

THE VIOLENCE OF BETTER:
RETHINKING MENTAL HEALTH IN LGBTQ COMMUNITIES

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INTRODUCTION

A person is shot in the streets. A woman experiences sexual assault. A soldier goes off to war never to return or returns to live with the wounds of war. A child is kidnapped. A theft occurs at gunpoint. A partner is beaten into an almost unrecognizable state by a loved one. Socially, we label these actions as violence. These forms of violence are easy for us to identify. News and social media feeds devour acts of physical violence and regurgitate these stories for general public consumption daily, hourly, and without respite.

While it is easy for us to see these overt acts as violent, there exists other subtle forms of violence that go unnoticed, unrecognized, and unreported. This concept of violence goes beyond life threatening or physical harm. Rather, I propose that violence exists as a complicated web that not only effects our physical selves but also effects our emotional, mental, and spiritual experiences of our “selves” in relation to the world. This writing is grounded in a composite case study. Our fictional character, who I will call Fred, is a character created from numerous patient encounters that I experienced during the time I spent providing pastoral care in a behavioral health unit.¹

¹ For this thesis I chose to work with a composite case study for two reasons. First, a composite case study allows this writing to foreground multiple issues experienced by same-gendered loving people facing mental health concerns. Second, a composite case study allows us to look at these issues as real issues, experienced by multiple people, while guarding care-seeker confidentiality. Therefore, it is important to note that this composite case study for Fred, is a fictitious character based on numerous experiences of LGBTQ people.

Case Study

Fred was admitted to an inpatient program after a suicide attempt. He is a same-gendered loving man in his early 20's who ran away from home as teenager after being sent to reparative therapy. When he "came-out" to his parents as a teenager, his mother was supportive; but his father vowed to disown him if he did not go to the reparative therapy suggested by his minister. When Fred confessed to his parents that reparative therapy did not change his orientation, he was disowned by his father and "disfellowshipped" from his church.² Fred then ran away from home and lived on the streets where he started using alcohol and drugs. Eventually, Fred tried to get his life back on track, found a job, and a partner. Still, he admitted to drinking heavily and using drugs on occasion to help him cope with his anxiety. Just when he thought his life was coming together, one night Fred and his partner were attacked as they walked down the street hand in hand. Fred was hospitalized with injuries from this attack that was later classified as a hate crime by law enforcement. Fred's mother was at his hospital bedside, but his father refused to visit. The stress from this

² A full review of reparative therapy (or gay conversion therapy) is beyond the scope of the paper. However, it is important to note that these therapies are designed to reorient a person's homosexual identity to a heterosexual identity. The National Center for Lesbian Rights states, "According to a 2009 report of the American Psychological Association, the techniques therapists have used to try to change sexual orientation and gender identity include inducing nausea, vomiting, or paralysis while showing the patient homoerotic images; providing electric shocks; having the individual snap an elastic band around the wrist when aroused by same-sex erotic images or thoughts; using shame to create aversion to same-sex attractions; orgasmic reconditioning; and satiation therapy. Other techniques include trying to make patients' behavior more stereotypically feminine or masculine, teaching heterosexual dating skills, using hypnosis to try to redirect desires and arousal, and other techniques—all based on the scientifically discredited premise that being LGBT is a defect or disorder."

The current practice guidelines for the National Association for Research & Therapy of Homosexuality (NARTH), which is a group of therapists who endorse and practice conversion therapy in the United States, encourage its members to consider techniques that include hypnosis, behavior and cognitive therapies, sex therapies, and psychotropic medication, among others." <http://www.nclrights.org/bornperfect-the-facts-about-conversion-therapy/>

incident led to the breakup of Fred and his partner which left him devastated and afraid to leave the house. Fred continued drinking and using drugs to cope with anxiety which eventually led to being terminated from his job. Fred had not left his house for three months when the Pulse Nightclub shooting occurred and his best friend lost his life in the mass shooting. Upon hearing the news of his friend's death, Fred lost hope and tried to take his life by overdosing on pills and alcohol.

