because it is particular to women's experience across the lifespan and offers an appropriate lens through which to read the publications being explored. Although other theories will be referenced in this paper, due its inclusivity, issues of feminism, lifespan psychology, shame resilience, and objectification will be primarily addressed through the lens of Womanist Theology. In this paper, the cases studied are influenced primarily by the author's account and other female voices speaking about women's experiences. The purpose of this study is to further the findings on women's well-being. This knowledge is expected to provide more information on women's well-being to mental health practices and religious institutions.

Statement of Problem

Unaddressed discrimination and objectification throughout womanhood affect women's well-being (Swim et al., 2001). Many scholars and researchers have speculated about how individuals might achieve a positive physical, mental, and social well-being. WHO (2016) delineates mental health as not only the absence of illness but the presence of positive manifestations of physical, mental and social well-being? A common proposition is that a well-being is rooted in realizing one's true potential in life, while a well-lived life is one that is grounded in meaning (Baumeister, 1991; Broderick & Blewitt, 2015). Research shows that women, regardless of their sexual orientation, who

are subjected to prolonged negative compound emotions report psychological issues such as addictions, post-traumatic stress, depression, anxiety, eating disorders, and domestic violence (Brown et al., 2011; Grippo, 2011; Watson et al., 2018). Objectification, bullying, and sexual harm, clearly generate prolonged long-term compound emotions in women, and impacts their sense of well-being (Fredrickson & Harrison, 2005; Grippo, 2011; Watson et al., 2018). Research suggests these contributors: community support, self-regulation, and meaning-making, display results of women with stronger self-efficacy who experience fewer feelings of powerlessness, shame, and flawed-self (Broderick & Blewitt, 2015; Brown, 2006; Siegel, 2010; Tangney & Dearing, 2003). Given these effects on psychological well-being and self-regulation, continued research on interpersonal awareness, meaning-making, and societal belonging is necessary in order to reduce the negative psychological impact on women (Almeida et al., 2009; Bernhard, 2002; Broderick & Blewitt, 2015; Brown, 2012; Ogden, 1999). Therefore, this study seeks to investigate contributors and deterrents that impact women's well-being through the lens of three manuscripts.

Significance of the Research Questions

The rationale for this study is expanding research on sexism and gender issues as it applies to womanhood and clarifying the contributors and hindrances to women's well-being. The World Health Organization (2017) identified women have higher incidences of anxiety, depression, and other somatic complaints than men, particularly within inequitable, sociocultural circumstances. Feminist therapists have long offered information that clients coping with societal oppression, gender-based stressors, income equality, and other discriminatory treatment is associated with issues of mental health

(Enns, 2004; WHO, 2016). Research (e.g., Carter & Parks, 1996; Symanski et al., 2011) shows that women's experiences may be shaped by these external environments and societal oppression is connected to more mental health issues among women, regardless of their sexual orientation. According to Watson et al. (2018) reports both "externalized and internalized heterosexism and sexism have been linked to higher levels of psychological distress among predominantly White sexual minority women" (p. 291). Further findings on case studies will strengthen the research on women's well-being and particular factors that will inform the mental health field and religious organizations. By reading these manuscripts through the lens of Womanist Theology (Walker, 1983), this paper will explore gender issues that impact mental health and will research factors that mitigate psychological impediments and strengthen psychological well-being.

Research Problem and Research Question

In response to the understanding that women are at an increased risk of mental health concerns due to discriminatory sociocultural impact, including gender-based stressors, scholars suggest that feminist identity attitudes along with coping skills (i.e., social support, advocacy, self-care, cognitive processes, connection to one's femininity, and religion and spirituality) may reduce the impact of oppression and stress (Erchull et al., 2009; Watson et al., 2018; WHO, 2016). While retaining a womanist and/or feminist identity has appeared to buffer well-being in many cases (e.g., Ernst, 2017; Lightsey, 2015; Marparyan, 2012; Richardson et al., 2006), in others, it has not (e.g., Hoffman, 2006; Ossana et al., 1992; Parks, 2008). Research offers maladaptive forms of coping in the relationship between biased experiences and harmful mental health effects; researchers do not specify factors that may shield against detrimental outcomes (Watson

et al., 2018). Further research on women's well-being particular to inequitable treatment and specific narratives will be conducted in these three manuscripts. The purpose of studying these particular publications is to investigate the effects of inequity on the well-being. Utilizing a qualitative case study approach and intersectional feminist methodologies, the study looks to identify factors that facilitated and impeded the well-being of women in this study. The research questions that the study will seek to identify include: RQ1: What factors affected the well-being of women in this study? RQ2: What barriers impeded the well-being of women in this study? RQ3: What factors facilitated the well-being of women in this study?

Definition of Relevant Terms

American Psychiatric Association (APA) – A common formatting style for essays and papers in the social sciences.

Bereavement Exclusion (BE) – Passage in the *DSM* which distinguishes ordinary grief from the diagnosable disorders of major depression (MD) criteria initially proposed in *DSM-III*: (i) A *context-dependent* approach to the evaluation of MD which requires that the diagnosis be given only when course, symptoms, and signs are "out of proportion" to experienced adversities, and (ii) Bereavement is the sole adversity for which this context-dependent approach should be utilized.

Coping – A dynamic process consisting of one's appraisal of a threat and one's perceived resources for dealing with the stressor (Lazarus & Folkman, 1984).

Diagnostic and Statistical Manual of Mental Disorders (*DSM-III, DSM-IV,* & *DSM-5*) – A taxonomic and diagnostic tool published by the APA.

Feminist Identity – Downing and Roush (1985) developed a model of feminist identity development to explain how women may move from a state of passive acceptance of sexism to a greater under-standing of the ways in which sexism has affected their lives. The 4 stages are: passive acceptance, revelation, embeddedness-emanation, and synthesis stage. Feminist identity is not a linear process, researchers often assess attitudes associated with these dimensions of feminist identity (Watson et al., 2018).

Feminist Theory – Seeks to understand gender inequality and is defined as a with the experiences with gender oppression, racism, and sexism (Watson et al., 2018)

Feminist Theology – The study of how women relate to the divine and the world around them as equal creations in the image of God. Longstanding patriarchal oppression and discrimination of women: *critique* of sexist interpretations and practices; *retrieval* of women's past contributions to ecclesial life and theological reflection; interpretations and practices. The idea of referring to God as "mother" or "she" is anathema to many modern Christians, theological language was in the past much more fluid in terms of gender, frequently referring to God, Christ, and the Holy Spirit in maternal metaphors and symbols. The appeal to inclusive language as masking rather than resolving the problem of androcentrism (Young, 2000).

Meaning-Making Model – Identifies two levels of meaning, global and situational (Park & Folkman, 1997). Global meaning refers to a person’s general orientation and views of many situations, while situational meaning refers to a person’s understanding in a specific instance (Park, 2006).

Objectification Theory (OT) – Posits that girls and women are typically acculturated to internalize an observer's perspective as a primary view of their physical selves (Fredrickson & Roberts, 1997).

Resilience – The lack of post-traumatic disorder following trauma. (Levine et al., 2009).

Sexual Objectification (SO) – Objectification theory (Fredrickson & Roberts, 1997) occurs when a woman's body or body parts are singled out and separated from her as a person and she is viewed primarily as a physical object of male sexual desire (Bartky, 2015; Szymanski et al., 2011).

Sexual Shame – A visceral feeling of humiliation and disgust toward one's own body and identity as a sexual being and a belief of being abnormal, inferior and unworthy. this feeling can be internalized but also manifests in interpersonal relationships having a negative impact on trust, communication, and physical and emotional intimacy. Sexual shame develops across the lifespan in interactions with interpersonal relationships, one's culture and society, and subsequent critical self-appraisal (a continuous feedback loop). There is also a fear and uncertainty related to one's power or right to make decisions, including safety decisions, related to sexual encounters, along with an internalized judgement toward one's own sexual desire (Clark, 2017).

Shame – The belief that there is something wrong with oneself, which is delineated from guilt, which is the belief that there is something wrong with the action (Tangney & Dearing, 2002; Vliet, 2009).

Shame Resilience Theory (SRT) – Proposes that shame resilience, as indicated by location on the shame resilience continuum, is the sum of (a) the ability to recognize and accept personal vulnerability; (b) the level of critical awareness regarding social/cultural expectations and the shame web; and (c) the ability to form relationships to which one feels belonging (Brene, 2006).

Subjective Well-being (SWB) – Well-being, including happiness, life satisfaction, and positive affect (Diener, 2009).

Womanist Theology – Womanist Theology re-evaluates women of color's role among religious settings, reinterpreting male-dominated imagery, sexism, oppression around the language of God, specifically in matters of career, motherhood, and matriarchal religion (Moradi et al., 2002). The following section of this chapter will include a description and discussion of Womanist Theology which will serve as the theoretical lens for this study.

Theoretical Foundation of the Study

The purpose of this study is to contribute to the literature on women's psychological well-being and health across her lifespan by specifically looking at the discriminatory socio-cultural influences of sexual objectification, sexual orientation, and grief across three manuscripts and through a Womanist theological lens. The three

publications are different womanist issues which particularly address gender-related stressors in people who identify as LGBTQ+, religious inequality and discrimination on the female body across the lifespan, grief and infant loss. Qualitative research will be used by four examiners who will code and theme the three manuscripts addressing the research questions: 1) What factors affected the well-being of women in this study, 2) What barriers impeded the well-being of women in this study, and 3) What factors facilitated the well-being of women in this study? Findings will then be complied to look for overarching factors that affect women's welfare as it applies to Womanist Theology. Due to the similarities in Womanist and Feminist theories, this study will use them interchangeably throughout the discussion and findings. The research will explore links between biopsychosocial well-being and gender issues related to spirituality, fields that continue to be significantly impacted by ongoing research.

Research Design

The interpretivist/constructivist paradigm originated from a hermeneutical lens, which is the study of interpretive understanding (MacKenzie & Knipe, 2006). A researcher who uses this study design often relies upon the "participants' view of the situation being studied" (Creswell, 2003, p. 8) while also accepting the influence of their own historical narrative and experiences. Interpretive approaches rely profoundly on reflection and scrutiny of existing text to construct meaningful findings (Angen, 2000). Qualitative research is often the approach used for interpretive analysis of sociology and the humanities (Creswell & Creswell, 2018). Within the five qualitative designs, case studies are a "design of inquiry," through which the researcher develops an in-depth evaluation of a case, which can be one or more individuals represented by the three

manuscripts (Creswell & Creswell, 2018, p. 14). A case study is "an empirical method that investigates a contemporary phenomenon (the 'case') within its real-world context, especially when the boundaries between phenomenon and context may not be clearly evident" (Yin, 2018, p. 15). The researchers will use this case study method by applying a style of inquiry, logic of design, and precise approaches to data analysis (i.e., coding and themes) to the following three manuscripts "cases" (Yin, 2018).

In an endeavor to study the intersection of the researcher's mental health practice and womanist theology issues, this researcher gathered the majority of data from her personal experience. The three main publications examined in this dissertation are all mental health resources: *Embracing Diversity*: Person Who Identifies as Lesbian, Gay, Bisexual, Transgender, and Questioning chapter (Edwards & Bauman, 2015), *Theology of the Womb*: "Breasts", "A Sexual God", and "Menopausal God" chapters (Bauman, 2019), and the documentary transcript of *A Brave Lament: For Those Who Know Death* (Bauman et al., 2017). Because these collections are composed of words rather than numbers, and because open-ended questions and responses are desired, a qualitative research design will be used to identify a thematic perspective across all three manuscripts (Creswell & Creswell, 2018). The research questions, which seek to explain contemporary circumstances such as "why" or "how," make the case study approach extremely relevant (Yin, 2018).

With each of the three publications, the researcher will analyze the manuscripts using a collective case studies approach (Creswell, 2013). Yin (2017, p.19) emphasizes that this method is not to be confused as a non-research, "teaching-practice" case studies approach; this study will follow a rigorous and explicit research method. Case study

research investigates multiple bounded systems over time that have been collected from documents, interviews, and audiovisual material (Creswell, 2013). The three publications will be coded and themed and then analyzed for factors applicable to the research questions (Creswell, 2013).

Organization of the Study

This manuscript-style dissertation is a qualitative research study that explores the relationships between gender issues and mental health in women. This dissertation includes three published manuscripts of original authorship. Each manuscript focuses on different psychological aspects of sexuality, spirituality in the female body, and grief. These have been coded by four individuals including myself, and three other female doctoral students. We identify as a Christian, Caucasian woman; a non-religious, Caucasian non-binary person; a Non-religious, African woman; and a Hindu, Eastern Indian woman, who work with qualitative research design, and have coded and themed the publications. Each researcher will calculate the top three themes of each work without collaborating with the other individual, thereby addressing inter-rater reliability. Research questions that will be answered are: Within current gender issues, what are the primary factors that affect women's mental health? What are the factors that facilitated the well-being of women in this study? What are the factors that impede the well-being of women in this study? In order to narrow thematic findings, I asked these additional questions: Why do these primary factors influence women's psychological well-being in this study? Are these primary factors connected to spiritual well-being and sexuality? The three manuscripts were coded and themed using the top three common themes found by all the

researchers. The themes are then explained in the summary chapter following the third manuscript.

Chapter Information

The following sections contain information about each manuscript chapter, including a literature review, research questions, data summary, and analysis.

Chapter 3: Lesbian, Gay, Bisexual, Transgender, and Questioning

Bullying, stigmatism, and social pressures are evident issues for those who are in a sexual minority population. Positive body image, acceptance, and advocacy are foundational desires for all people, especially for those with bodies and sexualities that are different than the stereotypical (Balsam & Mohr, 2007; Edwards & Bauman, 2015; McKenzie et al., 2018). Feminist Theory and Womanist Theology advocate for justice towards sexual identity, to be understood as an identity, not an act. Thus, discrimination of sexual identity and gender inequality negatively affect women's well-being (Lightsey, 2015). The Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ+) communities have long experienced societal bullying and stigmatization (APA, 2014; Kelleher, 2009); while women have incurred societal objectification (Fredrickson & Harrison, 2005; Grippo, 2011; McKenzie et al., 2018). In their efforts to be accepted, individuals in the sexual minority communities have found that their mental health has taken a toll, specifically in the areas of depression, anxiety, and substance abuse (Anderson, 2009; Edwards & Bauman, 2015). Resilience, positive body image, and safe counsel are minimal goals for the mental health community to pursue on behalf of the female and queer population.

High LGBTQ+ substance abuse and suicide rates demand that mental health providers develop expertise in this area of work (APA, 2014; Asakura & Craig, 2014). Societal bullying, although decreasing, remains an issue of concern. Mental health practitioners must be educated on ways to combat this problem, identify areas of growth in the approaches being used, and engage in further research and prevention efforts (Ahuja et al., 2015). Resiliency factors are linked to communal acceptance, societal encouragement, and the understanding of the family of origin (Edwards & Bauman, 2015).

Chapter 4: Theology of the Womb (only Chapters 4, 5, & 9)

Sexual shame is defined as internalized feelings of disgust and humiliation towards one's own body and identity as a sexual being; particularly, feelings of abnormality, inferiority, and unworthiness manifest both internally and within interpersonal relationships, which impacts well-being (Clark, 2017). Body image issues and sexual shame for church-going women have often been narrated through patriarchal theologies (Williams, 2006). As a result, many women who practice patriarchal-based faiths have a skewed understanding of body image and sexuality (Bernstein & Schaffner, 2004; Claussens, 2013). Women who identify as lesbian or queer, may receive a potential "double dose" of shame from the pulpit – first, due to their sexual orientation and secondly due to body image and general issues related to sexual activity (Eriksson, 1997; Faiver et al., 2000). The relationship between positive mental health and Christian women's sexuality has only recently begun to be studied (Rosmarin et al., 2016). Women are beginning to speak out against the purity movement, sexual shame and oppression in the church (Clark, 2017; Knoll & Bolin, 2018; Lightsey, 2015). There is a deficit of

theological and theoretical development as it relates to the female body, which becomes evident as one examines the psychological, sexual, and spiritual aspects of women's health (DeFranza, 2015; Hunt, 2014; Parks, 2008). Womanist and Feminist theories are highly influential in this manuscript, *Theology of the Womb,* due to their emphasis on the female gender as a lens of scripture in the church. Womanist and Feminist theology speak to the importance of narrative in our understanding of God, as women are made in the image of God (Townes, 2015). Thomas (1998) goes on to state the importance of lineage as "womanists bring forth the legacy of our grandmamas and great grandmamas and carry their notions in the embodiment of a life that we create daily. The words and actions of this language oppose sexism, racism, classism, heterosexism, and abuse to any of God's creation" (p.491). The three chapters of the author's memoir, *Theology of the Womb*, address issues of sexism, objectification, and inequality (Bauman, 2019). Objectification of the female body, which Feminist and Womanist Theology would argue is the image of God, demotes the female from creation to object (Lightsey, 2015; Welch, 2017). Patriarchal institutions and media negatively impact women's well-being, regardless of their sexual orientation, through the internalization of subtle and overt female objectification and gender inequality (Calogero & Thompson, 2009; DiAngelo, 2018; McKenzie et al., 2018).

Chapter 5: A Brave Lament Documentary Transcripts

Death and loss do not discriminate; grief is a natural part of most people's life (Pretchel, 2015). Mental health experts have grappled with proper grief diagnostic criteria over the last few decades (American Psychiatric Association, 1980, 1994, 2013). The *Diagnostic and Statistical Manual of Disorders* (*DSM*) has changed the clinical diagnosis

of bereavement with each new edition. Prior to the *DSM-5*, a "bereavement exclusion" had allowed clinicians to distinguish Major Depressive Disorder (MDD) and Post-Traumatic Stress Disorder (PTSD), which are considered non-impairing grief disorders (American Psychiatric Association, 1980, 1994, 2013). In order to avoid medicalizing ordinary grief, psychotherapists have explored more humanizing alternatives, such as meaning-making techniques in psychotherapy (Neimeyer & Raskin, 2000). In the manuscripts that follow in subsequent chapters, the researcher will examine how loss affects women's well-being. Senesce and loss displayed by the female reproductive system include the shortening of the menstrual cycle and the reduction of a woman's reproductive ability and sexual hormones; sexual desire and enjoyment of intercourse decrease after childbirth, breastfeeding, and the cessation of menstruation (Barrett et al., 1999; Broderick & Blewitt, 2015). *A Brave Lament* (Bauman et al., 2017) is a documentary designed as a therapeutic resource for those who have encountered it in their stories, particularly around infant loss. The film tells the story of two therapists who lost their firstborn son and how they used community, spirituality, ritual, and psychology as a way to understand the effects of grief and loss. Lifespan psychology played an integral part in how the couple marked the death of their child. In this study, the transcripts of the documentary will be used as part of the qualitative research on grief and well-being.

Limitations of the Study

Limitations of the study include researcher bias, as the researcher has counseled 435 clients within her practice and has been influenced by their stories. Two of the manuscripts are memoir-like publications based on her life experiences. The

documentary transcript, *A Brave Lament* (Bauman et al., 2017) is based on the researcher's personal experience with infant loss. The chapters from Theology of the Womb manuscript are based on the researcher's personal experiences and the insights influenced from clients' stories and professional interactions that occurred during therapy sessions in her private practice over the past 12 years. In addition, the researcher is a Caucasian female with Christian religious affiliations that influenced her understanding of sexuality and spirituality. This research uses several theories, as no one theory has been developed to explain the specific subject of the mental health of women's sexuality. Existing research that uses these theories to focus on sexual objectification, meaning-making, spiritual well-being, and shame experiences in women's mental health is limited (Bookcliin, 1993; Brown, 2012; Moradi & Huang, 2008; Ogden, 2007). Researchers acknowledge that internal and external implications in mental health concerning women's sexuality are influenced by social class, race/ethnicity, sexual orientation, spiritual history, family of origin, and other, unexplored factors. The sections that follow will provide a literature review of Womanist Theology and Feminist Theory, focusing particularly on identifying various aspects (e.g., substance abuse, interpersonal connections, shame environments/situations, meaning-making, etc.).

Background and Role of the Researcher

Because qualitative research is interpretive in nature, it introduces a host of issues into the research process (Creswell & Creswell, 2018). Because of this, researchers explicitly describe their biases, personal background, and values that frame their interpretation during the study (Creswell, 2013). This researcher's perceptions of higher education have been shaped by her personal experiences as a licensed mental health

practitioner and mental health supervisor. From August 2013 to January 2018, this researcher served as a term course instructor on a private campus of 5,000 to 8,000 students. From 2008 to the present time (2019), she has worked as a mental health provider to 417 clients and a supervisor of 18 pre-licensed practitioners during her private practice in the Pacific Northwest. As a mental health supervisor to clinicians, she works closely with current mental health risks and issues. Her most recent publication, *Theology of the Womb* (Bauman, 2019) is a book on womanist body theology and a few of the chapters are included in the research of this study. Recently (2017-2019), this researcher published a book and produced a film, both mental health resources on the topic of grief and loss. Due to her interest in mental health, the researcher is especially attentive to the ongoing research of this topic.

Due to countertransference issues and personal history, the researcher brings particular biases to this study. Although every effort will be made to provide objectivity, these biases may shape the way she views and understands the data. In addition, the manuscript-style dissertation consists of three personal publications that already have a specific narrative. The researcher hired three female academic colleagues as additional researchers to code and theme the manuscripts to ensure inter-rater reliability in her case study approach, which demonstrates a commitment on her behalf to further mitigate bias (Creswell & Creswell, 2018).

Chapter Two: Literature Review

Introduction

This chapter will review the literature that currently exists about Womanist Theology (Williams, 2006) for research of this paper. Womanist Theology (Mitchem, 2002) explores how levels of self-identification and societal influences (e.g., shame, objectification, and inequality) impact a person's well-being. Findings may offer mental health practitioners and clergy leadership insight into therapeutic engagement and care for women's well-being. WHO (2016) reported that women are more susceptible to depression and anxiety than men due to inequalities and discriminatory sociocultural contexts; thus, the need for further and specific research is important? Womanist Theology (Williams, 2006) will be the theoretical framework exploring what factors contribute to or hinder the well-being of women through the lens of three manuscripts: *Embracing Diversity: Persons Who Identify as LGBTQ* (Edwards & Bauman, 2015), *Theology of the Womb* (Bauman, 2019), and *A Brave Lament* (Bauman et al., 2017).

The literature review will share a written summary of published works about Womanist Theology (Walker, 1983) as it applies to the primary factors which affect the well-being of women in this study. Support and limitations of research addressing specific well-being in relationship with ordinary grief, meaning-making, acceptance, and interpersonal awareness contribute to building resilience in a women's psyche (e.g. Broderick & Blewitt, 2015; Diener, 2009; Park, 2008; Van der Kolk, 2015). Analysis of the literature will be organized as it applies to factors contributing to or hindering women's well-being over the lifespan. The literature review will include choosing the

theory, definition and historical background, findings and analysis, limitations and future research, and a conclusive summary.

Theoretical Foundation

Due to the wide scope of this study, the researcher began with a myriad of theories that support women's well-being over the lifespan. This list of theories supports the theoretical construct: Womanist Theory (Mitchem, 2002), Shame Resilience Theory (Brown, 2006), Feminist Theory (Heid, 2020), Queer Theory (Weed & Schor, 1997), Objectification Theory (Galdi et al., 2014), Lifespan Theory (Broderick & Blewitt, 2015). Although all of these theories support aspects of the research, Womanist Theology (Williams, 2006) supports the entire scope of the study and will be used as the primary theories and lens throughout the research (Boisnier, 2003; Comas-Diaz, 2008). Due to the similar nature of Feminist Theory (Thornham, 2000) and Feminist Theology (Young, 2000), they will be referred to in conjunction with Womanist Theology. These overarching theories offer a significant framework for the research presented in the three manuscripts which highlight gender issues of inequality, particularly shame and loss through womanhood.

Theoretical Framework: Womanist Theology & Feminist Theory

Womanist theology is a longitudinal theology created by female, black, scholars. Womanist theology is a theory and practice of inclusivity, gender (including sex, sexism, sexuality, and sexual exploitation), race, class, sexual orientation, and ecology seen through a theological lens. Womanist Theory, historically rooted in black womanhood, holds an inclusive methodology and conceptual framework, includes reconstructed knowledge beyond feminist theories (Thomas, 1998). Although Womanist Theology

(Walker, 1983) is a theory based on African American perspectives, it is best applicable because it has expansive inclusivity which include LBTQ+ women and theology and God as foundational to its infrastructure (Williams, 2006). Both feminist and womanist theologies focus on religious traditions and beliefs that exclude or are silencing to women, particularly in areas of race, class, LGBTQ+ issues, and impact of religious environment (Saulnier, 2014).

Womanist Theology (Williams, 2006) and Feminist Theory (Young, 2000) are the two major foundational constructs that will be used in this dissertation. Feminism includes liberal feminism, global feminism, lesbian feminism, radical feminism, ecofeminism, and womanism (Saulnier, 2014). Feminist Theory (Young, 2000) seeks to understand gender inequality and is defined as with experiences with gender oppression, racism, and sexism (Watson et al., 2018). While womanism is a form of feminism, womanist theology re-evaluates women of color's role among religious settings, reinterpreting male-dominated imagery, sexism, oppression around the language of God, specifically in matters of career, motherhood, and matriarchal religion. Due to the scope of all three manuscripts explored in this research, using Womanist Theology as the primary theory is important due to the spiritual lens it offers and the inclusion of LGBTQ+ communities. The literature review will address what we know and do not know about Womanist Theology and Feminist Theory as it applies to women's well-being in areas of sexual shame, inequality, and loss.

Societies generally aim to cultivate healthy citizenship where citizens are educated and accelerate in the societal norms, participating in societal cohesion (Losike-Sedimo, 2018). Societal influences such as lawmakers, social media, support groups, societal

stereotypes, peer groups, and stigmatizations are just a few of the social factors that have mental and psychological effects on a person (APA, 2014; National Institutes of Health [NIH], 2020). Bullying, objectification, and isolation are three common negative social influences that can affect a human. At the same time, belonging, meaning-making, and positive reinforcement are three common positive social influences that affect someone's mental health (Ahuja et al., 2015). Issues of gender discrimination and inequality are important to address in pursuing maturity in a global society (McCann & Kim, 2013; National Center for Transgender Equality [NCTE], 2020). Feminist Theory and Womanist Theology aim to understand the nature of gender inequality and sexual identities, examining women's social roles, experiences, interests, and chores, despite their sexual orientation (Heid, 2020; Richardson et al., 2006). Common themes within feminism include discrimination, objectification (especially sexual objectification), oppression, patriarchy, stereotyping, racism, sexism, and gender inequality (Kluger, 2020; Moser, 2012; Richardson et al., 2006).

Definition and Historical Background

Womanists often cite Alice Walker (1983), the American novelist, who coined the termed womanist as "a feminist of color." In her text, *In Search of Our Mothers' Garden*, we find the theory of womanism being born through the suppressed role of African American women through the American church, the community, the family of origin, and the greater society. The definition of womanist was established in 1985, and research has analyzed gender inequality, discrimination, sexual objectification, oppression, and patriarchy (Sotos, 2015). Womanist Theology became a lens of feminism that was specific to narratives of women through all seasons of womanhood, particularly through a

spiritual lens, claiming that women are made equal and in the image of God (Williams, 2006). Womanism expands on feminism to include the intersectional identities of women, especially with regard to sexuality, racial identity, and spirituality. These complex identities are understood through the narrative and voice of those embodying these identities. Spirituality adds to the dimension of the embodiment of a religious dynamic, inviting us to transformation in our circadian actuality, our lived reality (Maparyan, 2012). These two theories are used in conjunction as the theoretical lens of the manuscript stories (i.e., case studies) in the research.

Womanist Theology and Self-Identity Research

Research shows that women who have a strong identity in themselves and supportive communities have high resilience, report less stress, and positive well-being overall (e.g., Watson et al., 2018). These findings have been furthered using The Feminist Identity Composite Scale (Downing & Roush, 1985) and the Womanist Identity Attitude Scale (WIAS; Helms, 1990) as a way to embody self-identification levels in one's understanding (Hoffman, 2006). The scales were two developments that advanced the research in the psychology of women particular to racism, sexism, and gendered racism (Helms, 1990; Moradi et al., 2002; Watson et al., 2018). The WIAS measures at what level women identified within the four subscales of pre-counter, encounter, immersion-emersion, and internalization (Ossana et al., 1992).

Womanist identity and mental health have been researched using the Womanist Identity Attitude Scale (Carter & Parks, 1996) to explore the stress levels of women at different stages of womanist identity. There are four stages to the WIAS, pre-encounter, denial of societal bias against women (devalue of

women and favor men); encounter, questioning and exploring alternative ways of viewing societal roles for men and women; Immersion-Emersion, active rejection of male-dominated framework and idealization of women; and Internalization, the formation of a personal standard of womanhood, undue dependence on either societal norm or the antithetical position of the women's movement (Galdi et al., 2014). The research shows that while many women who held strong self-identity experienced a greater sense of well-being, particularly by advocating for self and others, social support, feminist-minded mental health practitioner care, self-care, connecting with femininity, rituals and spirituality, and body image (Watson et al., 2018). When this research was separated by race, results showed that Black women reported having higher self-esteem than White women due to self-acceptance, gender self-definition, familial and community support (Boisnier, 2003; Hoffman, 2006).

Objectification and (Sexual) Shame Research

Objectification is defined as the act of deducing someone to the status of a mere object ("Objectification," 1989). Inevitably, stereotyping of women and emphasizing beauty and sex is popular in entertainment (Galdi et al., 2014; McKenzie et al., 2018). The advertisement industry continues to succeed in heavily using the female body to sell products, and the majority of media and advertisements influence the societal expectation of body image norms (McKenzie et. al., 2018; Newsom & Congdon, 2011; Zimmerman & Dahlberg, 2008). Objectification Theory (OT) proposes that girls and women ascribe to the observers' viewpoint as their primary attitude toward their physical selves (Moradi et al., 2005). Womanist Theology states that the female body and sexual identity are

considered the life of natural environment, God's creation and made in the image of God (Lightsey, 2015). Womanist Theology (Williams, 2006) defines the reduction of a human through objectification or devaluation as the act of sin (Townes, 2015). Williams (2015) states, "this womanist notion of sin is unique in its suggestion of parallels between the defilement of Black women's bodies and the defilement of nature" (Townes, 2015, p. 147). Womanist Theology implores that taking away a human's "somebodiness" or treating them as invisible oppresses their spirit and self-esteem (Townes, 2015, p. 140). This internalized perspective of dehumanization or objectification increases habitual body monitoring, which can lead to feelings of shame and anxiety, lessening internal body awareness and imposing on women's well-being (Harrison & Fredrickson, 2003; McKenzie et al., 2018). Rumination and unrealistic expectations of body image are associated with negative mental health issues such as low self-esteem (McKenzie et al., 2018), shame (Brene, 2006), sexual shame (Clark, 2017) depression and anxiety (Watson et al., 2018), eating disorders (Grippo, 2011), and sexual dysfunction (Szymanski, Moffitt, & Carr, 2011). Research (e.g., Townes, 2015; Watson et al., 2018) shows that women's levels of self-identification with sexual identity and gender identity such as feeling "somebodiness", visibility, self-worth, agency, and empowerment positively affect the well-being of women in this study (Townes, 2015, p.140).

Shame is one of the compound emotions that influences women's well-being in a negative way (Matos et al., 2013). In the past, shame was perceived as a social and moral emotion that kept irresponsible conduct in check within societies. The shame emotion can play a positive role in society if it motivates people to self-govern their behavior according to their accepted value systems (Lightsey, 2015; Tracy & Robins, 2006).

Research (e.g., Matos et al., 2013; Tangney & Dearing, 2003) shows that guilt-proneness and embarrassment persuade individuals not to act in negative ways, while shame proneness inhibits acts of social irresponsibility by threatening individuals' sense of psychological well-being. The oppressive nature of American patriarchal and demonarchal society emphasizes the fundamental effects that shame, discrimination, and dehumanization have on citizens' psychological development (Brown, 2006; Tangney & Dearing, 2003; Townes, 2015).

Sexual shame is defined as internalized feelings of disgust and humiliation towards one's own body and identity as a sexual being; particularly feelings of abnormality, inferiority and unworthiness manifest both internally and within interpersonal relationships which impacts well-being (Clark, 2017). Women who are subjected to sexual shame report psychological issues such as addictions, post-traumatic stress, depression, anxiety, eating disorders, and domestic violence (Dearing & Tangney, 2011; Murnen, 2000). Clark (2017) reported, "sexual shame develops across the lifespan in interactions with interpersonal relationships, one's culture and society, and subsequent critical self-appraisal (a continuous feedback loop)" (p. 87). This looping pattern associated with sexual shame diminishes self-efficacy (Siegel, 2015). Self-efficacy is defined as self for valued success than blame for aversive failure, both self-efficacy and self-identity correlate with positive effects on women's well-being (Zimmerman, 2000, p. 83). Psychologists' understanding of self-efficacy and its ability to bolster resilience offers a foundation to address the effects of shame (Siegel, 2015). Given the overwhelming effects of shame on a woman's psychological well-being and self-regulation, understanding how sexual shame, in particular, affects women's mental health

is important to reduce negative psychological impacts (Rogers & Ebbeck, 2016, Roberts & Waters, 2004; Siegel, 2015; Weinberger et al., 2010).

Identifying mental health effects on women's sexuality is imperative to alleviating influential mental stressors on women's sexual health. The evaluation of sexual shame and its impact on women's self-efficacy will offer insight into shame-induced psychological impediments (Tugade et al., 2004). Women with stronger self-efficacy and self-regulation experience fewer feelings of powerlessness and flawed-self (Brown, 2006; Lewis, 1991; Tangney & Dearing, 2003). Brown (2012) described shame for women in particular, as the belief that one is debauched or unworthy, whereas guilt is derived from one's actions (e.g., "What I have done is corrupt or dishonorable"). Brown specifies shame as identifying oneself as corrupt or depraved, separate from one's actions. Brown's research, along with others, connects shame with feelings of unworthiness, subservience, and powerlessness (Brown, 2006; Brown, 2012; Dearing & Tangney, 2011). Guilt prompts a desire to confess or apologize and includes characteristics of remorse or empathy. While guilt offers an opportunity to change one's actions, shame is an attack on one's sense of self-worth and threatens to hinder self-efficacy (Matos et al., 2013; Tangney & Dearing, 2003). Research shows that women can build resilience to shame, and potentially, sexual shame (Brown, 2009; Clark, 2017).

Resilience Research

Resilience is defined as the amount of elasticity in a material, ecosystem, or human brain. In the psychological sciences, resilience is defined as the capacity to recover from acute or chronic stress and to emotionally regulate oneself and experience positive growth and development amid adversity (Bookcliin, 1993). Over two decades of

research link social ecology factors with resilience. Social-Ecological Systems (SES) is the study of relationships between people and their environment (such as institutions, organizations, and denominations) (Bronfenbrenner, 1992). Social Ecology emphasizes that environments influence resilience in humans on both physical and psychological levels (Best, 1998). Family, school, neighborhood, community, and culture are social-ecological factors that are as constructive as psychological aspects of self-regulation and growth when individuals are under stress (Ungar, 2011).

The science of resilience increases in complexity when researched through the multifaceted personal and environmental factors in a human's life. Research clearly shows that social ecology has a major influence on resiliency, specifically in the areas of bullying, peer pressure, trauma, and disasters (Espelage & Swearer, 2009). Culture and communal influences, such as social connections, shared identity, and empowerment, promote the well-being of people under stress. Ungar (2011) reported that even among people who have experienced war-related trauma, poor mental health was more influenced by traumatic experiences "linked to fractured family and a failure to achieve personal, social and cultural milestones. Resilience, meanwhile, rests upon a demonstration of family unity" (p. 7). In addition to refugees, resilient women comprise another subgroup that has been studied intensely; these are women who have endured depression at some point in their lives but who eventually re-attained a greater level of well-being. Common factors found in resilient women, despite their sexual orientation, were social structures such as educated parents, family financial stability, and stable marriages (Ryff & Singer, 2003).

Considering the efforts of social workers and mental health practitioners to address social and mental health issues, it is essential that practitioners and researchers become more invested in understanding and contributing to research in the areas of sexual shame proneness, self-efficacy, and resilience. Findings show guilt and embarrassment to be adaptive emotions and shame to be a maladaptive emotion (Brown, 2007; Tangney & Dearing, 2003; Van, 2008; Vliet, 2009). Additionally, mental health facilities report shame to be the most common emotion experienced by clients using their counseling services (Dearing & Tangney, 2011).

Lifespan and Meaning-Making Research

Gains and losses are unavoidable parts of aging (Broderick & Blewitt, 2015). Research over the full range of the human lifespan has demonstrated that when people learn how to make meaning with the gains and losses in their lives, they can maintain well-being throughout their lives (Baumeister, 1991). Life Span Developmental Theory offers a framework that organizes the developmental process across the life cycle (Broderick & Blewitt, 2015). In this developmental framework, where gain and loss are viewed as inevitable, adaptations such as growth, maintenance, and regulation of loss are coping factors which will in part determine the state of well-being and mental health in women (Baltes et al., 2006; Maparyan, 2012; Ogden, 1999).

The state of mental health and well-being can be determined by how women mark or make meaning with these gains and losses they experience over their lifespan. According to Van Bussel et al. (2006), “Common mental health disorders are frequent during pregnancy and the postpartum period, but pregnant and postpartum women are more at risk than those who are not pregnant or who did not deliver” (p. 297). As loss increases, a

woman's mental health and overall well-being are reflected in her resilience, which is influenced most by social ecology and meaning-making over her lifespan (Broderick & Blewitt, 2015; Park & Folkman, 1997; Ungar, 2011). Meaning-making has only recently been applied and studied in psychotherapeutic approaches to individuals coping with loss and grief (Park, 2008). Womanist Theology and Feminist Theory explore the transcript of *A Brave Lament* through the context of life and the loss of a child (Bauman et al., 2017; Maparyan, 2012). As shown by these models, ordinary grief, meaning-making, and shared communal experiences contribute to resilience, well-being, and positive mental health over the adult lifespan (Espelage & Swearer, 2009; Park & Ai, 2006; Park et al., 2008). Steffen (2019) links resiliency factors with meaning-making and, in particular, reconstructive meaning during bereavement seasons.

Marker events are commonly displayed in acts of ritual, rites of passage, and ceremonies, such as quinceaneras, bar mitzvahs, and other coming-of-age celebrations, weddings, or funerals. Whether they evoke situational meaning or ceremonial meaning, these acts have an important effect on the level of resilience and well-being in a person's lifespan (Park & Folkman, 1997; Ungar, 2011). Park and Folkman (1997) identify two levels of meaning, global and situational, in the Meaning-Making Model. Situational meaning refers to a person's understanding of a specific instance, while global meaning refers to an individual's broad orientation and perspective of multiple situations (Park, 2013). The theory of meaning-making has more recently been used in conjunction with narrative and social constructivist therapies as a way to humanize the assessment process and enhance therapeutic change. Meaning-making is used in case studies, clinical vignettes, and therapeutic dialogue. The integration of meaning-making practices into day-to-day talk

therapy sessions has shown positive results, and its application has assisted in closing the gap between theory and practice (Neimeyer & Raskin, 2000).

Findings and Critique

The literature review covered the research on coping methods for women's well-being. Specifically, the review surveyed the literature on self-identity, resilience, stress, objectification, inequality, and gender issues. There was compelling research (Watson et al., 2018) on the level of self-identity and gender self-acceptance as feminist/womanist to act as protection against stress and other negative psychological impediments. The limitations on the research did not have data on women who experience stress due to the feeling ostracized from the inner circle of self-identifying feminist/womanist (Hoffman, 2006). Sexual shame, objectification, and inequality all showed a negative impact on women's psychological health and proved the positive effects of self-identity, community, and belonging (Brown, 2009; Clark, 2017). Research (e.g., Lightsey, 2015; McKenzie et al., 2018) remains limited to what factors are particular to women's overall well-being as it applies to spirituality, inequality, and LGBTQ+ communities over the lifespan. Women's well-being has received more attention in the past two decades yet is only recently addressing the effects of gender issues such as inequality, classism, spiritual oppression, sexism, and objectification (Frederickson et al., 2011). Further research is needed in many of these areas to close the gap on uneducated authorities who govern with oppressive mindsets (Held, 2014).

Conclusion

In summary, research (e.g., Brown, 2007; Kluger, 2020; Park, 2013; Ungar, 2011) shows us that sexual minorities have incurred a variety of social discriminations which have

impacted these population’s mental health; while ordinary grief, meaning-making, acceptance, and interpersonal awareness contribute to building resilience in a person’s psyche. This review of literature implores further investigation of specific themes in women’s well-being through the lens of the research. This manuscript dissertation will allocate for the three publications which we will use as ‘cases’ in this research study the three publications previously identified. These publications will be used as cases in the case study methodology addressing the following research questions: Within the first article, *Persons Who Identify as LGBTQ+* and two memoir manuscripts*, Theology of the Womb,* and *A Brave Lament*, what are the primary factors that affect the well-being of women in this study? The research questions assessing the content are: What factors affected the well-being of women in this study? What barriers impeded the well-being of women in this study? What factors facilitated the well-being of women in this study? These questions will be addressed using qualitative research to code and theme throughout the three manuscripts.