While in inpatient care, Fred wondered why every time he cried the doctors gave him a sedative. Psychiatrists diagnosed him with Major Depressive Disorder (MDD), Generalized Anxiety Disorder, and possible substance abuse issues. While Fred was coming to terms with his diagnosis, the only things he could define for himself with certainty were: that he was hopeless and did not want to live; and if God existed, then God surely did not love him and was absent from his life. Fred not only stepped into that behavioral health facility with his own personal history, he also entered into a model of care with its own constructions of treating mental health concerns that were once labeled "madness." As we will see in subsequent sections of this paper, madness or mental illness is a condition that requires Fred to get *better*.

American secular culture is built upon a backbone of *better*. We must be *better* than we were the day before. We must become *better* than the next person in our professional and personal life. Cosmetic products and procedures promise to reduce the signs of aging, therefore, making us look *better*. If we lose weight, we will not only look better, but we will feel better. Self-help and pop psychology are all designed to help us feel better. We are constantly bombarded by messages of *better*. American religious culture is also built upon this backbone of *better*. However, instead of using the term better to describe one's spiritual

condition and relation to the world, binary terms such as sin and holy are used to connote a preferred religious state. These secular and religious cultures affect understandings of mental health.

The mental health field is built upon this notion of *better*: feeling better, acting better, getting better. The *Diagnostic and Statistical Manual of Mental Disorder* (DSM) is the guide that defines a myriad of ways that mental and emotional un-wellness manifests itself within the mind and body.³ Little attention (if any at all) is given to a person's spiritual understanding and experience. In these spaces, where a person cannot measure up to the concept of better, desperation and hopelessness live as companions of various forms of psychic-turmoil.⁴ Among those caught in the trap of better are LGBTQ persons who experience soul-suffering in ways that lead to diagnosable mental health conditions.⁵

As a pastoral caregiver and pastoral theologian, I often find myself with more questions than concrete answers. Who defines mental health? How does our dominant discourse on mental health push already marginalized persons into additional marginal spaces? Does our cultural pursuit of this concept of *better* ensnare itself within a tangled web of violence? How do we define violence? My thesis is that the concept of *better* does violence to those with self-identified LGBTQ identities because it frames the field of mental health and LGBTQ identities

³ *The Diagnostic and Statistical Manual of Mental Disorder* (DSM) is the reference guide used by mental health professions to diagnosis mental illness (Caplan xviii). The challenges of using the DSM to define and diagnosis mental illness are addressed in subsequent sections of this paper.

⁴ A primary guiding assumption of this writing is that language constructs reality. This premise is explored throughout this paper. I use the term "psychic-turmoil" as an invitation into a different language concerning mental illness. By leveraging Kathleen Greider's work *Much Madness is Divinest Sense*, I use the terms soul-suffering and psychic-turmoil interchangeably.

⁵ LGBTQ stands for the Lesbian, Gay, Bisexual, Transgender, and Questioning community. Some will use the letter "Q" to denote "queer" while some use "Q" to meaning "Questioning."

in marginalized social spaces that are informed by history, theology, science, modern medicine, and psychology. In this thesis, I challenge the dominant social and theological discourse of this concept of better. I will first argue that LGBTQ individuals experiencing mental health concerns are caught in the web of what I will call the *violence of better*. This *violence of better* occurs when those with LGBTQ marginalized identities are treated with the additional marginalized identity of a mental health diagnosis. Second, I attempt to propose an understanding of a theology of *better* that seeks to incorporate hope and justice as co-creative processes between God and humanity.

CONSTRUCTING A FRAMEWORK

I do not approach this writing endeavor from a formless void of experience. I have both personal and professional investments in this area of study. In the realm of my personal identity, I am one who has experienced what pastoral theologian Kathleen Greider calls soul-suffering.⁶ My family lived through the suicide of a family member, and a few of us have experienced depression as defined by the DSM. I am a same-gendered-loving (SGL), cisgendered woman who has experienced dangerous depression, and I continue to live with low grade depression and anxiety. In order to cope with my own soul-suffering, I have made use of medication, therapy, and spiritual practice in many forms throughout the years. In my professional identity, I am a United Church of Christ minister who works as a Chaplain specializing in providing spiritual care in behavioral health contexts. I approach pastoral encounters with narrative models of care that are grounded in deconstruction, social construction, poststructuralist, and postmodern theories. I am aware that in any given context both my privilege and areas of disadvantage intersect in complex ways as I seek to understand what it means to live an embodied flourishing life. I am not a medical doctor, a scientific researcher, or a licensed psychologist. I am a pastoral theologian, a pastor, and a clinical pastoral care giver. As a pastoral theologian it is not my job to make a medical or psychiatric diagnosis, but rather it is my job to stand at the intersections of science, history,