Chapter Three: LGBTQ Manuscript

Embracing Diversity: Persons Who Identify as Lesbian, Gay, Bisexual, Transgender, and Questioning

This chapter was published as Edwards, C. N. & Bauman, C. A. (2015). Persons who identify as Lesbian, Gay, Bisexual, Transgender, and Questioning. In Lee, T. (Ed.), *Embracing Diversity: Treatment and care in addictions counseling* (pp. 251-265). San Diego, CA: Cognella Academic Publishing.

This chapter will address the unique strengths and needs of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) populations when providing substance abuse treatment. The literature reviewed for this chapter includes articles specific to LGB, LGBT, transgender, and LGBTQ+ populations; therefore, these varying terms will be used throughout to describe the appropriate population. The following pages hope to serve the reader with an overview of the LGBTQ+ community, an awareness of treatment-specific needs, and recommendations for best practice. The chapter concludes with reflective questions for the treatment provider, as well as resources that may be helpful to LGBTQ+ populations and the support systems in their lives.

Overview of Population

In our society, there has been a steady, continuing progression toward the acceptance of sexual minority populations. Even within the LGBTQ community, acceptance and advocacy for alternative sexuality, such as transgender and questioning, have been demonstrated. In areas of research among same-sex and both-sex attraction,

there is cooperative growth around issues of health and psychology. Where psychologists once classified same-sex attraction as a mental health disorder, these relationships are now recognized with civil unions and same-sex marriages. In fact, in 2004, Massachusetts was the first state to issue marriage licenses to same-sex couples, and ten years later, in 2014, 17 states now recognize same-sex marriages (Ring, 2014).

Despite the progress made toward acceptance and interest in health concerns experienced by this population, there still appears to challenge influencing substance use rates. Compared to the general population, the LGBTQ population is more likely to use and abuse alcohol and other drugs (Anderson, 2009; Brewster & Tillman, 2012; Marshal et al., 2008; Russell, Driscoll, & Truong, 2002). In fact, current research contends alcohol abuse is more prevalent among lesbians than the general population. Also, transgender and gay men are estimated to abuse substances around 20–30 percent, in comparison to about 9 percent of the general population (Hunt, 2013). Hunt (2013) reports men who have sex with other men are over 9.5 times more likely to use heroin and 12.2 times more likely to use amphetamines than heterosexual men.

It should be noted, however, that researchers are not in agreement about the prevalence and trends noted in substance use among the LGBT community. Green and Feinstein (2012) indicate there are trends seen in this population such as a decreased likelihood of alcohol abstention, an increased risk for alcohol-related problems, and a lack of typical protective factors. However, methodological flaws exist in the research, which makes one question these findings. Some of these flaws include the specific recruitment strategies used and a lack of comparison groups. These flaws may impact the validity of the research completed with the LGBT populations

Although there has been a growth in exposure, research, advocacy, and treatment for substance abuse, issues continue to exist that impact the health of LGBTQ individuals. For instance, a lack of awareness by others and the micro-aggressions experienced around homosexuality contribute to the stress of those in the LGBTQ community. Consequently, using alcohol and other drugs is a way to relate and cope with this stress. Moreover, correlations between substance use and shame have been identified, which insinuates addiction for LGBTQ individuals is often perpetuated by embarrassment and guilt from societal pressures and judgments (DiClemente, 2003). Sexual minorities tend to experience high levels of stress associated with social prejudice and discriminatory laws in the areas of employment, relationship recognition, and health care (Center for Substance Abuse Treatment [CSAT], 2001; Hunt, 2013; Jordan, 2000). In order to help combat the misuse of substances in this population, a societal commitment must be made to increase awareness and education related to the particular substance abuse issues faced by the LGBTQ community. The next section addresses several of these substance abuse concerns that may explain the higher rates of chemical use among some people in this population.

Substance Abuse Issues

The etiological theories of substance use and abuse for the general population have a long history of research, and these should be considered for specific populations as well. For instance, biological predisposition and environmental stressors are causes that no doubt applies to the LGBTQ population; however, unique issues for this population should also be taken into account (Jordan, 2000). With research indicating the vulnerability of LGBTQ individuals using or abusing substances, the application of social

learning theory (Bandura, 1977) may help to provide an understanding related to reasons for use. Current scholarly literature identifies a correlation between individual substance use and peer and partner substance use (Homish & Leonard, 2008). This is based on the notion that behavior is learned through observation and imitation (Bandura, 1977), and individuals are most likely to mirror behaviors of those with whom they spend a significant amount of time.

In addition to social learning theory, several socio-cultural factors are also often cited in the literature as influencing substance use in the LGBT populations. Age, gender, bisexuality, affiliation with gay culture, sexual minority stress, "outness," *human immunodeficiency virus* (HIV) status, and body image are some of these identified factors (Green & Feinstein, 2012). Age is typically a significant protective factor among the general population; however, this is less robust within the LGBT community. In other words, as a person gets older, the frequency and amount of alcohol and another drug use usually decrease. This is not the case in LGBTQ populations. Another sociocultural factor cited to influence rates of use is gender differences. More specifically, female gender status has been identified as a protective factor in the general population, but this is not seen within LGBT populations. One reason for this could be the possibility that LGBT populations may be less conforming to typical gender roles. In addition to age and gender, bisexuality also appears to be a significant risk factor associated with substance abuse. Those who are bisexual indicate a higher likelihood to use and abuse substances to a greater extent than both the heterosexual and gay and lesbian populations. This may be attributed to a lack of social support or potential bias from both communities (Balsam & Mohr, 2007).

Affiliation with gay culture may impact substance use and should be viewed as a critical risk factor for abuse and dependency. As stated earlier, the social learning theory posits behavior may be learned by one's association with peers, partners, and family members. Therefore, the typical social outlets for LGBT populations may impact behaviors, including substance use. Green and Feinstein (2012) note "although LGB communities are not as confined to bars and clubs as in the past, gay bars remain one of the main social outlets in LGB communities" (p. 272). With these places as common settings for socializing, the stigma associated with LGBT populations and substance abuse is perpetuated.

Sexual minority stress is also a contributor to use and abuse, pointing to the social pressure of being part of a marginalized group. An additional consideration related to this issue is that of support systems. Compared to other marginalized groups (e.g., people of color), LGBTQ individuals may not have the typical support systems such as the family of origin, who understand or share their experiences as a member of a minority group. Often, LGBTQ individuals face discrimination and rejection by family and other typical supportive networks (Brewster & Tillman, 2012).

"Outness" is described as the degree to which an individual has made others aware of his or her sexual orientation or affection (Green & Feinstein, 2012). The literature (e.g., Green & Feinstein) purports that the more "out" an individual is, the greater the propensity for potential discrimination or harassment. This is likely due to the potential for family, friends, and acquaintances to respond negatively to the individual coming out or being out.

Yet another factor to address regarding substance abuse issues in the LGBTQ population is HIV status. Researchers indicate *HIV* status is positively correlated with substance use and abuse, perhaps due to the anxiety and stress associated with the diagnosis. Alternatively, substance abuse may place an individual at increased risk for HIV infection due to intravenous (IV) drug use and decreased inhibitions, leading to high-risk sexual behavior. In particular, LGB youth may engage in behaviors that put them at higher risk for HIV infection to cope with the stigma associated with sexual orientation/affection and sexual violence (Saewyc et al., 2006).

Substance use is also attributed to body-image issues within the gay community. Researchers noted participants indicated that some members of the gay community use drugs (crystal meth was specifically identified) as an appetite suppressant. These individuals report stress associated with maintaining a certain body image and use it to achieve fitness goals (Mutchler, McKay, McDavitt, & Gordon, 2013).

Of the sociocultural factors previously discussed, the most prevalent factor in the literature is related to the stress of being a part of this marginalized population. The application of a minority stress model to the LGBTQ population is one that conceptualizes substance use as a stress reliever (Meyer, 2003). There is a large amount of stress created by the "hostility, discrimination, and violence due to a largely homophobic culture" (Marshal et al., 2008, p. 553). This issue is particularly significant for LGBTQ youth, as substance use may be an attempt to fit into the subculture and rationalize same-sex attraction (Jordan, 2000). The next section outlines the various difficulties the LGBTQ population faces related to substance abuse services.

Barriers to Treatment

Substance abuse treatment providers will benefit from being mindful of potential barriers to treatment when working with LGBTQ populations. The social stigma associated with being a sexual minority is compounded when group members are also identified as alcohol or addict. This phenomenon is referred to as *double stigmatization* and is cited as an obstacle to individuals seeking treatment (Green & Feinstein, 2012).

Implicit and explicit attitudes of treatment providers toward LGBTQ populations, as well as an individual's own internalized heterosexism, may also present as barriers to substance abuse treatment. Even though the attitudes of counselors working with this population are likely to impact treatment retention and outcome, there is a dearth of research focused on the potential bias among mental health providers. Despite the lack of research, ethical codes mandate professional counselors to be culturally competent, and they must provide a safe environment for LGBT clients (Cochran, Peavy, & Cauce, 2007; Cochran, Peavy, & Robohm, 2007). Among this particular population, transgender clients are noted as the group often discriminated against by health care providers, as well as our health care system (Bockting, Robinson, Benner, & Scheltema, 2004).

Additional barriers include the lack of resources available to the person seeking services. For example, homelessness is identified as a major hindrance to treatment among the LGBT population, particularly among sexual minority adolescents (Corliss, Goodenow, Nichols, & Austin, 2011). Without stable housing or a permanent residence, continuity of care and ongoing treatment may be difficult. Another concern that causes problems with treatment is related to health care coverage. LGBTQ minors who need parental consent may avoid treatment because of confidentiality concerns regarding billing and coverage. Moreover, due to the obstacles regarding insurance benefits

between people who are gay and lesbian, insurance coverage may be limited. Therefore, the accessibility and attractiveness of treatment, as well as the retention in treatment, may be negatively impacted.

A final barrier significantly represented in the research is the co-occurrence of substance abuse and other mental health issues. LGBT youth tend to experience more bullying, harassment, and physical victimization than their heterosexual peers, and this may contribute to higher rates of depression, anxiety, self-harm behaviors, and suicide attempts (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Suicide Prevention Resource Center, 2008). Researchers indicate there is a rise in suicide attempts and ideation around the time of coming out. In fact, LGB youth who had disclosed to their families were more than four times as likely to have attempted suicide as LGB youth who had not disclosed (Suicide Prevention Resource Center, 2008). The severity and prevalence of mental health conditions among this population do not lessen as a person age. As stated earlier, the stress encountered due to (a) the prejudice, discrimination, and marginalization of being LGBT; (b) internalized homophobia; and (c) the coming-out process can all lead to an increase in depression and anxiety as an adult (Meyer, 2003). In a study focusing on LGBT individuals in a substance abuse treatment program, approximately 94 percent were diagnosed with at least one personality disorder. The most common diagnoses (listed in order of prevalence) were borderline, obsessive-compulsive, and avoidant (Grant, Flynn, Odlaug, & Schreiber, 2011). In summary, a mental health condition may facilitate substance use and can become a barrier to treatment. Given the likelihood that LGBT individuals experience high levels of stress—as well as depression,

anxiety, or even a personality disorder—counselors must consider the implications for treatment access, retention, and outcomes.

Screening and Assessment

Culturally competent and sensitive screening is imperative when working with LGBTQ populations. In essence, the most important screening and assessment consideration is the clinician. Substance abuse treatment clinicians must seek out appropriate training and assess their own biases and stereotypes prior to attempting to serve as advocates and providers for this population. Recognizing the contributing factors and barriers to substance abuse treatment is useful when identifying treatment options. Through formal (instruments) or informal (interview) assessments, counselors should be mindful of how the client's internalized oppression, cultural identity, and co-occurring challenges (e.g., homelessness, mental health diagnosis, HIV status, discrimination) impact current use and potential outcomes. Cochran, Peavy, and Cauce (2007) provide an example of an instrument that may be useful for clinicians to assess their competency related to serving clients who are LGBTQ. An adapted copy of this tool (the *Measure of Attitudes Toward Gay, Lesbian, Bisexual, and Transgender Clients*) can be found in Appendix A.

Specific assessment foci are recommended when interviewing a client who identifies as LGBTQ. Counselors are to be intentional in their understanding about the client's (a) self-identity and the coming-out process; (b) available social supports; (c) relationship with family of origin; (d) romantic and sexual history; (e) present attraction and relationships; and (f) spirituality and religious beliefs (Ratner, 1993). Exercise caution when attending to the aforementioned recommendations, as some topics may be better

broached once rapport is further established. A premature discussion of sexual history, for example, could evoke shame or perceived judgment and may inadvertently impact treatment negatively.

This chapter has predominantly focused on treatment for individuals who self-report as LGBTQ. However, given the importance of culturally relevant treatment that includes sexual identity, it is relevant to consider how to best serve LGBTQ clients who do not readily identify as such. In an effort to address this concern, Barbara, Chaim, and Doctor (2002) developed an assessment titled, "Asking the right questions: Talking about sexual orientation and gender identity during assessment for drug and alcohol concerns." Refer to Appendix B for sample questions. Whether or not an assessment specifically designed for reaching a non–self-reporting audience is utilized or not, it is important that practitioners consider factors related to affection, sexual orientation, and relationship history and attraction when assessing for substance abuse issues. To clarify, the purpose of this inclusion is not to identify an individual as lesbian, gay, bisexual, or transgender. More importantly, counselors should consider how factors associated with affection and attraction may impact substance use and treatment and acknowledge that the individual has the right not to self-disclose and is on a journey of identity development.

Resiliency Factors

Fostering resiliency in clients is extremely important in the work of a substance abuse treatment provider. Some clients may present with a fierce strength from within, while others appear broken and weak. A counselor must take on a strengths-based perspective that encourages clients to become aware of the support systems and personal attributes that will serve them well in their recovery. Thus, being knowledgeable

regarding typical resiliency factors among LGBTQ clients is useful in treatment planning.

Identifying, utilizing, and creating support networks, recognizing role models, visualizing self as a potential role model for others, and being able to self-advocate are identified as resiliency factors (Holmes & Cahill, 2013). Counselors may support clients by assisting them in identifying existing and available support systems in their lives and helping clients find their voices to advocate for themselves and others. Clients may be unaware of organized resources in their schools and communities that are well-positioned to serve as a means of support and an opportunity for them to help others. Although internalized heterosexism is often referred to as a source of pain, being able to resolve it through faith and spirituality can be a source of resiliency as well (Kubicek et al., 2009). Counselors may serve clients effectively by (a) considering the role of spirituality in the lives of their clients; (b) acknowledging the pain that may be associated with faith or religion, and (c) assisting clients in attending to themselves as spiritual beings.

Recommendations for Treatment and Therapeutic Considerations

There are therapeutic considerations that counselors must take into account regarding those within the LGBTQ population. First, the authors will address and define terminology that is particular to this population. Next, the therapeutic relationship and issues of sponsorship will be explored. Last, concerns about the coming-out process, families of origin and families of choice, and clinical issues pertaining to lesbians, gay males, bisexual, transgender, and questioning clients will be presented.

Terminology for LGBTQ

Counselors would benefit to use and understand the appropriate language when working with LGBTQ clients. For instance, sexual identity, sexual orientation, gender role, gender identity, heterosexism, and homophobia are basic terminology one needs to understand to offer constructive therapeutic work. *Sexual identity* is the awareness a person has toward his or her own sexual desires. Exploring and distinguishing the client's sexual identity in a safe environment is an imperative part of therapy. Once there has been foundational work around sexual identity, the client moves on to exploring sexual orientation. *Sexual orientation* is considered to be the romantic attraction to the opposite sex, the same sex, or both sexes (McCabe, Hughes, Bostwick, Morales, & Boyd, 2012). Sexual behavior does not equal sexual orientation; one's sexual orientation refers to self-concepts and feelings. Only more recently have lawmakers and activists fought to make sexual orientation treated with equality, non-discrimination, and dignity. Because of the negativity and prejudices in the past tied to sexual behaviors of the LGBTQ community, it is mandatory to differentiate sexual behavior from orientation (Human Rights Education Associates, 2011).

Indicators of one's *biological sex* include sex chromosomes, gonads, internal reproductive organs, and external genitalia. *Transgender* refers to persons whose gender identity, expression, or behavior does not correspond to that typically correlated with the sex to which they were ascribed at birth, whereas a *transsexual* shift from one gender to another and may involve transitioning to a gender that is neither traditionally male nor female. A *transvestite*, who is more often a male, is a person who adopts the dress and sometimes the behavior emblematic of the opposite sex, especially for purposes of emotional or sexual gratification. *Questioning* or *queer* is often referred to as the "Q" in

LGBTQ and encompasses any exploration or uncertainty of one's sexual orientation, gender, or identity (American Psychological Association, 2014).

Gender role is customary to a particular culture's view of behaviors, which are either perceived as masculine or feminine. Gender roles and sexual orientation are not to be confused with *gender identity*, which is one's sense of self as either male or female. Within the therapeutic process, each individual will choose how to relate these definitions to oneself within culture, family, religion/spirituality, and society. This type of dialogue will occur after clients have established how to admit, accept, and engage their own sexual identity and orientation (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012).

In correlation with understanding the terminology and psychological complexities of gay, lesbian, bisexual, and transgender issues, a counselor must also recognize the transference and countertransference of heterosexism and homophobia. *Heterosexism* is a bias for opposite-sex relationships and can mirror racism or sexism toward non-heterosexual relationships. Examples of heterosexism are acts such as internal beliefs, ideologies, and societal patterns that support superiority over same-sex couples. *Homophobia* is defined as an irrational fear or aversion toward LGBT sexuality or persons. Acts of homophobia might include interpersonal incidents such as conversations or jokes misrepresenting or putting down LGBT individuals. Counselors must not only define but also understand, these perceptions as an imperative part of doing effective therapeutic work with LGBTQ clients (CSAT, 2001).

The Therapeutic Relationship

Countertransference issues are important concerns to address because they can impact the therapeutic relationship. Therapists with the same sexual minority identity as their client might minimize the client's substance abuse more easily and might also anticipate the idealization of the client (Greene & Faltz, 1992). Alternatively, a heterosexual therapist's inaccurate beliefs about homosexuality might complicate therapy. Moreover, a therapist may assume that the client's sexual orientation is the cause of substance abuse problems and might lean toward inappropriately making a therapeutic goal of changing the client's sexual orientation. It is imperative for therapists to have done their own work and identify their personal stories, prejudices, and beliefs around sexuality.

Sponsorship

Another consideration for substance abuse counselors is sponsorship in recovery. Alcoholics Anonymous, Narcotics Anonymous, or other self-help groups encourage clients to obtain a sponsor. Although there is little research discussing sexual orientation and sponsorship, consideration must be given when choosing whether a sponsor has the same gender and sexual orientation (Ratner, 1993). In addition to the self-help group, considerations, substance abuse treatment programs and counselors should make efforts to provide competent services to this population. A counselor's spoken awareness and willingness to understand these issues can allow clients to speak openly and lessen their fears about their sexual orientation.

The Coming-Out Process

Counselors must be familiar with the "coming-out" process and the implications it has for clients. This process refers to the course of changing a negative self-identity to a

positive self-identity with regard to sexual orientation. This process is particularly important to many gay and lesbian people who are recovering from substance abuse, as recovery from addiction requires an affirming and positive feeling about oneself. Cass (1979) proposes six stages within the framework of interpersonal congruency theory, in which individuals form their own identity and self-concept with homosexuality. The six stages of sexual identity development are: (1) identity confusion; (2) identity comparison; (3) identity tolerance; (4) identity acceptance; (5) identity pride; and (6) identity synthesis. It is understood these stages play only a framework to the conversation of "coming out." See Appendix C for more detailed information regarding the six stages of the Cass (1979) model.

Using these stages to conceptualize the client's self-identification as lesbian or gay would benefit a clinician to cultivate work facilitating client movement toward an affirming identity. Often, degradation and shame are leading issues interfering with the attainment of a healthy and constructive sexual identity (Bradshaw, 1988). Addressing and combating the shame in the context of coming out is a positive step in the abstention or moderation of substance use. After sexual identity has been established, the counselor will move toward working with the client's family systems within his or her family of origin.

There are other issues that can arise in therapeutic work, as some individuals do not wish to come out or openly identify themselves as lesbian, bisexual, gay, transgender, or questioning. Clients may identify and "own" their sexuality in the therapy office while choosing to not make their sexual identity known elsewhere. The therapist must continue to offer a safe place for clients to continue to explore their sexuality and way of life.

Further, the category of Questioning includes people who are still uncertain about their sexual identity, gender, and sexual orientation and who may be still exploring these areas of their lives. Many times, questioning individuals are reluctant to put a name on their sexuality due to societal stigmas and labels. Although therapeutic work around naming sexual identity is helpful to those in the confusion identity stage, it does not alleviate the pressure of social and familial judgments. Therapy with clients who are questioning should incorporate discussions around gender identification and whom they have crushes on and/or fantasize about being with sexually (i.e., sexual identity).

To assist clinicians with clients who may be coming out, SAMHSA (2012) provides the following recommendations. The counselor can:

- encourage a discussion of how the client hid his or her LGBT feelings from others
- explore the emotional costs of hiding and denying one's sexuality
- discuss attempts the client has made to change in an effort to fit in
- examine negative feelings of self-blame, feeling "bad" or "sick," and the impact of shaming messages on the client
- foster the client's courage to accept and speak up about who he or she is (SAMHSA, 2012, p. 117).

Family of Origin and Family of Choice

One of the most noteworthy elements of treating issues of substance abuse is exploring the family dynamics a client has encountered. A comprehensive biopsychosocial assessment includes the exploration of family systems and origin. Thoughtfulness should be used when addressing family-of-origin matters, as unresolved

issues with family members are common in regard to disclosure of sexual identity. To assist with these issues, the support group Parents, Families and Friends of Lesbians and Gays (PFLAG) works with families of origin. The LGBTQ community may have also built close relationships with what is called the *family of choice*. Family of choice is usually comprised of people who are most noted for helping and caring for someone who has been rejected by his or her family due to sexual orientation. These usually include friends who have been accepting and understanding through the process of coming out.

Clinical Issues to Consider with LGBTQ Clients

This section of the chapter has mostly discussed treatment considerations for the LGBTQ population as a whole. It is also imperative to look at the specific concerns that arise for those who identify as lesbian, gay, bisexual, transgender, or questioning. The following is a summary of the particular clinical issues among the sexual minority populations, as identified in the literature:

Clinical Issues with Lesbian Clients (Hughes & Wilsnack, 1997)

- Patterns of substance abuse vary
- Alcohol problems are higher for lesbians than for heterosexual women
- Stressors to coming out or "passing" as heterosexual
- Effects of trauma from violence or abuse

Clinical Issues with Gay Male Clients (CSAT, 2001)

- "Gay ghetto," which refers to the area in each city where gay men tend to congregate and often is associated with alcohol and drug use
- HIV/AIDS continues to be a major factor

- Substance use allows men to act on suppressed feelings, but harder to integrate sex and intimacy
- Males who do not fit the stereotypical male role
- Being effeminate in the gay community is sometimes condemned and increases shame

Clinical Issues with Bisexual Clients (CSAT, 2001)

- Bisexuals may feel alienated, not just from the heterosexual majority, but also the lesbian and gay community
- Internalized biphobia may result in self-abasement
- Bias counselors who might see bisexuality as borderline personality disorder with fluctuating sexual behavior as a symptom of acting out or poor impulse control

Clinical Issues with Transgender Clients (Lewis, Dana, & Blevins, 1994)

- Transsexualism has historically been viewed as psychopathological and classified as a gender identity disorder
- Extremely high rates of substance abuse in the transgender community
- Treatment must be multimodal to address multiple problems and patterns of abuse
- Societal, internalized transphobia, violence, discrimination, family problems, isolation, low self-esteem, lack of educational and job opportunities
- Often distrustful of health care providers because of many negative experiences

- Hormone treatment and therapy must be monitored closely through treatment for substance abuse
- In-patient treatment faces multiple issues with housing, restrooms, and sleeping arrangement logistics
- Open-ended questions should be asked regarding sexual and gender orientation

Clinical Issues with Question Clients (APA, 2014)

- Often, adolescents are in a period of experimentation, and many youths may question their sexual feelings
- Affirmation that awareness of sexual feelings is a normal developmental task that is beneficial to explore
- Exploring and talking through same-sex feelings or experiences that cause confusion about their sexual orientation
- This confusion appears to decline over time, with different outcomes for different individuals
- Open-ended questions should always be used when working with Questioning clients
- Inquiring about stereotypes and prejudices that might obstruct the client's desire to explore further

Conclusion

This chapter serves as an introduction to the distinctive needs of many individuals within the LGBTQ community. It is important to note that many factors impact the culture. Therefore, the information presented is based on social norms and should not be

considered as an absolute for individuals within this specific population. Cultural competency and sensitivity are imperative when serving all populations, but particularly those who are often marginalized and underserved. Counselors providing substance abuse treatment to LGBTQ populations will benefit from ongoing self-reflection, professional development and training, and consultation/supervision. This chapter ends with questions for reflection, as the reader begins or continues the journey of advocating for the health and wellness of LGBTQ clients. References and resources are also found in the appendices that may be of further support.

Reflection Questions

1. How prepared are you to work with LGBTQ clients? Why?
2. Identify at least two areas of additional training that would help you be a more effective advocate and supporter of LGBTQ clients.
3. What bias or stereotypes about lesbians, gays, bisexuals, and transgenders do you hold?
4. When is the last time you participated in an LGBT event or have been socially engaged with people who are lesbian, gay, bisexual, or transgender?
5. What plans do you have to continue to grow professionally (e.g., professional development), personally (e.g., your own work), and socially that will best support you to serve the LGBT population?

Appendix A

Measure of Attitudes Toward Gay, Lesbian, Bisexual, And Transgender Clients*

1. I monitor my competence in working with GLBT individuals by receiving consultation, supervision, or continuing education.
2. Substance abuse treatment is typically more effective for heterosexuals than for GLBT clients.
3. It is often difficult to relate to the specific problems that GLBT clients present in treatment.
4. I treat all clients the same, regardless of their sexual orientation or sexual identity.
5. I think that clients should see the nuclear family as the ideal social unit. My agency provides a supportive environment for clients, regardless of sexual orientation or sexual identity.
6. I have seen or witnessed discrimination against clients based on their sexual orientation or sexual identity at my current agency.
7. I believe that many of the substance abuse problems that GLBT individuals have are related to the cultures in which they live.
8. I am aware that being heterosexual carries with it certain privileges and rights in our society.
9. GLBT individuals would probably be best served by having a counselor who is also a sexual minority.
10. I think that being GLBT is very similar to being a person of color.

11. GLBT individuals must come to terms with their sexual orientation or sexual identity before they can really benefit from substance abuse treatment.
12. I believe that GLBT individuals are more vulnerable to relapse than heterosexual clients due to the additional difficulties they face.
13. There is no reason to believe that it will be more difficult for a GLBT individual to complete substance abuse treatment than anyone else.
14. It is probably more difficult for someone who is GLBT to come to treatment than it is for someone who is heterosexual.
15. I believe that I must know my client's sexual orientation if I am to understand who he or she is and how to best help my client.
16. I feel adequately trained to work with GLBT individuals in treatment.
17. My agency has specific outreach programs to serve the GLBT community.

Options: "strongly disagree," "moderately disagree," "disagree somewhat," "neutral," "agree somewhat," "moderately agree," and "strongly agree."

Adapted from Cochran, B. N., Peavy, K., & Cauce, A. (2007). Substance abuse treatment providers' explicit and implicit attitudes regarding sexual minorities. *Journal of Homosexuality*, *53*(3), 181–207.

Appendix B

"Asking the Right Questions" *

Part A

Are you currently dating, sexually active or in a relationship(s)? Yes_______

No_________

If yes... is (are) your partner(s) __ female __ male __ transgender __transsexual __other

____

How long have you been dating or in a relationship?

____

How important is this (are these) relationship(s) to you? __ not much __ somewhat __

very much

If you have had previous relationships, was (were) your partner(s) __ female __ male

_____ transgender____

transsexual______ other ____________

In terms of your sexual orientation, do you identify with a particular group? gay______,

lesbian______, straight/heterosexual______, bisexual______, unsure______, or none of

the above______

Are there concerns, or questions related to your sexual orientation/identity or do you ever feel uncomfortable about your sexuality? Yes______ No______

Part B

Can you tell me about any interactions you have encountered because of homophobia?

How open are you about your sexual orientation? How do you feel about the orientation with which you identify yourself?

Where are you regarding your coming out process?

How has your sexual orientation affected your relationship with your family?
Is your family supportive of you?

Can you tell me about your involvement and acceptance in the gay, lesbian, bi, and trans community?

For gay/bisexual men only: Do you ever worry about HIV? If yes……In what ways?

Have you ever used substances to cope with any of the issues we mentioned above?
Yes______ No______

If yes…In what ways?

Adapted from Barbara, A.M., Chaim, G., & Doctor, F. (2002). *Asking the right questions: Talking about sexual orientation and gender identity during assessment for drug and alcohol concerns*. Toronto: Centre for Addiction and Mental Health.

Appendix C

Cass Model of Homosexual Identity Development

1. **Identity Confusion:**

“Could I be gay?” Person is beginning to wonder if “homosexuality” is personally relevant. Denial and confusion are experienced.

Task: Who am I? –Accept, Deny, Reject.

Possible Responses: Will avoid information about lesbians and gays; inhibit behavior; deny homosexuality (“experimenting,” “an accident,” “just drunk”). Males: May keep emotional involvement separate from sexual contact. Females: May have deep relationships that are nonsexual, though strongly emotional.

Possible Needs: May explore internal positive and negative judgments. Will be permitted to be uncertain regarding sexual identity. May find support in knowing that sexual behavior occurs along a spectrum. May receive permission and encouragement to explore sexual identity as a normal experience (like career identity and social identity).

2. **Identity Comparison:**

“Maybe this does apply to me.” Will accept the possibility that she or he may be gay. Self-alienation becomes isolation.

Task: Deal with social alienation.

Possible Responses: May begin to grieve for losses and the things she or he will give up by embracing their sexual orientation. May compartmentalize their own sexuality. Accepts lesbian, gay definition of behavior but maintains

"heterosexual" identity of self. Tells oneself, "It's only temporary"; "I'm just in love with this particular woman/man," etc.

Possible Needs: Will be very important that the person develops own definitions. Will need information about sexual identity, lesbian, gay community resources, encouragement to talk about loss of heterosexual life expectations. May be permitted to keep some "heterosexual" identity (it is not an all or none issue).

3. **Identity Tolerance:**

"I'm not the only one." Accepts the probability of being homosexual and recognizes sexual, social, emotional needs that go with being lesbian and gay. Increased commitment to being lesbian or gay.

Task: Decrease social alienation by seeking out lesbians and gays.

Possible Responses: Beginning to have language to talk and think about the issue. Recognition that being lesbian or gay does not preclude other options. Accentuates difference between self and heterosexuals. Seeks out lesbian and gay culture (positive contact leads to more positive sense of self, negative contact leads to devaluation of the culture, stops growth). May try out variety of stereotypical roles.

Possible Needs: Be supported in exploring own shame feelings derived from heterosexism, as well as external heterosexism. Receive support in finding positive lesbian, gay community connections. It is particularly important for the person to know community resources.

4. **Identity Acceptance:**

"I will be okay." Accepts, rather than tolerates, gay or lesbian self-image. There is continuing and increased contact with the gay and lesbian culture.

Task: Deal with inner tension of no longer subscribing to society's norm, attempt to bring congruence between private and public view of self.

Possible Responses: Accepts gay or lesbian self-identification. May compartmentalize "gay life." Maintains less and less contact with heterosexual community. Attempts to "fit in" and "not make waves" within the gay and lesbian community. Begins some selective disclosures of sexual identity. More social coming out; more comfortable being seen with groups of men or women that are identified as "gay." More realistic evaluation of situation.

Possible Needs: Continue exploring grief and loss of heterosexual life expectations. Continue exploring internalized "homophobia" (learned shame for heterosexist society). Find support in making decisions about where, when, and to whom he or she self-discloses.

5. **Identity Pride:**

"I've got to let people know who I am!" Immerses self in gay and lesbian culture. Less and less involvement with heterosexual community. Us-them quality to political/social viewpoint.

Task: Deal with incongruent views of heterosexuals.

Possible Responses: Split's world into "gay" (good) and "straight" (bad). Experience's disclosure crises with heterosexuals, as he or she is less willing to "blend in." Identifies gay culture as sole source of support; all gay friends, business connections, social connections.

Possible Needs: Receive support for exploring anger issues. Find support for exploring issues of heterosexism. Develop skills for coping with reactions and responses to disclosure of sexual identity. Resist being defensive!

6. **Identity Synthesis:**

Develops a holistic view of self. Defines self in a more complete fashion, not just in terms of sexual orientation.

Task: Integrate gay and lesbian identity so that instead of being the identity, it is an aspect of self.

Possible Responses: Continues to be angry at heterosexism, but with decreased intensity. Allows trust of others to increase and build. Gay and lesbian identity is integrated with all aspects of "self." Feels all right to move out into the community and not simply define space according to sexual orientation.

* Cass, V. C. (Spring, 1979). Homosexuality Identity Formation: A Theoretical Model. *Journal of Homosexuality, 4*(3), 219–235.

Chapter Four: Theology of The Womb Manuscript

Breasts, A Sexual God and A Menopausal God

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4

Breasts

Taught from infancy that

beauty is woman's scepter,

the mind shapes itself to the body, and

roaming round its gilt cage, only seeks

to adorn its prison.

—Mary Wollstonecraft

Bras & Breastplates

My mother-in-law has turned her head and covered her eyes with one hand as her other hand holds onto my 6-month-old son. I laugh out loud that she thinks I need privacy as

the store clerk measures my bust for the correct bra size. My sister-in-law is there with us too, in the dressing room, and she is almost more eager than I am to know the correct size bra I should be wearing. The woman explains to us that the seam of the bra should not be directly under your armpit but rather the seam should run closer to the back of your arm for proper circulation. We three women at the ages of 70, 42, and 38 years old had never been measured for the correct size bra to wear. We giggled like school girls all through the mall after that lesson, talking about our experiences with bra knowledge or lack thereof.

Bra shopping was not a rite of passage in my family, in fact, breastplates, as armor, were the closest understanding I had imagined as a teenager for the purpose of a bra. All I knew about breastplates were that they were used to protect soldiers when going to battle or breastplates were fitted for horses as they ride in sport. By definition, breastplates are "devices worn over the torso to protect it from injury, as an item of religious significance, or as an item of status". The definition itself sounds so beautiful compared to the definition I had been told by my brother for a bra, "over the shoulder-boulder-holder". If I put on my bra every day as an item of clothing symbolizing protection or status, and even as an article of armor with religious significance, how might I have come to experience my breast on my body? Come to find out, biblically, El Shaddai speaks about God's breast as mountains and with the undertones of protection. The breastplate was also worn by the high priestesses as a symbol of judgment. The amounts of spiritual concepts we could teach women about what it means to put on a bra are endless.

If bra to breastplate isn't enough for you, how have you come to be with the size of your breast? As a young girl, I never talked about my breasts with anyone when I was

growing up. I didn't know what a" normal" size was supposed to be; I was unaware of what size breast guys liked. My friend Amanda Napoli told me once, "As long as it's a handful, it is enough." Other than that, I was clueless to the purpose or expectations of my breast. If anything, breasts were a nuisance to me. Playing sports my whole life, there was nothing more frustrating than having to scrape a sweaty, tight sports bra off after a game. If you had asked me when I was a teenager what God's intention were for creating breasts, I would have said it was to annoy women and make men stumble. In her book, Honoring the Body, Stephanie Paulsell writes: "Young people who have grown up learning that the body mirrors back to us something important about God and that the body's desires are a precious gift from God worth of being sheltered and allowed to develop in freedom have a compass to help them negotiate the road to sexual maturity." When women truly realize what it means that their breasts and their vagina were created in the image of God, to display the mysteries and perfections of God, women will give themselves permission to allow these body parts to develop in freedom and to be cared for well. Research tells us that when we honor our bodies and the stories our body parts hold, we develop a healthier psyche and sexuality. Women's breasts often live within the dance of invisibility versus visibility. We hide the breast of our youth in hopes of not being objectified, though we will one day grow old and become incensed by our withered, sagging breast which no one longs to look at. *Our sexual body parts are at war with being seen, we don't know if we should hate, hide, or enshrine the beauty they offer.* Breast are a divine mystery. They offer comfort, nourishment, rest, and pleasure. Objectification is a war against the purpose of our breasts. As women, we often wear our breasts like hidden shields of shame rather than a breastplate of righteousness.

Satisfying Breasts

As a woman, growing up in the church, I did not find much teaching illuminating the beauty of my specific female reproductive body parts. The female body has multiple body parts that reproduce life. Breasts are one of these life reproducing parts, often referred to Biblically in the context of drinking from or giving drink. We often associate the breast as giving drink by lactation, literally giving milk to infants, but breasts are also referenced sexually as giving satiating drink. Proverbs 5:19 speaks about "letting her breasts satisfy at all times". Within sexuality, the breasts refresh and fully satisfy the husband. Her breasts are referred to as a gift for them both to delight in. The word *dadeyah*, "her breasts," only occurs here and is equivalent to *dodeyah*, "her love"; and satisfy reads as "water thee" literal meaning the *y'ravvuka*, "to drink largely," "to be satisfied with drink." In a world where women's breast is usually objectified, it is refreshing to see God had a deeper intent when He created them.

First, we must begin by clarifying that God is not a sexual being, neither man nor woman, rather the Trinity is a spirit which bears God's mysteries in our humanity and in our sexuality. Sexuality is not a human projection; it is an expression of God's image by creating us with male and female body parts. We are made in God's image, not God in ours. "God is pure spirit in which there is no place for the difference between the sexes. But the respective "perfections" of man and woman reflect something of the divine, infinite perfection of God." Thus, we must ask ourselves, what perfection of God is being portrayed by the woman's breast? Breasts sustain life.

Breast Pump

River, at three days old, is laying in the Isolette with what looks to be Ray-Bans strapped to his face. The image would be the perfect advertisement for a tanning bed company, but unfortunately, it is because I birthed him five weeks early and we are spending the next thirty days boarded here in the hospital NICU. After the emergency C-section, he was taken immediately to the neonatal ICU. Although I was relieved at his safety, I sadly wasn't able to spend the first few hours with my baby. The doctors told me that when I could move my legs and walk to the NICU, I would be able to see him. I was desperate to wear off the anesthesia residing in my lower limbs, so I spent those hours distracting myself by squeezing colostrum into tiny syringes and sending them via my husband to give to my precious newborn. This was the beginning of a long season: being boarded in the hospital for a month, pumping every two hours, washing the equipment, measuring and fortifying the amounts exactly, and gavage feeding the breast milk into his premature belly. There were charts, calendars, and storage bags that were being constantly updated. Name, date, amount. Every two hours, again and again, name, date, amount.

The hours accrued in the rocking chair near his Isolette seemed countless. Around the clock I would watch and wait for a moment to hold my four-pound little baby. When I would get him, I wouldn't let him go. It would be three hours at a time of skin to skin, before the nurses would beckon me to go back to pump or sleep. My body was so desperate to be near my baby; my heart was hungry to have him on my chest. I stared at all the machines monitoring his vitals. My body had done the work that the many machines filling an entire room were now doing. I have never been more in awe of the female body than at that moment of realization. The womb was as powerful as these

medical machines, and my breast provided milk that was the perfect life source he needed for growth.

Momma's Milk

At three years of age, my oldest son Wilder is laying in his bed drinking a bottle, trying to fall asleep. I am laying with him while I nurse his baby sister during our bedtime routine. He watches me in deep thought. "Mom, how much momma milk can you make?" He is looking at me with sheer curiosity as I calculate the usual ounces, I can pump in one sitting. "Well buddy, I think I probably can make 10 to 12 fluid ounces, which is a full bottle." His immediate impatience surprises me, "No mom, how much momma milk is in you?". I realize he is asking about *all* the milk my body has made. I begin to calculate the last two years of feeding every few hours. He is frustrated with my math skills, and I stop calculating around 20,000 ounces. I knew he wouldn't understand 2,000 so I say, "I have about 200 gallons of momma milk in me, my love." He is satisfied that I have given him an answer and is silent for a while. He finishes his own bottle and very quietly says, "Your body is amazing." His inquiry was so intriguing to me, I calculated how much momma milk I produced for all three of my kids. Let's just say my body has been the barista of about 5,475 venti cups in my lifetime. That is the amount my body has produced over the past decade to nourish my 3 babies. Wow, breasts really are amazing.