⁶ Kathleen J. Greider, *Much Madness Is Divinest Sense: Wisdom in Memoirs of Soul-Suffering* (Cleveland: Pilgrim Press, 2007), 13-14.

philosophy, psychology, anthropology, sociology, and theology to ask the hard questions about what it means to live the flourishing life in our current individual and social contexts.

I establish the context from which I write because there is no way to create a way of *being* that is neutral.⁷ Sometimes we conflate the counseling notion of “nonjudgmental presence” with a notion of neutrality. Theology is not neutral. The field of psychology is not neutral. Science and the field of medicine are not neutral. I have spent a considerable amount of time and energy searching for neutral theologies, psychologies, and ways of being only to discover my desire for a framework that appears neutral is really indicative of a deeper theological desire rooted in an understanding of a God who includes all, who extends grace to all, and who desires the flourishing for all of creation (including humanity). My personal and professional experiences inform my desire to seek an understanding of the kin-dom of God where “all are welcome at the table,” while resisting theologies that continue to “other” and marginalize the diverse expressions of race, class, gender, gender orientation, and gender identity in our culture.⁸ As a pastoral care-giver, I encounter people in the midst of suffering, anguish, and psychic turmoil. While the illnesses experienced by these patients vary, they all have one thing in common: circumstances in their lives bring a type of soul-suffering that

⁷ Bonnie J. Miller-McClemore and Anderson Herbert, “Gender and Pastoral Care,” in *Pastoral Care and Social Conflict*, ed. Pamela D. Couture and Rodney J Hunter (Nashville: Abingdon Press, 1995), 111.

⁸ The term kin-dom has been used by Christian feminists for decades and is believed to be a term first used by Ada María Isasi-Díaz in her work based on Mujerista Liberation theology. Isasi-Díaz interpreted the word “kingdom” as reflective of the dominant and oppressive male culture that existed in Biblical time. She ground her understanding of “kin-dom” in familial relationships as a sustaining construct necessary for societal flourishing. The term “kin-dom” has been used by many feminist scholars to refute the patriarchal images that the language of “kingdom” invokes. The *Dictionary of Feminist Theologies* states, “perhaps Ada María Isasi-Díaz’s translation of Jesus’ eschatological metaphor of the “kingdom” into the “kin-dom” best characterizes the growing edge of feminist theology: a space-time of edgy hope, of present possibility already actualizing itself in relations of mutuality that prefigure a global solidarity which is not yet (Russell 87).”

This writing uses the word kin-dom in ways that are consistent with the feminist theological understanding that seeks to decenter the language of patriarchy present in Christianity.

extends beyond diagnostic tests and diagnosis and into the unquantified realm of what it means to be human. Kathleen Greider uses this term soul-suffering to intensionally engage, “the most profound aspects of psychic life and on spiritual issues related to it—questions of ultimate meaning and values that psychic turmoil commonly precipitates.”⁹ Therefore, this writing uses the term soul-suffering to engage our composite case study in ways that move beyond diagnostic terminology and into Fred’s lived experiences.

Narrative Theory

We all have social, theological, and psychological lenses through which we view and engage the world. One primary way I engage pastoral theology and practice is through the framework of Narrative Therapy. Therefore, in order to deconstruct this concept of *better* we must first define how Narrative Therapy is used as a framework for engaging Fred and the construct of *better*.

Narrative Therapy uses the principles of postmodern thinking rather than a set of predefined techniques. Based on the work of Michael White and David Epston, Narrative Therapy adopts a postmodern, narrative, and social constructionist worldview designed to offer useful truths about knowledge and power.¹⁰ There are four main assumptions that inform this narrative world view:

⁹ Greider, 11.

¹⁰ Jill Freedman and Gene Combs, *Narrative Therapy: The Social Construction of Preferred Realities*, A Norton Professional Book (New York: Norton, 1996), 22.

1. *Realities are socially constructed.* Social constructionists place emphasis on, “social interpretation and intersubjective influence of language, family, and culture.”¹¹
2. *Realities are constituted through language.* Postmodernists propose language constructs societal understandings of reality. Narrative therapists, Freedman and Combs, unpack this postmodern understanding of language further by claiming, “Our language tells us how to see the world and what to see in it.”¹² This discourse about language creating reality is the guiding premise I use to deconstruct and construct what I am naming as *the violence of better*.
3. *Realities are organized and maintained through narrative.* Realities are created by the language we use and are, “kept a live and passed along in the stories we live and tell.”¹³ Through our stories we organize, maintain, and transmit knowledge of ourselves.¹⁴
4. *There are no essential truths.* For postmodern thinkers, “Different selves come forth in different contexts, and no one self is truer than any other.”¹⁵ This concept of multiple selves emerging from different contexts allows one’s problem story to be located within race, class, gender, gender identity and gender orientation, as well as the ways people experience asymmetries of power within their social location.

¹¹ Greider, 25.

¹² Ibid., 28-29.

¹³ Freedman and Combs, 30.

¹⁴ Ibid., 30.

¹⁵ Ibid., 35.

Based on the above concepts, Freedman and Combs leverage the work of Narrative Therapist, Michael White when describing Narrative Therapy:

White writes that cultural stories determine the shapes of our individual life narratives. People make sense of their lives through stories, both the cultural narratives they are born into and the personal narratives they construct in relation to the cultural narratives. In any culture, certain narratives will come to be dominant over other narratives. These dominant narratives will specify the preferred and customary ways of believing and behaving within the particular culture. Some cultures have colonized and oppressed others. The narratives of the dominant culture are then imposed on people of marginalized cultures.¹⁶

Epston and White utilize the work of French philosopher Michel Foucault who studied the ways people in Western society have been categorized as either “normal” or “abnormal.” In his work *Madness and Civilization*, Foucault examines illness, criminality, and sexuality as concepts that informed society’s label of insanity.¹⁷ For Foucault, language was an instrument of power and “people have power in a society in direct proportion to their ability to participate in the various discourses that shape that society.”¹⁸ Building on Foucault’s work, White posited that we have internalized the dominant narratives of our culture and believe that these dominant narratives speak truth to our identities.¹⁹

Narrative Therapy does not pathologize human experience. Rather, it seeks to separate the person from the problem while finding counter narratives to a person’s dominant story that lead to different understandings of one’s identity, greater agency, and alternative meanings to lived human experience. This therapeutic practice is strongly influenced by feminism, queer theory, and postcolonial analysis of how race, class, and gender intersect with the notion of

¹⁶ Freedman and Combs, 32.

¹⁷ Ibid., 37

¹⁸ Ibid., 37-38.

¹⁹ Michael White, *Maps of Narrative Practice* (New York: W.W. Norton & Co., 2007), 39.

power and structural inequalities.²⁰ Epston and White state, “A person’s story, the influences that shaped this story, and the right to tell this story from multiple perspectives are at the center of narrative therapy practice.”²¹

A central concern for Narrative Therapists is the relationship between the person and the problem. Narrative therapist, Michael White, states:

Many people who seek therapy believe that their problems are reflections of their own identity, or the identity of others, or a reflection of the identity of their relationships. This sort of understanding shapes their efforts to resolve problems, and unfortunately these efforts invariably have the effect of exacerbating the problems. In turn this leads people to even more solidly believe that the problems of their lives are a reflection of certain “truths” about their nature and their character, about the nature and character of others, or about the nature and character of their relationships. In short, people come to believe that their problems are internal to their self or the selves of others—that they or others are in fact the problem. And this belief only sinks them further into the problems they are attempting to resolve.²²

White’s concept of *externalizing conversations* seeks to separate a person from their problem by objectifying the problem, therefore, creating the opportunity for the person to separate their identity from the problem.²³ Within the framework of an *externalizing conversation*, the problem ceases to represent the “truth” by using language in ways that maintain the association of the problem with the problem and not the person.²⁴ By engaging in *externalizing conversations* the person is separated from the problem, and placed in the center of knowledge regarding their own story. Externalizing seeks to disrupt the commonly held practice of inscribing pathologies onto a person by locating the problem outside the person’s body. As problem stories are located in the context of race, class, gender, ability,

²⁰ Stephen Madigan, *Narrative Therapy, Theories of Psychotherapy Series* (Washington, D.C.: American Psychological Association, 2011), 21.