Mastectomy

The rhythmic jerk of our little speedboat steadily rocked us back and forth as we crossed the Mekong River on a four-hour boat trek into the remote Northern tip of Thailand. Aunt Jinx and I were taking an excursion to the Golden Triangle, the point where Laos, Thailand, and Myanmar meet. We had just finished teaching in the Chang Rai province.

It had been my eight-year dream to finally meet the Compassion child I sponsored, and my aunt took me on a trip to meet my sponsored child and then learn about different native tribes of women in the area.

My mind wanders into a deep nautical trance thinking about White Karen tribe of women we had just met. Each woman was wearing multiple gold rings holding up her elongated neck and adorning her wrists. The number of golden rings is connected culturally to the status and beauty of the woman. I am awed by the strength and capacity of these tribal women to live in these rural countries while raising children, yet still making space in their lives for markers of beauty, such as colorful beaded-work, metals made into jewelry, and vibrantly dyed cloth. I find I am surprised at beauty is a sought-after commodity, even to women in most rural locations.

My Aunt Jinx, on the other hand, was not a woman consumed or seeking after beauty. Now, let me tell you about Aunt Jinx – she is quite a character. This is a woman with more life in her eyes than a kid in a candy store. Every day is magical to Aunt Jinx, and every moment is an opportunity for goodness to be created. Aunt Jinx has no regard for filters and would often lift up her shirt and show her mastectomy scar at any family event. She had survived breast cancer 11 years prior, and although we were deeply grateful, she was alive, we struggled to politely navigate her placing your hand on her breast-less chest, mid-conversation. We pretended not to notice her one exposed breast. To her credit, she made sure that her missing breast wouldn’t be glossed over or ignored. Her survival scars spoke of grit and bravery, and she would not allow them to be silenced. Aunt Jinx was celebrating her 11th year of remission from breast cancer, and, on this trip, we learned that she had had a re-occurrence. This was a very sobering part of

our trip as she wrestled with the acceptance of potential death, but we continued with the determination to live life to the fullest. As we docked the boat on a grass shore, the Hmong tribe stood there to greet us. We spent the afternoon with them, few words exchanged, exploring this remote and breathtaking island. As we prepared to leave, an older woman from the tribe hugged Aunt Jinx and noticed her missing breast. She patted her own chest where she, too, was missing a breast. They both put their hands on the others' scars and were silent for a moment. I, as a young college girl, felt the weight of this moment, as these two unlikely friends stopped and honored their connection through their scars. The woman pulled out a small emerald carved elephant with a raised trunk, which I came to find out symbolizes long life, and wrapped it with Aunt Jinx's hand. No words were spoken, yet volumes were communicated as both women shared this meaningful moment. Scars are a reminder that death did not take away one's life.

More Mastectomies

Lord, have mercy. I mouth the silent prayer as I listen to her muffled whimpers through the heavy metal restroom door. She has locked herself in the women's bathroom, which is located right outside my counseling office on the second floor of the Oncology unit. Her double mastectomy surgery a few weeks prior was successful—successful in the sense that the cancer was removed, along with her dignity. She has had her first follow-up appointment and the bandages will be removed today, and aftercare plan made. The somber air is thick as another woman bears the image of her newly scarred and marked body. Where her breasts once were, she sees an imperfect diagonal suture line across her chest. She will no longer see the breasts that she bought bras to fit, tugged blouses to cover, her bosom where lovers had nuzzled, her babies suckled. She stares, taking in the

unjust barter of her beautiful breast replaced by a purplish-red scar. I wait patiently for her to reach composure and come join me for our therapy session. At this point, I have been an oncologist therapist for a little under a year and have worked with a handful of women who've undergone mastectomies and double mastectomies. I journey with these women as they navigate the long road of processing what it means to have an appendage removed for the sake of continuing the battle to live.

It is an emotionally disturbing process to be put to sleep and wake up without your breast, or any part of your body, for that matter. The sounds echoing from the recovery room bathroom are, at times, horrifying. Some women lock themselves in bathroom stalls and weep. Some women refuse to come out of surgery without having breast reconstruction the same day. Whatever a woman's reaction to the loss of her breast, it is difficult to navigate society's expectation, the healthy grieving process, and what it means to heal from the loss of our good body. Research shows mastectomy as a "lifesaving treatment for many women diagnosed with breast cancer. Yet, like other surgeries, it can leave painful adhesions and scarring. Women who have undergone a mastectomy may experience a variety of post-mastectomy symptoms. Pain may occur at the surgical scar, throughout the chest wall, and into the shoulders, arms or neck." The loss of a body part takes time to process, grieve, and become accustomed to this new body. There is an emotional component tied to the loss of a body part, as intimate as our connective tissue visibly showing the severance of an appendage. In the medical field, the stress response is the hormonal and metabolic changes in the body following injury or trauma, such as surgery. Research confirms that our bodies hold trauma in our sinew and tissue, and we are able to see the trauma much like scar tissue around a once-severed site. The body

remembers what anesthesia numbs or erases, and often our minds block out. In his book, The Body Keeps Score, Bessel Van Der Kolk explains, “Long after a traumatic experience is over, it may be reactivated at the slightest hint of danger and mobilize disturbed brain circuits and secrete massive amounts of stress hormones.”

It does not have to be the extreme of a mastectomy or constructive surgery; our breasts hold stories. With every client who comes into my office, at some point during therapy I pose the questions: “What is the story of your breasts? What would your breast, or any reproductive part of your body, tell me if they could speak? What has it been like living as a part of your body?”

These questions are not limited to your breasts, they apply to any reproductive part of your body, such as the womb, vagina, or pelvic floor. As women, God has built our bodies with magnificent reproductive abilities: our breast lactate, our clitoris orgasms, our uterus creates life. All of these incredible parts of our bodies are invitations to know and understand our Creator. God was so kind when He invited women to co-create life with Him. This invitation, this gift of our reproducing body parts, is also very vulnerable and susceptible. We, as women, are invited know the story of our body parts – in particular, the reproductive ones—in order to understand God in a deeper way. Having worked in the psychological world of women for over ten years now, I am keenly aware of how many times evil moves to strike the woman’s reproductive body parts as a way to minimize or silence them. Women must study the wounds, scars, and triumphs of our bodies inside and out, thus meeting a God who created us perfectly in His image.

Bravely bearing the wounds and scars of our body takes the deepest work of the soul. Our body was given to inviting us into the act of creation. The human body is

capable of creating the joys of art, pleasure, and health. Conversely, we must understand that the body's greatest battle is to bear grief well when it is wounded or severed. How we address the scars of our bodies is crucial to our emotional health. It is important to identify the scars on our bodies, physical and emotional, and to know their origin in detail. Scar stories give us insight to the themes of our wounded-ness and recovery. If we are mindful, it gives us information on what our bodies are capable of enduring and, ultimately, what our bodies can know and experience.

My time working in the oncology unit was harrowing, as burned and mutilated bodies are enormously costly to bear, work with, and aid in healing. There is one patient whose story has stayed with me these past 10 years. After a double mastectomy, this woman returned to my counseling office with her husband, desperately trying to save her marriage of 32 years. As she and her husband sat in my office, they told me that sex did not seem possible anymore. Her husband reported that every time he saw her scars across her chest, he wanted to vomit. I restrained myself from shuddering when he stated flatly, "I definitely can't get it up to have sex when I see those scars." These were my early years as a therapist, and while I hid my disgust at his honesty and callousness, I was at a loss. Immediately after the session, I consulted with my supervisor. I needed direction to work effectively with this couple. I couldn't think of how to help this couple see hope in this situation. My wise supervisor was clear and confident in her response. She explained that *scars become our body's most intimate invitations*. Deeper than genitalia, the marks on our body where we barely escaped death are the most powerful conduits for intimacy. I will never forget Tina's supervision about this subject. She said, "To allow someone to enter our wounds is to allow someone to enter the most intimate place, more intimate

than any orgasm." Her words were profound, and I believed her. I went back with the confidence to continue working with my distressed couple.

Scar Stories

All scar stories of trauma and hardship have power. Intimacy is in the sharing of places of pain. Engaging our own intimacy within our own bodies and scars are the first steps. Writing down the stories of your reproductive body parts and how they have been marred or scarred is a great place to start on your road to knowing God through your body's story. When I stand bare before a mirror, I know the curves, scars, stretch marks that my body has endured. I know what I think about those places, and I have asked God to name what those stories have meant to Him. Naming these places allow us to make meaning of how our calling is being informed from our life events. God is aware of the details: *He knows every hair on our head*, *He holds every one of our tears in a jar,* and *He knit us in our mother's womb*; God intimately knows the details of our bodies and our scars. From this place, I am able to choose to offer my husband the invitation of knowing what my body has endured and how he can know me more intimately. When a committed and safe spouse is able to know the stories of your body's scars there is an invitation to deeper intimacy. The sharing and co-bearing of our agony is the fearful and sacred road to true connection and intimacy. This tension is a beautiful journey when we engage what has been asked of our bodies.

Chapter 4 Questions: Breasts

1. What do you believe is God's reason for creating your breasts?
2. If you asked your breasts to tell the story of what it is like to be on your body, what would the story be?
3. What are you scar stories, and can you see themes to what your body has survived or continued to hold inside that needs to be released? Scan your body and note all the places where there are scars; be curious of what these stories are.

Scar Intimacy Exercise:

All scar stories of trauma and hardship have power. Intimacy is in the sharing of places of pain. Engaging our own intimacy within our own bodies and scars are the first steps. How do you engage your own scarred body and how do you invite a partner into that space? Have you ever touched the scars on your body with intention? Have you ever allowed your partner to touch the scars on your body? Writing down the stories of your reproductive body parts and how they have been marred or scarred is a great place to start on your road to knowing God through your body's story.

5

A Sexual God

"Insofar as the body is a site of divine presence

(seen most definitely in the Incarnation),

women must see their wombs and erotic energy as a sacrament.

We must teach young women and girls to feel

the pleasure, pain, sadness, and creativity

that is bubbling up from their pelvic bowl and their sexual organs

and greet these sensations as teachers,

not as shameful enemies."

-Karen Ross, *Womb Energy and Erotic Justice for Women and Girls*

Delight of the Body

Her dramatically cut, dark hair is moving back and forth just past her chin as she shakes her head no. I have been working in my counseling practice with this client for over a year now targeting her lack of emotion when it comes to her desire. Our therapy sessions are proactive and logistical, her gut response rigid to join the conversations. She has grown to trust me, sharing stories of deep betrayal and hurt, yet her face is set, her frame always composed as if she doesn't feel the pain she articulates. It dawns on me that her

stories of shame and legalism are often stories of her and her mother. I ask her, why is it that she can discipline self-care for her physical body, but she cannot engage her emotional sadness or sensual desires? Immediately, a story of shame and nakedness she told early in our work comes back to me, I hear her repeating her mother's words out loud when catching her daughter innocently delighting in her body, "Ladies don't act that way." Take note, evil is subtle and simple when it can be; so, you are likely to overlook it. Over and over, I have come to recognize that evil is spoken over us and we agree and make a vow. Evil is not complex if it doesn't need to be because it doesn't want to be exposed. Evil is dark, subtle, and mean. She still believes her mother's words; she is still mothering herself just as she was taught, with a sterile and conforming distance to her own body. We began to unwrap the shame and embarrassment around her body's pleasure and vulnerability. We realized that she had no idea how to mother herself into being a woman. She had never been allowed to explore and delight in her body without shame; had never been taught to be imaginative and listen, to mark and honor her body. We have defined shame as a belief that there is something wrong with us, and so to not feel that shame we will turn to self-contempt or other-centered contempt. Contempt is an effective way to make delight and glory pay for showing up in our bodies. We can hate ourselves or the other's body, we make it evil and therefore, we cannot love or delight in our own pleasure and glory. In these moments, we join evil and obliterate ourselves or others because it is easier than joining God who fearfully and wonderfully made us.

Historical Sexuality & God's Design

Doctors, therapist, parents, teachers, and pastors have trouble openly talking and teaching about sex. Sex is a powerful and difficult subject to explore through the eyes of God.

Most churches have little education on who is equipped to navigate the conversations of sexuality and God, other than mandating abstinence. God's design for sex is obviously intentional and powerful, and I believe God has given us power through the holiness involved in the act of sex and pleasure. My professor and mentor for many years, Dr. Tina Schermer Sellers, is a Christian Certified Sex Therapist who trains Christian therapists on how to counsel clients around healthy sexuality. She teaches about the history and practices of the Law of Onah, laws directed mainly to men which command the man to give his wife pleasure during sexual acts, not to just think of himself. Research records these laws from the Torah, specifically outlining a sexual principle that protects women as a direct rule:

> [EXT]"Sexual relations should only be experienced in a time of joy. Sex for selfish personal satisfaction, without regard for the partner's pleasure, is wrong and evil. A man may never force his wife to have sex. A couple may not have sexual relations while drunk or quarreling. Sex may never be used as a weapon against a spouse, either by depriving the spouse of sex or by compelling it. It is a serious offense to use sex (or lack thereof) to punish or manipulate a spouse. Sex is the woman's right, not the man's. Although sex is the woman's right, she does not have absolute discretion to withhold it from her husband." [/EXT]

These laws invite us to begin the exploration of God's design for sex as it relates to pleasure and spirituality. It was during my first seminary class discussion that my professor mentioned that the female clitoris is the size of a pencil eraser head but has more nerve endings than the head of the male penis. I was shocked; no one had ever told me that. She posed the question, "Why would God give women a clitoris which only the

physiological function has to give pleasure?". I researched the function of the clitoris, finding it described as an extremely sensitive organ made up of erectile tissue which has thousands of nerve endings, with its central function being to produce sensations of sexual pleasure. I was stunned to confirm that the clitoris, in fact, has no function in reproduction and has 8,000 nerve endings, which is double to amount of the nerve endings on the penis. *Who knew seminary could be so helpful?* This information has been a stunning revelation for thousands of students and clients that I work with. We are under-educated as a Christian population about God's design of the female body, especially concerning sexuality. How can we expect to build a healthy theology around God's plan for sexuality if we don't study His design of our sexual organs?

While the female body requires obvious honor and awe, objectification of the female body brings death. If a woman's reproductive, life-creating body parts which are created God's image are objectified, it prevents her body from being engaged with the way God intended. Rob Bell describes Christian sexuality as a dance between being "angel", a spirit without a body, or "animal", a body that lives by basic instinct. Bell writes about how we, as believers, must live as a human, neither angel or animal, but somewhere in between:

> [EXT]"Angels were here before us. Animals were here before us. When we act like angels or animals, we're acting like beings who were created before us. We're going backward in creation. We're going the wrong way…our actions, then, aren't isolated. Nothing involving sex exists independent of and disconnected from everything around it. How we act determines the kind of world we're creating. And with every action, we're continuing the ongoing creation of

> the world. The question is, what kind of world are we creating? How we live matters because God made us human. Which means we aren't angels. And we aren't animals." [/EXT]

The question he asks is applicable to every person, at every juncture of life, what kind of world are we creating? In the context of our sexuality, we must ask ourselves this question. Do we see sexuality as something to fear, or have we trusted the God created sexuality as a powerful tool for creating? How do we use our sexuality for the glory of God? How do we use our bodies for creating? The secular culture leads us to believe that we are animals (i.e., over-sexualized) and often the church leads us to believe we are angels (i.e., asexual). In particular, the woman's body through pregnancy demands us to see that sex is designed to create life. What kind of a world are you creating, one of objectification or true intimacy?

Objectification: Gray Matter

My husband has a brilliant red t-shirt that reads, "porn kills love". I will tell you what, if anything it is a conversation starter whenever he wears it. My husband also is a therapist who specializes in porn addiction. I am a therapist who specializes in healthy sexuality, so you can see we are constantly around conversations and research about sexual harm and sexual health. It wasn't surprising to me when I woke up one night after jarring sexual dream. In the dream, I was watching a man masturbate as he looked at pornography on a computer screen. There was gray ash-like matter coming from his moving hand and drifting into the air, much like fog from pollution. I was suspended into the night atmosphere as I watched the gray matter slough off of houses all through the city. The gray matter filled the atmosphere like smog in a major industrial city. I become

aware that women all over the world are breathing in this toxic haze, and it is making them sick. I am suffocating from the claustrophobic pollution, waiting for a call from my husband to tell me where to go to find safety from it. There are men looking for me, and I know they are trying to find and rape me. My husband finally calls, and through the broken-up reception he explains that the gray matter is killing women everywhere. It fills their lungs and their bodies, and they are dying. I hear the men who are chasing me getting closer and I start running, my husband tells me that he will never see me again but that I must run to the forest's edge where my sister is waiting to drive us across the border. I run, but before I can make it to her, I am captured by the men and raped to my death. I wake up screaming.

Whew. Take a deep breath. It is a sobering and intense dream.

Because I work with women who are partnered with sex addicts, much of the transference my brain attempts to regulate after years of working with stories about sexual trauma and abuse. Thankfully, I have had some training in dream analysis, and as a therapist who often works with the realms of sexuality, I know a bit about how to navigate this dream. I woke up and wrote for hours after I had this particular dream. Evil felt very near. The dream's narrative speaks to why I believe we as Christians absolutely must understand sexuality. God created sexuality with power in mind, power for good. Evil has had other ideas about how to use sexuality for harm, hate, and darkness. Sexual assault, rape, and incest are prevalent in our world. One out of every three women have been sexually abused. *Evil would not be running rampant with sexual harm if it weren't just as powerful a weapon for good.* Again, evil would not have the ability do so much harm with sexuality if God had not created it with the intent of empowerment. Would

God have created sex if He had known how much pain and harm it would bring? Our Creator had a plan, a good one when he designed sex.

For weeks after this encounter, I pondered my dream and what could combat this "gray matter" from sexual harm, if indeed it were poisoning us. I spent a few weeks reading peer reviewed research on the effects of pornography on women's sexuality and health. There is causing to believe the effects of an objectifying society can be seen in the deterioration of women and their health. How could we stop this? What counteracts this destructive gray matter? My answer is holy intimacy and sex, or what I call gold dust.

Intimacy: Gold Dust

There is a small corner in North Seattle, the intersection of 90th and Aurora Avenue to be exact, where my church runs a neighborhood ministry for sexually trafficked women. These are women who spend their lives selling sex for money, food, and drugs. You can imagine the sexual harm and trauma these women have endured and witnessed. I am friends with some of these women. I spend time with them every first Wednesday of the month, and they teach me about God in more ways than I ever imagined. They teach me about hope and resilience, but even more they teach me about what combats this gray matter of sexual harm. *Gold dust* is the term I have given to what I believe is produced when someone engages in sexual health. Sexuality is objectified in society and shamed and/or silenced in the Christian world. As believers, we must learn the power of holy and healthy sexuality. Pope John Paul II wrote an entire book on the subject, The Theology of the Body: Human Love in the Divine Plan, in which he states:

[EXT] "Man thus ceases to live as a person and a subject. Regardless of all intentions and declarations to the contrary, *he becomes merely an object*. This neo-Manichaean culture

has led, for example, to human sexuality being regarded more *as an area for manipulation and exploitation* than as the basis of that primordial *wonder* which led Adam on the morning of creation to exclaim before Eve: "This at last is bone of my bones and flesh of my flesh" (Gen. 2:23). This same wonder is echoed in the words of the Song of Solomon: "You have ravished my heart, my sister, my bride, you have ravished my heart with a glance of your eyes."[/EXT]

We must realize that we are not objects, manipulation and exploitation; the body is something of wonder. Good sex, life-giving sex, metaphorically emits a gold dust into the atmosphere. Of course, there is no scientific research affirming the existence of gray matter or gold dust, but the imagery is helpful when considering the effects of sexuality in the realm of spiritual warfare. I often recall my seminary professors' question: what is God's design for sexuality? It can't only be a reproduction, otherwise, He would never have given women a clitoris. The clitoris has more never endings than the head of a penis and it has no other biological function than to give pleasure. God was to be intentional when He created the clitoris, a body part that is only for pleasure and this pleasure has to have a spiritual component, which I believe is spiritual power. As I pondered these concepts, I eventually began to envision that gold dust could dissipate the gray matter. It took me twelve years of research to answer my professor's question. I believe God created the clitoris as a part of His intent for sexuality play a role in defeating evil.

Gold dust is life. Gray matter is death.