²¹ Madigan, 17.

²² White, 9.

²³ *Ibid.*, 9.

²⁴ *Ibid.*

gender identity, and gender orientation, new stories emerge that help a person to re-author their story in ways that lead to alternative identities.²⁵

Since the seventeenth century, science has owned the body especially in the fields of medicine, psychology, psychiatry, and other helping professions.²⁶ Understandings of identity were constructed in terms of the conditions of one's body. In the case of Fred, pathologizing language would state that Fred *is* depressed and Fred *is* homosexual. However, Narrative Therapy understands identity as cultural, discursive, multisited, multistoried, contextual, and relational.²⁷ Our identities are not our own as understood by the Enlightenment era. Rather our identities are realized within certain dialogic, ideological frameworks constructed by the dominant social order. People are not viewed as fixed within problem identities. Rather people are viewed within the politics and power of a "culturally constituted self."²⁸ Quoting Spivak, Madigan states:

From this perspective, the problems that people encounter can be situated within a dialogic context and not placed under individual sovereignty. Within Narrative Therapy's mode of practice, problem-saturated stories in our lives are seen to gain their dominance at the expense of more preferred, alternative, or subordinate stories that are located in marginalized discourse. This marginalized discourse is a form of knowledge and practice that is often disqualified or "invisibilized" by discourses that have gained hegemonic prominence through their acceptance as guiding cultural narratives.²⁹

²⁵ A full review about the practice of Narrative Therapy is beyond the scope of this thesis. I highlight this concept of externalizing conversations to build upon the premise that language constructs reality. However, other concepts of Narrative Therapy include: re-authoring conversations that invite a person into the more neglected parts of their story while searching for unique outcomes. These unique outcomes are stories that include counter narratives to the dominant narrative of the person's story. In these unique outcomes other identities emerge (Madigan 81-83).

²⁶ Ibid., 66.

²⁷ Madigan, 66.

²⁸ Ibid., 70.

²⁹ Ibid., 69.

Therefore, if we separate Fred from his problem, we could say: “Depression visits Fred; or Fred’s experiences of violence invite depression into his life.” By using language in this way, Fred is allowed to explore other aspects of his identity by separating Fred from his problem story of depression.

Narrative Therapy is poststructural, postmodern, and can be deeply theological. If used within a theological framework, Narrative models of care invite deconstructing core narratives about how one understands the Divine/human relationship; yet it does not have to be expressly Christian. A narrative approach to pastoral counseling is a valuable resource because it seeks to resist oppressive narratives by finding empowering stories.³⁰ People construct meaning and it is this meaning that people attribute to themselves and their experiences that constitute both identity and the development of resources for living.³¹ As a person finds alternative narratives and reconstructs new meanings for their lives, a renewed sense of agency develops, and the theological concept of hope emerges. This understanding of hope is not unique to one mode of theological discourse and bears the weight of multiple meanings and expressions.

Narrative concepts provide a framework that locate Fred’s soul-suffering in his lived experience in multiple contexts of race, class, gender, gender orientation, and gender identity. A strength of a Narrative model is that a person’s lived human experience is located beyond one’s individual body. This model accounts for areas of marginality that influence soul-suffering while seeking more equitable power distributions between the care-seeker and care-

³⁰ Christie Cozad Neuger, *Counseling Women* (Minneapolis: Fortress Press, 2001). 60.

³¹ Neuger, 60.

giver. However, I believe it is also important to identify the limitations of Narrative models of care in order to avoid essentializing a framework that seeks to resist being essentialized.

Each model or theory of care contains ideas and practices that are both helpful and limiting. Therefore, it is important to understand the limitations of Narrative Therapy so that practitioners can accommodate the limitations of this model. Using the work of pastoral theologian Charles Gerkin, pastoral theologian Barbara McClure provides four critiques of Narrative approaches. First, one of the primary limitations of Narrative Therapy is that, “it reduces the self to an interpreter of meaning and does not encourage seeing oneself as an active agent as well as it might.”³² While self is seen as the primary interpreter of meaning, structural realities are not emphasized. Therefore, meaning is generated in the midst of structural realities that do not change. Second, meanings of narratives are inherently social, all meaning is relational; therefore, there is no meaning that can be derived apart from social relationships.³³ Third, McClure asserts that narrative therapies can, “mistake a change in discourse or interpretation with cure.”³⁴ She equates this change in discourse with assumptions rooted in an individualist heritage. An understanding of individualism will be explored in the next section. Finally, Narrative Therapy has a tendency to reduce stories and meaning making to the telling of one person. McClure asserts that meaning is generated in the context of relationships by stating, “meaning is an ongoing byproduct of relationships that are set within sociocultural contexts.”³⁵

³² Barbara J. McClure, *Moving Beyond Individualism in Pastoral Care and Counseling: Reflections On Theory, Theology, and Practice* (Eugene, OR: Cascade Books, 2010), 161.

³³ McClure, *Moving Beyond Individualism in Pastoral Care and Counseling*, 161.

³⁴ *Ibid.*

³⁵ *Ibid.*

One additional critique of Narrative models that I would add is that this framework does not always afford space for a person's biological realities. While I do propose that identities are products of our "selves" experienced in relation to culture, I do not want to overlook a person's biological realities and that biological realities can be informed by psychological, social, and spiritual qualities of our social selves.³⁶

Narrative Therapy possesses limitations. However, it is also helpful because it focuses on separating the person from the problem, providing for a more balanced power dynamic between the care-seeker and caregiver while using deconstructive language to help care-seekers find their own sense of identity, agency, and meaning. This thesis tries to leverage the strengths of Narrative Therapy as a way of using language to deconstruct and reconstruct preferred realities. Pastoral theologian, Christie Neuger, states:

Narrative therapy theory is based in postmodern/poststructuralist philosophies that include the assumption that our interpretation of reality is reality and that this reality is socially constructed. Realities, according to this theory, are organized and maintained by stories that are personal, familial, and cultural. Thus a major part of the world of narrative counseling is to help people generate new language and new interpretive lenses and thus create new realities. How people engage the experiences they have and the contexts in which those experiences occur is fundamental to the way they move forward and build their future stories.³⁷

This use of language in Narrative Therapy helps the care-seeker to move between problem-focused and solution-focused approaches to the difficulties of life.³⁸ By focusing on stories rather than pathology, the care-seeker is afforded the opportunity to explore unrealized

³⁶ While McClure acknowledges that a full review of neuroscience is beyond the scope of her work, she also leverages key pieces of neuroscience by foregrounding, "Neuroscience is beginning to make claims about the ways our neurologies and genes are related to the psychological, social, moral, aesthetic and spiritual qualities of ourselves, to the extent that some are willing to argue that our very selves are the result of socialized patterns of interconnectivity between neurons in our brains. These patterns are determined by genetics, by the experiences we have, and by our engagement with people and the world in which we are (McClure 190)."

³⁷ Neuger, 43.

³⁸ *Ibid.*, 45.

stories hidden in the discarded plot-lines of their lives. As new stories are discovered, new languages emerge, and new realities are available to the care-seeker. Therefore, it is Narrative Therapy's postmodern use of language that determines how we will deconstruct the language of *better* in light of Fred's lived experience.

THE LANGUAGE OF BETTER

Because a guiding premise of this paper is that language constructs reality it is important to understand what we mean when we use the word *better*.

Language is the power of naming-and thus the capacity to exercise some control over-the shameful truth about oppression that unjust systems would prefer go unspoken. Language is resistant when we use it to articulate the ambiguity of our lives and thus refuse “the seductions of segmenting life, reducing life’s complexities to false simplicity, or collapsing life’s paradoxes to immobilizing moralisms.”³⁹