Blessing and Encounter

True intimacy invites us into the divine. Technology is a false example of intimacy, and pornography is a false example of sexuality. We have come to replace our real human experiences will counterfeits that are keeping us from the true design God intended our bodies to experience. In his book Anam Cara, John O'Donohue writes,

> [EXT]"The Bible says that no one can see God and live. In a transferred sense, no person can see himself and live. All you can ever achieve is a sense of your soul. You gain little glimpses of its light, color, and contours. You feel the inspiration of its possibilities and the wonder of its mysteries. In the Celtic tradition, and especially in the Gaelic language, there is a refined sense of the sacredness that the approach to another person should embody. The word ***hello*** does not exist in Gaelic. That way that you encounter someone is through blessing. You say, *Dia Dhuit,* God be with you. The response, *Dia is Muire dhuit*, God and Mary be with you. When you are leaving a person, you say, *Go gcumhdai Dia thu*, May God come to your assistance or *Go gcoinne Dia thu*, May God keep you. The ritual of encounter is framed at the beginning and at the end with blessing. [/EXT]

The word hello does not exist in Gaelic.

The way you encounter someone is through blessing.

I find myself simultaneously intrigued and turned off by this statement. No one says "hello", rather they say a blessing? Wow. Will we as a society learn to bless ourselves and each other instead of making the human soul an object. The work it takes to make eye contact and say a blessing when you see someone. The exhausted woman in me

cringes at the thought of using my imagination and energy to bless someone, rather than sit on my phone and click "like" on forty of my friends' photos social media accounts.

In my house, we have been working on saying "excuse me" when walking through crowds while in public places. My three-year-old looks directly in strangers' eyes and yells "Excuse me!" with pride and confidence. My five-year-old, on the other hand, looks down and mumbles the words as we move through the masses. I sometimes come down to his level and ask him to speak up and make eye contact with the person we are walking past. He wrestles with the work of encountering the other.

To bless someone is intimate; it produces intimacy between the two blessings each other.

To encounter take someone in and invited to the sensuality and often sexuality of the other person. In a research study on the levels of oxytocin in rats' brains, studies showed that oxytocin never spiked higher than at the initial time a rat met another rat. Monogamy offered little opportunity for heightened arousal, but when a new rat partner was introduced, oxytocin once again spiked. For parturient and lactating rats, oxytocin was elevated after birth and during breastfeeding. The conclusion of the study showed a defeating result for monogamous couples, your oxytocin likely doesn't ever spike higher than the first time you kiss or have sex, except during breastfeeding. Thus, the term "mating in captivity" brings a difficult challenge to keeping the love alive in your marriage, particularly on a hormonal level.

If there is room for me to push you further into this concept, I might venture to say in particular of a women's sexuality, God created women's sexuality with a purpose. Our voice and our sexual pleasure are part of our calling to live a holy life. There is

something in the beauty of a woman's body that reminds all humans of glory. This glory is most personified when it resonates deeply with our own beauty and a clear remembering of where I come from. The power of the female gender is living and wild. We have the power to save the world through God-ordained pleasure, healthy sexuality, and the belief that love defeats all evil and death. There is no war, no death, no hopelessness that can take away what the power of love can do. I believe women hold this truth deep inside of them.

Blessing the Sexually Wounded Place

It has been three weeks since the D&C, there is little bleeding if any, and I am crying in my husband's arms. The kids are asleep, and we are attempting to have sex, but I can't stop crying. Sex is such an act of the present. My body and mind are timid and scared. My vagina remembers what my mind can't articulate, three weeks ago the pieces of our lifeless child were taken through this passageway and now my husband wants to enter this same place. Truly, this is not a moment I can explain completely, yet my choices are to either: engage and share this deep sadness with myself and my partner, or to silence this great grief and not offer him any invitation to intimacy. Sex is still such a taboo conversation in the church, yet there is such a power and holiness in sex that is not taught. When we offer our stretched skin and scarred bodies, which we have carried all of our lives, we are offering the greatest intimacy. When we bring our history of wounded heartaches and our broken pieces to another person, again and again, we are invited into a the holy of holies. What has come to be mating in captivity can be an invitation to the most intimate place.

The holy of holies is the inner chamber of a sanctuary, separated by a thin veil. A place believed to be the most sacred and to be entered to receive atonement. I cannot prove that God made a woman's vagina to represent this concept, but there is something so sacred to be invited to enter into a person's body. I remember going into the hospital to birth my second child and my OBGYN wanted to try to break my water. She looked at me straight in the eyes, her lavender gloved hand ready, she said, "Christy, I am going into God's country now". I laughed out loud. Yet her words ring clear in my mind, there was a jovial honoring that she was going to enter my body with reverence to check on the baby ready to be birthed. Her recognition, as a doctor, was that something divine had created my uterus and my vagina and it was a holy place. Our vaginas are not to be entered or engaged without honor and awe; it is an invitation to the holy of holies.

Sadly, I have the honor of working with many women who have had some type of sexual harm done to their bodies. Whether by childhood sexual harm, domestic violence, rape or trauma, I sit with hundreds of women who have received scars in the most sacred place inside of their bodies. Sometimes these memories don't surface until decades later when they are engaged in some type of physical act: sex, birth, a painful period, etc. Once these stories emerge, we begin the process of psychological surgery in which we clean out a wound and re-suture. Our bodies want to heal and if we follow a few practices, our bodies will recover. This process can only be done when we honor our wounding by grieving and burying what has died. My husband and I were ambivalent around intimacy and pleasure during our grief; we had no guide on how to offer our traumatized bodies to each other in the holy and pleasurable act of sex. We had to first grieve together before we were able to find any pleasure in this sacred place. Sex needed to become something

more than pleasure and an act of procreation, sex had to become the most powerful prayer where both grief and pleasure could co-exist.

During a podcast interview with my friend and author Beth Bruno, she made a statement about the parallel between the way of a suffering Christ walked within the woman's body. She said, "I just pictured as you spoke about the theology of the womb, that the vaginal canal is like the Via Dolorosa, the way of suffering, it is placed in the woman's body that is the path from death into life." I was taken aback by her imagery, because yes, she was naming so clearly what I have come to find true, the place in which death and life pass within a woman's body is her vaginal canal. Blessing the wounded sexual place requires one's partner to enter her most wounded place, the vaginal canal. This imagery of entering each other's wounded places, through sex, is mimicked with Christ's invitation to understanding the *cost and gift* of co-creating, it is a part of the sacrament of marriage. Sex and marriage invite us to know the co-creation with our Creator. Individually, as women, we are being offered an invitation to know God as Creator through the cycle of our womb.

Breasts

Chapter 5 Questions: Sexuality

1. What do you believe God's purpose was when He created your sexual organs and sexual pleasure?
2. What do you think about your clitoris only being created to give you pleasure, as it has no other physiological function?
3. What is your understanding of God's hope and plan for sexuality in this world as a Christian?
4. How do you engage your sexual health, sexual pleasure, and the power of God's design for your sexuality?

9

A Menopausal God

"I don't like to call them hot flashes, I prefer the term, *power surges*."

-Mary Christine Anthony, my mom

Empty Nesting

The oak wood kitchen is quiet. She loads the dishwasher while worship music plays in the background. It had been a beautiful, full weekend with her grown kids all home from college, but they were each headed their separate ways back to school. Her husband had left for work at 8:15am, as he had for the past thirty-two years. She exhales. *What will I do with my life now that motherhood is slowed down?* She thinks of her art studio in the backyard, she hasn't been in there to paint for more than a few hours in the past twelve years. She doesn't know who she will meet if she returns there. Her all-consuming task as mother has shifted, and she is settling into her empty nest. Much of the younger woman's life is determined by how her body is looked at and the level of objectification to her physical beauty. For many women, this season of aging often has been described as the feeling of disappearing and becoming invisible. Because a woman learns to navigate this world in relationship to her body, she must relearn the process of engaging her voice in the final season of her life.

Studies show that the average women reach menopause by the age of 52 and that lower socioeconomic areas report women reaching menopause as early as 43 years of age. Richard Rohr writes about this season of life as falling upward, He explains that first half of our life is about building a strong "container" made up of rites of passages, marking, gains, and losses. He explains that "the task with the second half of life is to take what we have been given and learn how to deliver it". In other words, the container we built in the beginning of our life holds all that we are to birth in the second half of our life. This is a new season for women, a postpartum of sorts, for the womb. Psychological well-being is shown to be high among menopausal women who have marked gains and losses throughout their lives.

Lifespan of the Womb

No matter how gray and rainy the Seattle sky might be, for over five years of Wednesday afternoons, you could find me in a chipper mood crossing the beautiful but soggy campus of Seattle University. As I settle into my dry classroom, I let soft music play as I begin to draw graphs and notes on the dry erase boards around the perimeter of the classroom. On Wednesdays, I teach one of my favorite classes, Human Growth and Development, or otherwise called Lifespan. There are so many things I enjoy about counseling theories in the lifespan, but my favorite is the lifespan of the female womb and how it illustrates a timeline filled with wonders, anguish and the mystery of cyclical life and death.

Psychology implores us to observe physiological patterns, such as the fact that when a baby girl is in utero, she has about 6 million egg cells in her body, and when she is born, she will still have around 2 million egg cells. In the first 10 to 13 years of life, her growing body will absorb almost 1.5 million egg cells, leaving about 400,00 eggs in her

ovaries. As a young girl reaches puberty, her body will begin by budding breasts, followed by pubic hair and finally axillary hair. Once the female body produces axillary hair, within a few months, a girl will begin her menstrual cycle. There are only about four hundred eggs that will actually go through the ovulation process. If we continue to follow the woman's body, we see that after ten years of practicing ovulation, she will reach her peak decade for reproduction. Reproduction will span a woman's mid-20s to mid-30s, encompassing but not limited to: infertility, miscarriage, stillbirth, birth, postpartum, and breastfeeding. During a woman's late 30's to early 40's, she moves into a stage called senescing, which means growing down. Climacteric is specific to the uterus senescing; the womb will gradually lose the ability to reproductive because of a decrease in the circulation of estradiol and estrogen.

The lifespan of this one organ echoes to us that the heart of our Creator longs for humans to create. This cycle of creating something is more complex than we ever imagined; it requires seasons of growth, risk, failure, and success. Creating is an intimate process that requires incredible vulnerability. Our Creator desired for us to co-create with Him. God is a God who wants life, and don't limit this idea to physical life alone; it is so much larger than just a human life. God invited all humans to take part in creating, because our God is an Ever-bearing God. Our loving God has made every creature ever-bearing with hopes that we will worship by creating life everywhere we are. Whether this is spiritual, emotional, or physical life; there is a cycle we can engage in with God as we co-create. This cycle, which includes everything from hope and celebration to trauma and loss, is studied in the psychological process of gains and losses throughout our lifetime.

Marking: Gains & Losses

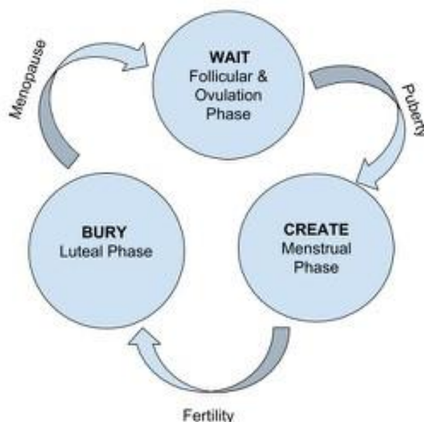
Over each of our lifespans, our life cycle will have gains and losses. Our losses increase as we grow older; these losses begin to increase in the later 30's to mid 40's and spike significantly after 70 until death. How we manage increased losses in our aging life will often mirror how we marked the gains in our adolescent life. Earlier in the chapters of menarche, we talked about rites of passage, which are indicators of how we marked significant moments in our life. Rites of passage are described as marking an important stage in one's life or an event associated with crisis or change of status: especially birth, puberty, or illness. How did we come to celebrate rites of passage such as naming, coming of age, graduations, leaving home, weddings, birthing children, empty nesting? If done in an intentional and healthy way, a person can look to their story and see times of marking or making meaning of both gains and losses in our lives. In many cultures, marking is done through intentional actions that we participate in to make meaning of different events in our lives: a baptism, *quinceaneras*, bar mitzvah, wedding, or funeral. Rites of passage, ceremonies, and rituals are all historical ways humans have engaged our bodies as we grow older. Research shows that marking and finding meaning impacts how we cope later in life with the increased losses that we inevitably encounter as we age.

This life-cycle of increased gain followed by increased loss is easily seen in parallel to the life cycle of the woman's womb. The womb moves through the stages of ovulation and reproduction, which compose our season of significant gains, and finally comes to the stage of menopause, to our season of increased loss. In the season of senescing, the womb goes to sleep and in the death of a woman, she is remembered by her legacy. God created the womb to leave an everlasting legacy through the birth of

another female who carries a womb. In every female body is a womb that carries eggs and every woman gives a "x" chromosome which creates another female who will continue her legacy with the womb filled with eggs her mother gives her. The life cycle of one's ovaries and uterus were created with the potential to birth a life which would, in most cases, continue to bring forth more life, even after her death. For example, a woman who has a daughter is gives life to an ever-bearing life. A womb that creates another female leaves a legacy.

Cyclical Theology & Life Cycles

My sweet boy's hands are shaking with excitement as he shows me the project he has been working on for weeks now at school. I look slowly and deliberately at each page of the book he has compiled and read aloud to him the words he has carved out. The book is on the subject of the life cycle of an apple tree: seeds, tree, bud, flower, and fruit. His pages contain seeds and drawings, which he explains with great detail. His voice holds such wonder at the cycle of life. My forty-year-old body is very aware of the life cycle, as it has spent the last decade navigating pregnancies and births. All life is cyclical. Our produce moves from seed to bud to flower to fruit; our planet spins on its axis each day and rotates around the sun each year; our seasons move through spring, summer, autumn, and winter.



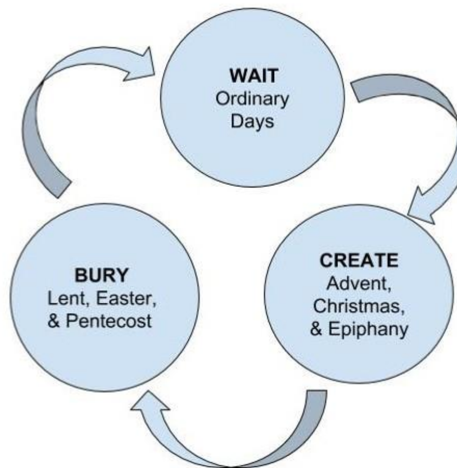
These life cycles are all interconnected, and miraculously so. For humans, the female body bears and illustrates the power of the life cycle. The female body is birthed, grows into puberty, on to fertility and pregnancy, and then menopause. There is a cyclical pattern to the lifespan and, in particular, the lifespan of the uterus or womb. The womb, or uterus, is an organ held in a woman's body which will naturally cycle through three stages in its lifetime: adolescing, a decade for practicing ovulation; procreation, a decade for peak reproduction and senescing, a decade of climacteric. In other words, when we observe the lifespan of a uterus in a woman's body, the uterus will grow, menstruate, reproduce, and eventually die. A woman's body bears another cycle every 28 days, and much like the 24 hours from sunrise to sunrise tells us a story of creation, the uterus tells a story monthly through the female cycle. If we look to these cycles and study the phases, we see that the Creator was trying to explain to us again and again the process of creation. When God created woman, he tucked in the core of her being an organ that is capable of creating human life. God designed the uterus to convey God's image as Creator. This organ tells us a

story in its life, in the cycles it makes every month. The female uterus is the part of the body that illustrates the *imago dei* through the process of creating. We will compare the cycle of the uterus with the cycle of creation; the God as Creator, demonstrated by women as co-creators with God and man to bring human life into this world.

There are four phases in the monthly cycle of the uterus: menstruation (day 1 to 5), follicular phase (day 1 to 13), ovulation phase (day 14) and luteal phase (day 15 to 28). Imagine these phases as being parallel to the story God has created on this earth for His people. The sacred text of Genesis 1 illustrates these phases within the creation story: light and darkness, water and land, male and female animals, and finally the human, both body and soul. Science gives a technical breakdown of the hormones and actions in each phase, but in essence, there is a phase in which one must: birth (menstrual), wait (follicular), consummate (ovulation), and bury (luteal).

The circle has long been known as one of the most powerful symbols representing wholeness and cyclical movement. Mercury Trismegistus, *De Docta Ignorantia*, says, “God is a circle whose center is everywhere and whose circumference is nowhere”. We often use the circle as a way of coming together in power, such as a when we gather into a circle to pray. The crown of thorns that Jesus Christ wore on the cross is the most powerful circle to ward against evil; those who work in spiritual warfare use the power of the blood that Christ shed on the cross as their foundation of healing.

These cycles are not only found in the metaphysical life; they also are Biblical and correspond to the life of a believer, for example:



When our way of living is examined through a cyclical lens, we find that our bodies and, in particular, a woman's uterus, work in a consistent rotation. With earthly eyes we can easily see the changing of seasons, and with spiritual eyes we can understand the cyclical holy days in the church calendar. Consequently, from a bio-psycho-spiritual understanding, we can see that the female body invites us to uncover a cyclical pattern which can help clarify concepts of spiritual, psychological, and physical interconnectedness.

Theology of the Womb

Chapter 9 Questions: A Menopausal God

1. How do you mark gains and losses in your life?
2. How do you celebrate and how do you grieve?
3. How do you see life cycles in your own story and what themes do they hold for your story?

Chapter Five: A Brave Lament Manuscript

A Brave Lament

This chapter published as Bauman, A. & Bauman, C., Tucker, B. (2017). *A Brave Lament*. [Motion Picture]. United States: Fob & Dongle Productions.

A Brave Lament Film Transcription

Christy:	00:02	Gosh, I don't know how old I was, but 2005.
Andrew:	00:08	I had one buddy, he was going out with a few girls and needed a wing man to just kind of get his back because he was a little nervous and I had my eyes on Christy and I was like, man, I think this girl is funny and cute.
Christy:	00:22	I really talked to him. [inaudible 00:00:23] we're walking down the street, there's a bunch of us friends and he hears me talking about teaching cycling and he runs in front and pulls up his pant leg and he's like, feel my calves, I cycle.
Andrew:	00:35	I have pretty good size calves, I don't know if you have time to show my calves but at some point I can show you my massive calves. So, I use those to my advantage

Christy:	00:44	And I'm like that's really weird, no I'm not going to feel your calves.
Andrew:	00:48	It was a little awkward but it worked, she was intrigued.
Christy:	00:53	We were like out and we were just kind of like bar hopping until like two in the morning and he and I were outside of the bar drinking water, talking about Kierkegaard and these like crazy philosophers.
Andrew:	01:06	That was the beginning of that long journey.
		[MUSIC]
Andrew:	01:33	Ready? One, two, three, Christy's pregnant, one, two, three, Christy's pregnant.
Christy:	01:48	We're having a baby, were pregnant.
Unknown:	02:07	You're having a baby.
Andrew:	02:10	What does that, what does that mean? What did that mean to you guys?
Christy:	02:17	I would say in anticipation of our first child we were wildly free.
Andrew:	02:23	Stick it out.
Christy:	02:24	I think there was this like an abundant play in the whole process. It was like fun to give life.

Andy:	02:30	Andrew and Christy are such, they get really excited about things, dreaming and imagining. So, when they were pregnant that kid was alive. He had an identity, he had a name. We all felt like we knew him already.
Heather:	02:43	I think the way that they were so anticipatory of their son, like I was connected to that. They live very outwardly and so I had an attachment to Brave.
Alyssa:	02:55	I don't know that I've experienced two people more excited to meet their baby.
Andy:	03:02	You know, they would talk about like what he was doing in the womb and like, they would have conversations with him and we all kind of, you know, felt pretty responsive to that.
Andrew:	03:14	I was wildly, as static, wildly naive and just wildly hopeful.
		[MUSIC]
Christy:	03:40	My body birth a baby and it's like this powerful moment and then this really futile like infant tile feeling.
Andrew:	03:51	I could not believe that he wasn't alive and I just remember, falling to the ground and just crumbling.