Random House Dictionary defines the word better in the following ways:⁴⁰

	Definition
Adjective	compar. of <i>good</i> with best as superlative. <ol style="list-style-type: none">1. Of superior quality or excellence: <i>a better coat; a better speech.</i>2. Morally superior; more virtuous: <i>They are no better than thieves.</i>3. Of superior suitability, advisability, desirability, acceptableness, etc.; preferable: <i>a better time for action.</i>
Adverb	compar. of <i>well</i> with best as super. <ol style="list-style-type: none">1. In a more appropriate or acceptable way or manner: to behave <i>better</i>.2. To a greater degree; more completely or thoroughly: He knows the way better than we do. I probably know him better than anyone else.3. More: I walked better than a mile to town.
Verb	<ol style="list-style-type: none">1. To increase the good qualities of; make better; improve: to better one's grades; to better the lot of the suburban commuter.2. To improve upon; surpass; exceed: We have bettered last year's production record.3. Cards. to raise (a previous bid).
Noun	<ol style="list-style-type: none">1. That which has greater excellence or is preferable or wiser: the better of two choices.2. Usually, betters. those superior to one in wisdom, wealth, etc.

³⁹ Greider, 69.

⁴⁰ Better,” Dictionary.com, www.dictionary.com/browse/better. (accessed: March 16, 2017).

	Definition
Idioms	<ol style="list-style-type: none"> 1. better off <ol style="list-style-type: none"> a. in better circumstances. b. more fortunate; happier: <i>Because of his asthma, he would be better off in a different climate.</i> 2. better oneself, to improve one's social standing, financial position, or education: <i>He is going to night school because he wants to better himself.</i> 3. for the better, in a way that is an improvement: <i>His health changed for the better</i> 4. get /have the better of <ol style="list-style-type: none"> a. to get an advantage over. b. to prevail against. 5. go (someone) one better, to exceed the effort of; be superior to: <i>The neighbors went us one better by buying two new cars.</i> 6. had better, would be wiser or more well-advised to; ought to: <i>We had better stay indoors today.</i> 7. no better than one should be, morally inferior; immoral or amoral: <i>Don't speak to him; he's no better than he should be!</i>

This term *better* is indicative of an increased state in a positive direction of advancement, wellness or goodness. I suggest that *better* serves as a linguistic construction that promotes movement toward our preferred socially constructed states of being in the world, albeit in overly simplistic ways. We practice a skill or a hobby in order to become *better*, and with *better* comes an increased status, or monetary compensation; and perhaps social, political, religious, or corporate power. We attend to our physical appearances in the ways we dress, lose or gain weight, our hairstyles, makeup, jewelry, and cosmetic procedures in order to look *better*. If we are ill, we seek medical treatment in order to get well (*better*). And when we experience emotional, spiritual, or psychological symptoms, we seek care in order to feel *better*.

Through this concept of *better*, we attempt to create what Narrative Therapy refers to as a “preferred self.”⁴¹ I am not strictly arguing that the concept of *better* is either bad or good. I am also not arguing that individual and collective progress (however this is defined) is inherently bad, or sinful, or evil. In fact, I do believe that this concept of *better* when constructed in helpful ways can be one of many ways to describe and enter into an eschatological understanding. What I am claiming is that how we incorporate this notion of *better* into our identities is a result of how we configure our “selves” through the course of social interaction rather than an exhibition or discovery of an ontological, “true” or “authentic self.”⁴² McClure draws on the work of social theorist Ian Burkitt by stating:

Positing a self that is formed within relationships and sociocultural contexts is not to say there is no real self; rather that there is no self prior to interaction with persons embedded within social orders. It is only as we become more “social” that we are increasingly unique and individual, and as increasingly unique persons we change human interactions, and the relationships with those we encounter. Indeed, all of our conscious and unconscious processes (even those that feel utterly personal such as our emotions and psychic processes) have social elements.⁴³

Languages of the “self” are malleable and as our language changes so does social life.⁴⁴ This construction of the concept *better* uses social understandings of what constitutes deficiency in order to promote movements away from our perceived deficit. Consider for a moment some of the following descriptions of “self” provided by psychologist Kenneth J. Gergen:⁴⁵

⁴¹ Freedman and Combs, 35.

⁴² My understanding of “self” is informed by McClure who defines self as persons, “thinking, feeling, relating, giving, receiving with conscious and unconscious elements, hidden and performative qualities, sinful, graced, alone and related, consistent and surprising...“Self” should be thought of more as a verb than a noun. I understand selves to be the result of a dialectical, mutual construction between some basic genetic coding and persons always and necessarily embedded within a social, material, and politically structured context. The self is real, just not inevitable in its form (McClure 181).”