Christy:	04:03	It's like the epitome of everything being so wrong, in the midst of something being so right.
Andrew:	04:10	I couldn't believe the courage that my wife had in that moment and I want it to match, her courage and be, half as brave as she was.
Andy:	04:24	So, I held him in the hospital, which was one of the greatest honors in my life. I remember when Andrew handed him to me, he was like, you need to remember our son. Like I'm willing to let you hold this boy, but you have to commit to remembering him.
Christy:	04:45	We kept him in the room with us for 12 hours, it's a little bit crazy making, holding death that close for that long.
Andrew:	04:55	And that moment, neither of us had a choice, right? Like it wasn't a choice. We had to choose, and we had to choose to do death the best we could, whatever that means.
		[MUSIC]
Christy:	05:10	Looking back, if anything, I wish I could have captured all of those moments so I could remember that woman because she was so free and she was so wild and she was so excited and I don't think that I

		can tap into that kind of excitement like I used to, I don't think I'll ever feel that again.
		[MUSIC]
Andrew:	05:47	Hey, breakfast kitty, kitty, Kitty breakfast. Wow, the kids listened to me. Five seconds to come down here or you're all in trouble forever.
Child :	06:03	It's hot.
Andrew:	06:06	Blow on it.
Child :	06:10	You scoop it and then you blow on it.
Andrew:	06:10	That's right.
Child :	06:16	I'm thirsty too.
Andrew:	06:19	Well, how do you ask?
Child :	06:19	Please.
Andrew:	06:22	Here, we had Wilder like a year after we lost Brave, which was soon and we had so much anxiety. Christy struggled with deep anxiety and panic attacks for at least two years after. Part of me went back and forth of like struggling with it, but also hiding my own anxiety to try to be strong for Christy, but yet, I was so scared too, I was so scared that we were going to lose Wilder and it's interesting how I think it's more particular to wilder

		than it even is to Salem and maybe just because of how close we had him from after losing Brave.
Andrew:	07:18	I was in my second year of being a private practice therapist when we lost Brave. As I re-entered the work just to kind of allowed clients to engage with me, any questions they had and just being very open with my heartache and open with my grief and even giving my clients permission to enter their own stories of heartache and grief and me honoring my own story. I felt like even just freed my clients all the more to engage their own.
Christy:	08:10	I think I told you guys the story of working in the oncology unit and women who were getting mastectomies and I sat with a couple and the husband just said, I'm still hormonal, I still want sex, my wife doesn't want it, I'm not as attracted to her, her body has been harmed, she doesn't have breasts anymore. What do I do? I'm not attracted to her.
	08:33	And I'm sitting there like, Geez, this is my, like second year I'm working in an oncology unit and I'm like, I'm so glad I still have a supervisor because I have no idea what to do. I go to my supervisor and

I say, what do I do? And she says, the most incredible intimacy is when we enter the wounded place. I'm working with people one on one in therapy to kind of free them and to find their voice and help them step into their voice and in the classroom, I feel the same way, like I am trying to educate people to then help other people find their voice and step into it and the only way I've learned to step into my own voice has been to hold and face my own tragedy and my own grief.

[MUSIC]

Andy: <u>09:28</u> If you have come here to help me, be comforted or giving some sort of reassurance that everything is okay, Somehow, I think you will find yourself dissatisfied today.

[MUSIC]

Bonnie: <u>09:42</u> I have never been through anything like this before and I loved him. I love how the nurse did his foot prints and his finger prints and you can't see it in this picture, but his arms were covered with black hair like Andrew's.

Alyssa: <u>10:04</u> As we prepared to go to the hospital on Wednesday evening, many times you've looked me in the eyes,

Christy and you asked me, how are you going to do this? My answer was, I don't know. The truth is I didn't know what needed to transpire in the next few days would require courage that I couldn't comprehend to be my role as simply reminded you put one foot in front of the other. But it was nearly impossible to stay in the present as you birth your son. Christy, you did it. With your hands holding the womb where he slept, you spoke to your son often throughout labor. “You got this Brave”, you would say as you coaxed him into this world. And I, I heard him speak loving encouragement right back to you. We got this mom.

Christy: 11:36 It's interesting when I think about how I survived in my sorrow, I can only think of stories, images in my head and I remember when we got in the elevator and went to see the ultrasound and it was the eeriest empties sound because you could see there was no heartbeat right away. And we got in the car and drove to Andy and Lisa's house and there were people there.

Andy: 12:07 Everybody just ended up coming over to our house. Somehow, our house turned into this really sacred

		just space of lamenting and crying out. It was this really intense, just wailing.
		[MUSIC]
Christy:	12:28	There were so many people there, like all the people who knew Brave was coming any minute and they're just weeping. Like no one even said anything to me, not even a word. No one said anything, they just were weeping when I walked in. I didn't want to be alone and get swallowed up by my grief and somehow their example taught me, taught me what mattered. It matters to not be alone; it matters to ask to be loved, it matters to be touched. It matters to have a place to talk about it.
Christy:	13:20	Oh, that's your favorite?
Andrew:	13:27	I think we love our kids differently because of how much we lost and how much we didn't get to love Brave in the way we wanted to. I think we just love them really intensely, which I think allows them to feel safely attached to us and freer to be their true selves in a really cool way.
Andrew & Child:	14:13	Good night hyena. Good night, Good night, Good night. **[Scream]** There’s a monkey in my bed.
Christy:	14:37	I’m pregnant.

Andrew: 14:51 What did it say?

Christy: 14:52 I'm pregnant.

Female: 14:53 I understand that you're calling to schedule a new OB appointment. Is that accurate?

Christy: 15:00 Yes, I am.

Andrew: 15:02 I think I'm more hopeful because we've had a couple of successful pregnancies and couple of beautiful kids and yet there's still something that in my heart that's stopping me, that's whispering to me, no, Andrew don't, don't get excited, don't hope. How do you feel?

Christy: 15:21 I feel like it's part of the process, you know. I mean, I just feel like relief doesn't come when right now relief will come when I hear a heartbeat, but I mean that's our story. Relief won't come until there's a baby in our arms that's live and healthy and that's just how it is for us.

[MUSIC]

Christy: 15:54 The fear of being mocked has come up for me with death. Like there's a sense of, when I choose life, the only thing that can mock me is death and I've had to war that with anxiety, where I either choose to keep living or I just, I become crazy in my

anxiety because I'm so fearful of more death and there's something about being in the midst of a pregnancy that I'm always kind of at the mercy of death mocking me. That's where I think play in life is the only way I can respond.

[MUSIC]

Alyssa:	16:41	The minute I get in the car with these women, it's complete ease. I've been at several of their births. I have been in deep grief with them and your relationships catapult to another level when you've experienced that kind of hardship together and done it well. So, to face grief, head on and to greet it as you would any other emotion and to spend time with it and to not run from it.
Christy:	17:16	The women who surrounded me taught me how to keep breathing taught me that ritual is necessary, to not go crazy and I can figure that all out in psychology it says the same things, but it didn't say it the way doing life with these women said it, they were my teachers.

[MUSIC]

Andrew:	17:50	I think that jacket is going to fit you, it's a little big, but you think we should keep it or should you try it on another one?
Wilder:	17:59	Keep it.
Andrew:	17:59	That's cool. Which way you going?
Wilder:	18:02	I'm going this way.
Andrew:	18:03	Should we follow you? Can we follow you?
Wilder:	18:12	Yeah.
Andrew:	18:14	Let's go right here and we're just going to stop by.
Child:	18:20	There he is, it's a bear.
Christy:	18:26	In the beginning it feels as if we were visiting the grave multiple times a day.
Andrew:	18:33	I want to just be really gentle.
Andrew:	18:35	Respectful. You couldn't pull me away from the grave. I mean, I was there every day, sometimes multiple times a day.
Christy:	18:46	Okay, jump in, tell Brave you love him.
Child:	18:48	We love you Brave.
Andrew:	18:52	It was no longer kind to myself and my own process to go. And that brings up guilt, like, am I doing enough or am I loving him enough? And I still wrestling with that at times and yet, in my kinder

moments, I think I'm doing what's best for us, for him, for me,

[MUSIC]

Andrew: 19:23 I think one of the hardest parts after losing Brave was basically engaging people who didn't understand.

[MUSIC]

Andrew: 19:35 They didn't like seeing me hurt, they didn't like seeing me grief, they didn't like seeing me write blog after blog of heartache, basically sharing my grief and people wanted to fix me. And yet, their ways of helping actually hurt worse. I remember someone wrote me in short email and they basically said, you know, I was praying for you and God told me you were going to have another kid. I got so furious, like how dare you? Even if it's right, it doesn't matter, be with me now. Feel the pain now of the son I lost. Don't talk to me about the kid, I don't know yet, and I couldn't tell you how many people basically didn't know how to engage with me or just stopped, we're just silent, we're just cowards. They didn't know what to say, so they said nothing at all and the pain of silence was worse than

		the pain of them saying something foolish and stupid.
		[MUSIC]
Andrew:	20:38	Because we don't know what to say in the midst of heartache and that's okay, just say, I have no idea what to say, but can I be with you? And that's enough. And that's what many of my friends did and many of my friends didn't do.
		[MUSIC]
Andrew:	21:04	When you lose something so precious, you don't want to be the one to, you know, you want someone else to talk about it. Someone else to bring his name up just to speak his name out loud. Because he's always in me or always with us and so it's always there and so I think, and yet I'm glad to have done enough emotional work to know what I need in the process like.
Andy:	21:34	I think we trust you in that and so I see what the women do and how much they need that. I, I mean, even as they have these like rituals and memories together, I don't know that they're necessarily directly engaging your memory of Brave or I mean,

		probably sometimes, but you know, it seems like that's not the most important thing.
Andrew:	22:01	And just being with each other and whatever they need.
Andy:	22:04	So, there's a way that we're doing that. That's our version of it, you know. Because I think I can see, like if we said, hey, we're going to have a really intentional and ritual time together to remember Brave, like that could feel sort of forced or weird for you or for us. So yeah, it's interesting to think about what the basic needs of a grieving man or grieving community event.
Andrew:	22:38	Totally. If you actually feel your grief, you don't actually have a choice. You just got to do what's inside and yet, it's like I felt that, like I got to be strong or...
Andy:	22:53	You felt that with us?
Andrew:	22:54	No, I think just in general, just like, in regards to living in this world, being a man, having a penis, like I've got to somehow be strong and I can't show my vulnerability or show my weakness in moments of incredible brokenness and I'm wondering how much that plays out and I don't know just start

normal engagement and I think it's unconscious because it's so deeply embedded in us.

[MUSIC]

Heather: 23:36 Part of what I've heard from you guys is that this child of yours is situated in a greater story. The sorrow that you feel for her is different from the sorrow that you felt with the child in the fall and with Brave. The child that you're grieving over it's different this time and that's okay. And that part of what we have to do is remember how this child is connected to the life that's here to the life that has gone already to Brave.

[MUSIC].

Christy: 24:33 We're doing ritual everywhere. However, we're engaging in life and however we turn off the intensity of it is where you're doing ritual. As we're gaining **[inaudible 00:24:47]** more lost, our resilience is pretty depleted, we don't have creativity around how to build resilience, so we look to how we regulate it. We look to ritual to see; how do I make sense of that?

[MUSIC]

Christy: 25:11 So, I come to you with a body that's broken, that's scarred, and what is it to enter the scar? That is the sacred place, but we don't talk about loss. We don't understand that loss is an invitation to the most sacred place. A lot of your clients won't have creativity for their own bodies and for marking and making meaning of what's happening as lost is increasing. Which is why I want you to study what you were taught. How were you taught to cope? How were you taught to relate? What was regulation like in your own story and then therefore, what kind of resilience do have? How do you mark and make meaning of loss?

I love to listen to my voice now. Before it was really quiet and uncertain and shaky and now it just feels like that's the best me and at the end of the day I rest because it's a good voice. But it's taken a lot to name it, good.

There is something in doing life with each of you through the most terrible moments that also like, there's something tenuous and tangible about the moments where we're just together and just speaking freely and sharing stories and being put to

		sleep and having this baby taken out of me. I'm like disoriented, like I'm grasping for life and I'm grasping to create life wherever I can. And I think I'm just, I'm tired of being embarrassed and being quiet and being silent and I'm a grown woman. And I think the thing that keeps calling me too, is I'm going to have to teach my daughter, like she'll carry this story depending on the way that I tell her the story, but I'm learning it too, like for the first time in a way.
Lady:	27:39	Really, it's like in that ancestry that we've been taught to like, not tell the story. It's like a more of a collective story than just you. You know? It's like all of our story, that we share and like there's something we're breaking of that cycle when we actually speak.
Lady:	27:57	It is part of the gift that we give each other is the collective story of life and grief together, joy and anticipation and suffering and none is as rich if we don't have all those elements.
Christy:	28:16	Tonight, like in the ritual, it's like I want to do this. I don't even know if I feel anything, like I don't want to do this. And yet I'm like, I am mothering and

		coaching my own body through what I've watched me have to do with my clients. I'm like, it's going to come up again, Christy, so mark it, walk with your body through it, teach your body, mother your body through this.
Lady:	28:43	Grief works on its own timetable and that you have to honor grief, just as you honor the life.
Alyssa:	28:56	The amount of grief that you allow yourself to experience. I can hardly bear to look at sometimes. I want you to know that, we can hold some of this grief for you, so you don't have to hold it yourself.
Christy:	29:14	I think as I tell this story or tell my story, I think of all women and I think of all men who are choosing in their everyday smallest, most mundane moments to keep breathing and to create something and to create life even if it's their own life. Putting my hands with the kids, it was so mundane. It's like we do it so often, it's like playing in the sand but I always have this flashback of burying Brave and feeling like it was my only time to play with him in the dirt and I replay it in my head and it makes these moments really sacred.
		[MUSIC]

Christy: 30:38 We were just reflecting that the reason we celebrate to the level we celebrate is because of how we've known death and so, I want us to celebrate more and be better at celebration and at marking and so this is our mark. I feel like this is our celebration of the day that we were both born and brought into this life and that's how I think Brave's death has marked us. There are many ways, but how we celebrate is particular to how we've grieved.

Male: 31:14 My Dad's an OBGYN, so I'd seen a lot of pregnant women in my day, but I had never seen two parents so excited, so jovial and so innocent and like what could go wrong? Like children, you know like I've also never seen people so crushed.

Bonnie: 31:41 When we're expecting a baby, we expect to share life, there are certain people's faces that we can't wait to tell. We can't wait to see their joy and their surprise and those people when they find out that a baby's coming, they start having these little hopes. They hope with us, there’s hugs before bedtime or sea shell hunts on the beach or dance parties on the trampoline. I helped these hopes for Brave, as I know many of you did too. When instead of life,

		death came, Christy and Andrew had to come through a crossroads of whether or not to share him, whether or not to share Brave because the task of holding and caring for your still born son is too great for mother and father. We took turns holding him, singing to him and giving him to you, Christy and Andrew, when you asked.
Female:	32:44	I do not remember my life, all life, this life with or without Brave. I don't. Something that I always think about was the moment that we went to bury your son and we saw this machine coming up to put the dirt on top of him and we all knew that was our job. We will bury him, this is our work, no matter how tired, no matter how broken you all were, how exhausted, this is still the work. You make visible what I want so much to be invisible.
Male:	33:51	Your marriage, it was hard to watch you guys grieved differently and throw grief at each other and anger at, you know. It was so hard and there was more anger for me because of what you guys used to play like so easily, you know? And then how to see you guys, I'm strong and I feel like in this season you're in first bloom after a forest fire and as

everyone's speaking here, I just saw the ashes, the landing on everybody's heads and in people's hair and on our food and I think that there's just, there's just a beauty in people who are willing to bloom again after being decimated and I think that's a gift. So, bless you.

Andrew: 34:59 Because of you all, we are semi-normal. Because of you all, we're alive. So, thank you for carrying our broken hearts and being with us in this and continuing to six years later, like the cost is high, it sucks. And yet, we truly believe that as we continue to honor what is true, we will continue to feel a liberation and the deeper goodness and connectedness with each other.

Christy: 35:49 To the level that we've grieved is the level that we've actually found laughter to play. That was our choice after death.

[MUSIC]

Christy: 36:17 The hardest thing after you buries something and something so important is just to have pleasure even just to be naive again, to dance again, to sing again. I think I'm just aware, I see Brave moments in

anybody who chooses to keep creating after they've buried.

[MUSIC]

Chapter Six: Methodology, Findings, & Conclusions

Methodology and Research

Research is mainly divided between qualitative and quantitative methods (Creswell & Poth, 2017). In this manuscript style dissertation, a qualitative case study methodology uses the three manuscripts as ‘cases’ to be explored for factors that impact women’s well-being. Qualitative methods are used when hypothesizing about social sciences, natural sciences, and market research. Qualitative research relies heavily on text and image data obtained through collected narratives. It seeks to answer not only “what” but also “why.” Key components of qualitative research are done by collecting in natural settings, using multiple sources of data, applying inductive and deductive data analysis, allowing for the emergent design, and being holistic and reflective (Creswell & Creswell, 2018).

The researcher is a major instrument in the design, collecting the data themselves through examining documents, observing behavior, and, ultimately, interpreting it. There are unique steps in data analysis, particularly in case study design, in which data is analyzed through coding and theming. In this study, the role of the researcher was to code and theme three manuscripts, searching for the response to her questions. With personal and ethical concerns in mind, inquirers explicitly identify their biases; in this particular study, the researcher is a Caucasian, Christian woman from a high socioeconomic status (SES). Due to the biases of self-reported data, the researcher hired additional researchers to help code and theme to address inter-rater reliability. The importance of inter-rater reliability is to ensure the data collected in the study is representative of the variables measured and assigned the same score. Prior to the collaboration with the other coder, the

researcher used thematic analysis to examine and record patterns that emerged in the data. Both researchers were to list their top three themes from the collected data (Creswell & Creswell, 2018; Creswell & Poth, 2017).

Case studies generally use one of four types of strategy: relying on theoretical propositions, working data “from the ground up,” developing a case description, or examining plausible rival explanations (Yin, 2018, p. 26). The researchers relied on theoretical propositions, which yielded analytical priorities from the data. The original research questions asked were: What factors affected the well-being of women in this study? What barriers impeded the well-being of women in this study? What factors facilitated the well-being of women in this study? These questions were asked during the initial part of the research, which seeks to understand more clearly what affects women’s well-being in areas of inequality, discrimination, and sexism. The primary theories used were Womanist Theology (Walker, 1983) and Feminist Theory (Young, 2000). In contrast, aspects of other theories: Queer Theory (Weed & Schor, 1997), Objectification Theory (Frederickson et al., 2011), Shame Resilience Theory (Brown, 2006), Social-Ecological Model (Ungar, 2011), Lifespan Theory (Broderick & Blewitt, 2015), and the Meaning-Making Model (Park, 2008) were mentioned. Originally, pattern matching, and time-series analysis were considered in the analytical approach to the data. Ultimately, cross-case synthesis was chosen, which applies a cross-analysis of multiple case studies. A cross-case synthesis is a case-based approach that retains the entire case’s integrity and then synthesizes within-case patterns across other cases (Yin, 2018). Only after drawing some tentative within-case patterns were the other cases analyzed for replicative relationships.

Data Description

Manuscript style dissertations allow the researcher's publications to be used as part of the data being researched. The three publications examined in this study have been analyzed with case studies in a qualitative research approach. All three publications are psychological resources used in therapeutic venues of loss, sexuality, and mental health. The manuscript' contained content comprised of personal experiences, therapeutic vignettes, interviews, and clinical case studies. The two memoir manuscripts were heavily cases of personal experience based on the author's personal life and professional experience as a mental health therapist who has served over 435 female clients. The first publication, titled "Persons Who Identify as Lesbian, Gay, Bisexual, Transgender, and Questioning," was a chapter in the book *Embracing Diversity*, which offers Christian counselors a therapeutic guide to addressing substance abuse in LGBTQ+ clients. The second publication was three chapters from the book *Theology of the Womb*, titled "Breasts," "A Sexual God," and "A Menopausal God." *Theology of the Womb* shares therapeutic vignettes and personal experiences that explore the lifespan of women's wombs. The final publication was a transcription of a documentary film, *A Brave Lament*, which is about the grieving process after loss and death (Edwards & Bauman, 2015; Bauman et al., 2017; Bauman, 2019).

Data Analysis

Initially, the researcher coded the data by marking positive or negative mental health issues in the texts as they relate to female sexuality. Each manuscript was coded and themed individually, and then all three were coded and themed as a collective. The researcher color-coded negative themes such as stress, depression, anxiety, negative body

image, isolation, objectification, shame, and internalized oppression. Positive themes that emerged were color-coded also, such as self-awareness, intimacy, connection, resilience, meaning-making, positive body image, and celebration. This data was then analyzed and themed by common particularities in the positive and negative responses. These can be seen in Table 1 below. Each manuscript chapter has a results section that explores the individual themes that emerged from the particular work. This chapter will report on all the data and analyses of the three manuscripts as a collective. Many theories could be used to interpret these findings. I have chosen the lens of Womanist Theology because it incorporates a theology of suffering that comes from discrimination, loss, and objectification that is found in each of the manuscripts. Racial identity is a significant part of Womanist Theology; however, race is not one of the significant themes in these manuscripts. This will be the primary lens of interpretation. In the following sections, secondary theories will provide additional understanding into the themes present therein.

Table 1

Mental Health Corresponding Events

Positive Mental Health	Events	Negative Mental Health
Grieving	Events of Loss	Silence
Create/Co-create	Pleasure	Shame
Acceptance	Vulnerability	Stigmatization/Stereotype
Resilience	Trauma	Stress/Cortisol (PTSD)
Communal Connection	Societal Event	Isolation (lack of community)

		Minimizing/Lack of
Meaning/Marking	Gains	meaning
Positive Body Image	Scars	Negative Body Image

Findings & Results: *Embracing Diversity: LGBTQ* Manuscript

Feminist Theory and Womanist Theology are the major theoretical frameworks evident in this publication. Mental health effects of internalizing the others' perspective of your body and mitigating your internal experiences were connected with objectification and discrimination. Negative body image and self-esteem issues were common both in this population and overall general issues of sexuality. There were no significant connections to positive body image or self-esteem. The social and communal influence was very highly correlated with negative or positive mental health experiences. Stress (32), shame (30), and substance abuse (28) were all closely associated with the social environment. Social support (61) was the highest indicator of positive mental health in the LGBTQ+ population. Societal Systems (31) (i.e., laws, lawmakers, and judicial support) and communal support (30) (i.e., family of origin, family of choice, and peers) were the prominent factors of advocacy, resilience and other positive mental health. Therapist support (10), including self-reflection and empowerment work, was not as influential as social connection and societal acceptance. Here is an example coding negative factors, such as stress, pressure, marginalized, rejection, and discrimination in the manuscript from the LGBTQ+ chapter, *Persons Who Identify as Lesbian, Gay, Bisexual, Transgender and Questioning*, illustrating these findings is shown as:

> Sexual minority stress is also a contributor to use and abuse, pointing to the social pressure of being part of a marginalized group. An additional consideration related to this issue is that of support systems. Compared to other marginalized groups (e.g., people of color), LGBTQ individuals may not have the typical support systems such as family of origin, who understand or share their experiences as a member of a minority group. Often, LGBTQ individuals face discrimination and rejection by the family and other typical supportive networks. (Edwards & Bauman, 2015, p. 253)

Here is an example of coding positive factors that affect the well-being of women in this study, particular in the LGBTQ+ chapter is as follows:

> Identifying, utilizing, and creating support networks, recognizing role models, visualizing self as a potential role model for others, and being able to self-advocate are identified as resiliency factors. Counselors may support clients by assisting them in identifying existing and available support systems in their live and helping clients find their voices to advocate for themselves and others. (Edwards & Bauman, 2015, p. 256)

These quotes offer examples of how the researchers coded the impacts of social support, self-identity, discrimination, and stress on a person who identifies as LGBTQ+. A Womanist lens addresses heterosexism, classism, feeling bullied, dehumanizing experiences (e.g., invisibilization and somebodiness) which is being identified in the chapter as common experiences which affect overall psychological well-being (Townes, 2015, p. 140). Secondary, Objectification Theory supports the notion that reduction of human's bodies to objects has a negative impact on body image, self-esteem, self-

efficacy, and self-compassion (Watson et al., 2018). Throughout the LGBTQ chapter, individuals who identified their sexual orientation other than heterosexual incurred some kind of discrimination which resulted in a negative impact on their well-being. There was a connection in the literature (e.g., Ahuja et al., 2015; Almeida et al., 2009; Lightsey, 2015) between the societal devaluation of a human based on sexual orientation with stress and shame.

Findings & Results: *Theology of the Womb* Manuscript (Chapters 4, 5, & 9)

The negative mental health factors in the *Theology of the Womb* manuscript (Bauman, 2019) display shame (48) and negative body image (39) attributing highly with trauma (37), and societal influences (20). These findings are in congruence with the Womanist Theology with secondary theories such as Objectification Theory, Sexual Objectification Theory, and Shame Resilience Theory supporting these results (Brown, 2006; Clark, 2017; McKenzie et al., 2018). Results show affirmative mental health ascribed mostly with meaning-making (76), positive body image (57), positive social connection (28), and spirituality (26) in this manuscript. These outcomes are consistent with the Womanist Theology, Objectification Theory, and Shame Resilience Theory.

One example of negative mental health factors from the *Theology of the Womb* manuscript (Bauman, 2019, p. 49) is illustrated as:

> Where her breasts once were, she sees an imperfect diagonal suture line across her chest. She will no longer see the breasts that she bought bras to fit, tugged blouses to cover, her boson where lovers had nuzzled, her babies suckled. She stares, taking in the unjust barter of her beautiful breast replaced by a purplish-red scar. I wait patiently for her to regain composure and join me for our therapy session.

> Her husband reported that every time he saw her scars across her chest, he wanted to vomit. Whatever a woman's reaction to the loss of her breast, it is difficult to navigate society's expectations, the healthy grieving process, and what it means to heal from the loss of our good body. In addition, there is a negative impact to the patient's sexuality and body image. The loss of a body part takes time to process, grieve, and become accustomed to.

Another example from the text which offers factors coded for negative impact on a woman's well-being in this study is such as:

> She still believes her mother's words; she is still mother herself just as she was taught, with a sterile and conforming distance to her own body. We began to unwrap the shame and embarrassment around her body's pleasure and vulnerability. We realized that she had no idea how to mother herself into being a woman. She had never been allowed to explore and delight in her body without shame; had never been taught to be imaginative and listen, to mark and honor her body. (Bauman, 2019, p. 55)

These examples demonstrate factors of trauma, shame, negative body image, and societal influences found in text which negatively affected the well-being of women in *Theology of the Womb* chapters (Bauman, 2019).

An example of positive factors that appeared in the manuscript is demonstrated as:

> How we manage increased losses in our aging life will often mirror how we marked the gains in our adolescent life. earlier in the chapters on menarche, we talked about rites of passage, which are indicators of how we marked significant moments in our life. Rites of passage are described as marking an important stage

> in one's life or an even associated with crisis or change of status: especially, birth, puberty, or illness. If this is done in an intentional and healthy way, a person can look to their story and see times of marking or making meaning of both gains and losses in our lives. (Bauman, 2019, p. 119)

This quote gives an example of how self-awareness and self-identity are coded as having a positive and resilience effect on the women in this text. In each of the quotes, we can distinguish the negative effects of objectification, sexual shame, and loss and the positive effects of meaning-making, body image, social connection, and spirituality on the well-being of women in the *Theology of the Womb* manuscript (Bauman, 2019). This is significant because this helps practitioners and partners name and identify factors which attribute negatively to women's mental health in regard to self-esteem, body image, self-efficacy, and self-identity.

Womanist Theology helps us understand this by the concept of "somebodiness" or the act of being visible to society and others as more than our sexuality but someone with a narrative, a human with a soul and a story (Townes, 2015, p. 140). Objectification Theory (Fredrickson & Roberts, 1997) and Shame Resilience Theory (Brown, 2006) are secondary theories supporting the notion that sexual shame devalues and silences the female body (Brown, 2006; Clark, 2017; McKenzie et al., 2018). In this study, we see the spiritual and sexual story of women being deduced to shame rather than as Womanist Theology (Thomas, 1998) implores, to look at the female body as one made in the image of God (Townes, 2015). These theories support that stronger self-identity, self-awareness, body image empowers women with coping skills and resilience when encountering

shame, loss, and trauma (Asakura & Craig, 2014; Chrisler, 2004; Hoffman, 2006; Vliet, 2009).

Findings & Results: *A Brave Lament* Transcripts

The results found in this manuscript were separated by factors that attributed positive or negative responses. Negative factors impacting mental health included increased feelings of loss (18), depression (19), and anxiety (28) were connected with the lack of socialization or isolation (20) during the early grieving stages. Anxiety (28) was the number one negative response attributed to a lack of social support during a time of grief. Resiliency factors (56) were considered positive mental health factors of social engagement/connection (45) and meaning-making (23), such as funerals, ceremonies, rituals, photographs. Social connections such as belonging, and connectedness were higher indicators of resilience than meaning-making after grief.

Negative factors of loss, depression, anxiety, and lack of socialization were coded in an example demonstrated as:

> I think one of the hardest parts after losing Brave was basically engaging people who didn't understand. They didn't like seeing me hurt, they didn't like seeing me grieve, they didn't like seeing me write blog after blog of heartache, basically sharing my grief and people wanted to fix me. And yet, their ways of helping actually hurt worse. (Bauman et al., 2017, p. 19:23-19:35)

Here is one example from the transcripts coded for positive factors of resilience from social support:

> We will bury him, this is our work, no matter how tired, no matter how broken you all were, how exhausted, this is still the work. You make visible what I want

> so much to be invisible. Your marriage, it was so hard to watch you guys grieve differently and throw grief at each other and anger at, you know. And then now to see you guys, be strong in this season you're in first bloom after a forest fire and…I think that there's just a beauty in people who are willing to bloom again after being decimated and I think that's a gift. (Bauman et al., 2017, p. 32:44-33:51)

Womanist Theology (Williams, 2006) is grounded in overcoming and going through what you have lost and in doing so finding yourself. Maparyan (2012) expounds on Womanist Theology (Williams, 2006) through the lens of suffering theology and communal support as integral parts of grieving and loss through the lens of womanism and spirituality. Lifespan Theory (Broderick & Blewitt, 2015) is a secondary supporting theory which demonstrates that how an individual makes meaning of gains and losses in their adolescents while influence how they cope with gains and losses (i.e., aging, LGBTQ woman, grieving woman) over the lifespan (Broderick & Blewitt, 2015). These theories support the findings in this manuscript *A Brave Lament*, that resilience is acquired through communal support and making meaning through spirituality or rituals (Bauman et al., 2017).

Collective Findings

The collective findings of all three manuscripts showed the top themes relating to negative and positive factors affecting women's wellbeing regardless of their sexual orientation. The negative contributors will be discussed first by listing common terminology, top themes and overall factors that impede women's wellbeing. In accordance with the literature review, we have research confirming the negative impact

on women’s well-being regarding discrimination and a lack of self-identity (Watson et al., 2018). The terminology that emerged as impediments to women’s well-being were “issues with self-image or body image,” “feelings of shame,” “miscarriage or stillborn as bodily grief,” “economic and social positioning,” “being marginalized or underserved,” “women’s voices being silenced for a long time by society,” and “racial and ethnic experiences of sexual and gender minority individuals.” When observed across all three manuscripts, the top themes of negative impact that emerged, in congruence with our theories, included themes of stigmatization, lack of advocacy, harassment, trauma, scars, and prejudice. The overall negative factors impacting women’s wellbeing in the manuscripts are: 1) shame and objectification of body (87), 2) societal and environmental impact (64), 3) stress and anxiety (56), and 4) trauma and loss (55).

The positive contributors will be listed similarly by common terminology, top themes and overall factors that contributed to women’s wellbeing. The literature review offered some research on the level of self-identity and communal belonging as positive contributors to women’s well-being (Watson et al., 2018). The most popular positive terminology facilitating well-being were described by words such as “safe and acceptance,” “provision of others/connection,” “advocates of health and wellness,” “cultural competency and sensitivity,” “self-awareness/self-identification,” “hope/making meaning,” “pleasure/deepening intimacy,” “religious significance.” Often these words were preceded in the manuscripts by a marking event or a life event of some gain or loss, such as a physical scar, sex, trauma, death, advocacy, community, or birth. The top constructive themes which emerged from all three manuscripts were: self-knowledge, resilience, body awareness, sexual intimacy, meaning making, communal support,

affirmation, and religious significance. The overall factors contributing to women's wellbeing throughout the manuscripts were: 1) societal support and understanding (134), 2) self-knowledge/body awareness (110), 3) meaning-making/acceptance (81), 4) empathetic community and family relationships (75).

The most common factors of mental health themes were coded from the following results in the manuscripts. A median summary of the *LGBTQ+* manuscript found Stress (32), Shame (30), Substance Abuse (28), and Social Influence Factors (24) as negative impactors (Edwards & Bauman, 2015). At the same time, the positive mental health themes were Societal Influence Factors (31), Peer Support (30), and Resilience Factors (28). Within the median summation of *Theology of the Womb* manuscript, Shame (48), Negative Body Image (39), Trauma (37), and Societal Influence Factors (20) were the prominent negative mental health contributors (Bauman, 2019). In contrast, Meaning-Making (76), Positive Body Image (57), Societal Influence Factors (28), and Spirituality (26) were the emerging positive mental health contributors. In the final manuscript, *A Brave Lament*, Anxiety (24), Social Influence Factors (20), and Loss (18) were the three highest contributors to negative mental health. At the same time, Resilience Factors (56), Social Connection (45), and Meaning-Making (23) were the positive indicators of wellbeing (Bauman et al., 2017).

The basic theme was empowerment or disempowerment influenced by self, community, society or life events. The organized theme was the emotional event, which is gains or losses, the actual life events which were happening to the individual such as "coming out", pregnancy, or death. Last, the global theme was positive or negative mental health or wellbeing. The communal influence was the greatest predictor of a

negative or positive mental health response. Self-awareness was an indicator of wellbeing, although not as strong as societal impact. While Feminist Theory shows life events in one's story is a large factor in wellbeing, these findings suggest the type of resilience and shame reduction are impactful on the sense of wellbeing, such as acceptance of gender-identity and sexual orientation, acceptance or rejection of society and communities, the amount of loss, trauma and death in an individual's lifetime. Self-awareness, societal acceptance, and communal support were the highest indicators of women's wellbeing over the lifespan.

Discussion

Social environment, meaning-making, and self-awareness were the top four themes that impact women's mental health as it relates to sexuality. Social support, lawmakers, peer support, family of origin, and family of choice were the main examples of social environments that influenced mental health. The findings in these publications show that an individual's social support buffers negative mental health during negative life events, which is congruent with another research (Dalgard et al., 1995). Early studies of resilience were focused on individual traits such as self-efficacy (Bandura, 1977), self-esteem (Brown & Lohr, 1987), and health-promoting functions of support (Werner & Smith, 1982). Studies in the past two decades have looked at external situations and environmental settings. Positive social environments can serve as a protector from negative influences and poor mental health (Tugade et al., 2004). In Shame Resilience Theory (Brown, 2006), belonging is an indicator of resilience and shame reduction; while Feminist Theory (Young, 2000) shows self-identity as an indicator of protection from stress (Hoffman, 2006). Communal impacts are also supported by Womanist Theology

(Thomas, 1998), Feminist Theory (Young, 2000), Social Ecological Model (Ungar, 2011), and SRT (Brown, 2006) supports the findings that societal and communal support has a large influence on mental health. Womanist Theory (Williams, 2006) and Lifespan Theory (Broderick & Blewitt, 2015) both state individual "marked" gains over the lifespan are strong indicators of how women will emotionally handle death and loss (Maparyan, 2012). This implies that how one marks an event and makes meaning early in life will help one cope with losses at the end of one's life (Broderick & Blewitt, 2015). Lifespan research strengthens the evidence of meaning-making and self-awareness and shows how gains and losses affect one's mental well-being.

Meaning-making was also an important factor, having significant effects on women's sexuality and wellbeing. Meaning-making consists of rituals, ceremonies, rites of passage, and marking. These events make lasting impacts on women's mental states regarding their sexuality. There is a residual positive mental effect for those who experience a meaning-making ritual (Wickramasinghe, 2009). Finally, self-awareness was a strong thematic indicator of a person's mental health experience. Counseling, education, and reflection impacted the perspective of an aging woman and aided in perceived resilience.

Limitations of Findings

This case study must consider alternative perspectives other than the findings of this research, such as the unexplainable. The link between social connectivity, meaning-making, and psychological impairments is underdeveloped in research around women's sexuality. Further exploration is important to measure shame resilience specific to women who struggle with psychological issues from sexual shame. Shame and self-blame are

both specifically attributed to female sexual objectification and sexual victimization (Uji et al., 2007). McKenzie (2012) links shame-proneness with women who have been exposed to sexual harm and sexual harassment. Outside societal influence, such as stigmatizing or objectifying media, are negative contributors to women's well-being. Researchers show strong evidence that "exposure to objectifying television in which women are shown as sexual objects increases the likelihood of harassing conduct" (Galdi et al., 2014, p. 398). Multiple researchers attribute sexual shame in women, regardless of their sexual orientation, specifically to PTSD, depression, eating disorders, and anxiety in women from their exposure to sexism, inequality, and discrimination (Rahm et al., 2006; Talbot et al., 2004; Uji et al., 2007). Womanist research strongly implores that objectification strips away a woman's humanity and reduces her worth to a commodity (Williams, 2006). This theme, found across all three manuscripts, shows the negative impact on well-being when one deduces another human to a stereotype, sexual orientation, or mere object. The findings highlight particularities in women's self-identity and aspects of resiliency to strengthen self-efficacy and self-regulation but were inconclusive as an overall result (Watson et al., 2018).

Conclusion

The conclusions draw on the published research (Clark, 2017; Lightsey, 2015; Maparyan, 2011; Wickramasinghe, 2009) using case study qualitative research. The top contributing themes impacting women's well-being were self-awareness, therapeutic meaning-making, and communal or shared grief. The research indicated that women of all ages experienced body image dissatisfaction and negative ramifications due to internalized experiences of inequality, dehumanization, sexual shame, objectification,

prejudice environments, and prolonged stress or loss. Womanist Theology and Feminist Theory have supported these findings connected to women subjected to sexism, classism, racism, and heterosexism (Williams, 2006). A majority of women reported an associate of well-being and body image satisfaction with meaning-making rituals, societal connections, and internal psychological awareness. This paper should be viewed as both an exploration of factors that affect the well-being of women in this study through the interpretive lens of Womanist Theology (Thomas, 1998) and Feminist Theory (Young, 2000) and as an invitation for further research into these dynamics. These findings expose the negative and positive impacts on women's well-being. By becoming aware of these, leaders, ministers, mental health counselors can identify and name them for clients, parishioners, and students. Raising the consciousness of individuals to these trends will begin to dismantle them as they increase *psychological awareness* (Boisnier, 2003). Leaders can also do their part to *build societal connection* and incorporate or teach *meaning-making rituals* into their work. These discoveries are influential in mental health practitioners working with issues of sexuality and applications to individual treatment plans, overall mental health programs, and church congregations for women recovering from sexual and spiritual shame.

The findings in this study are connected to Womanist Theology (Thomas, 1998) through research (e.g., Watson et al., 2018) confirming the level of self-identity and self-awareness women have correlates with resilience and coping skills with discrimination. Particularly in areas of meaning-making as rites of passage through womanhood and communal support through significant moments of gain and loss (Maparyan, 2012). Support from Womanist Theology regarding psychological awareness and building social

connections includes, advocacy, social support, self-care, self-awareness and disengagement, and connecting to one's femininity, religion, and spiritualty were all positive way of coping with discrimination including objectification, sexism, discrimination, loss, aging, grief, (Watson et al., 2018). Self-identity is a huge factor in womanist theology research supporting the understanding that invisibility is overcome through "somebodiness" (Townes, 2015, p.140). The well-being of a woman was impacted by the belief in self. Devaluation and objectification created negative impacts on self-esteem and self-efficacy (McKenzie et al., 2018). Building societal connections, sisterhood and belonging, and supportive communities were large factors in resilience and positive mental health (Brown, 2006; Lightsey, 2015; Maparyan, 2012).

Further Implications

Clinicians, ministers, and leaders are encouraged to explore the ways in which these findings might be used to enhance client, parishioners, and students' well-being. The most frequently noted coping mechanisms were self-awareness, sexual identity, social support, and advocacy. For ministers with womanist beliefs, Womanist Theology (Williams, 2006) can be used as a framework for acknowledging the importance of these factors which affect well-being. For example, women who struggle to bring their voice in a patriarchal society might be invited to participate in mental health practices, classroom activities, and church liturgies that allow them to explore and name their own identity and share them with others in their community. Szymanski, Carr, and Moffitt (2011) listed collective ways in which women and queer individuals can engage in action including developing empowerment and anti-sexism/heterosexism programs, donating money to various empowering causes, educating others about sexism and heterosexism. Counseling

training programs and religious organizations can educate their participants and integrate womanist practices as a way to support the well-being of women (Parks, 2008; Watson et al., 2018). Further research specific to the well-being of women in this study will prove to fortify the mental and spiritual health of religious institutions, counseling modalities, and communal welfare (Frederickson et al., 2011; Moradi et al., 2005; Parks et al., 2008).

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