⁴³ Barbara J. McClure, “The Social Construction of Emotions: A New Direction in the Pastoral Work of Healing,” *Pastoral Psychology* 59, no. 6 (December 2010): 804.

⁴⁴ Kenneth J. Gergen, *The Saturated Self: Dilemmas of Identity in Contemporary Life* (New York: Basic Books, 2000), 13.

⁴⁵ Gergen, 13.

Low Self Esteem	Authoritarian
Depressed	Burned out
Stressed	Paranoid
Obsessive-compulsive	Bulimic
Sadomasochistic	Midlife Crisis
Identity crisis	Anxious
Antisocial personality	Anorexic
Seasonal affective disorder	Kleptomaniac
Self-alienated	Psychopathic deviate
Post-traumatic stress disorder	Voyeuristic

The terms commonly used by mental-health professionals have seeped into the language of the public sector as a way of making sense of our “self” resulting from the “scientizing” human behavior.⁴⁶ Gergen proposes,

First, all these terms have come into common usage only within the present century (several only within the past decade). Second, they are terms of mental deficit. They discredit the individual, drawing attention to problems, shortcomings, or incapacities. To put it more broadly, the vocabulary of human deficit has undergone enormous expansion within the present century.⁴⁷

I attribute this expansion of the vocabulary of deficit to the rise of *individualism*.

McClure defines individualism as, “a cultural ideology that prioritizes the individual as a center of moral value and fundamental philosophical construct; it also emphasizes the rights of the individual for freedom of thought and action.”⁴⁸ While McClure acknowledges the multiple and interrelated sources that informed the emergence of individualism, she outlines four

⁴⁶ Gergen, 14.

⁴⁷ Ibid.

⁴⁸ McClure, *Moving Beyond Individualism in Pastoral Care and Counseling* 25.

dominant streams that feed contemporary individualist ideology in the U.S.: 1) the Protestant Reformation, 2) the emergence of market economies, 3) the emergence of liberal political institutions, and 4) the emergence of Romanticism at the turn of the eighteenth and nineteenth centuries.⁴⁹ Therefore, this construct of *better* is placed in tension with our individual relationality to our understanding of the Divine, our individual capacity to engage in the market economy, our individual relationship to political institutions, and our individual capacity for authentic expression of identity and feeling.

This construction of *better* informs Fred's understanding of his identity. He is given a DSM diagnosis of Major Depressive Disorder and Generalized Anxiety Disorder, and he is seeking an understanding of what *better* looks like for his life. Fred must unknowingly grapple with versions of self that are searching for identity, agency, and meaning in the midst of individualized conceptions of his relationship with the Divine, the economic realities he experiences, political ease or dis-ease regarding his identity, and what he perceives as authentic expression of self and feelings in the midst of his own suffering. However, Fred's struggle with mental health and wellness not only emerges from contemporary notions of individualism, but also constructions of madness that emerged centuries ago. As we will see, *better* in the Medieval period did not look like what *better* looks like today.

⁴⁹ Ibid., 25-26.

HISTORY OF MADNESS

For centuries each generation has created ways of inscribing notions of emotion, behavior, and morality onto individual and cultural bodies. The moment I walk through the locked doors of what we now call a “behavioral health unit,” I step into the echoes of a long, sordid historical conversation and practice of treating those with mental health concerns.

Throughout history, this construct of normalcy has been defined through political, social, and economic influences. According to multiple sources who critically engage notions of mental health, the construct of mental health emerged centuries ago as a transfer of social energy once held by positions of marginality such as the lepers, then moved into social confinement, and became regulated by the field of medicine. Therefore, the concept of mental illness is rooted in positions of marginality and disadvantage from its inception.

Feminist theologian, Serene Jones, quotes Iris Marion Young saying:

The injustice of social exploitation consists in social processes that bring about a transfer of energies from one group to another to produce unequal distributions, and in the way in which social institutions enable a few to accumulate while they constrain many more.⁵⁰

I propose that it is Young’s concept of the “transfer of energies” that shifted the social energy from the marginal place held by lepers during the middle ages to emerging constructs of madness.

⁵⁰ Iris Marion Young, *Justice and the Politics of Difference* (Princeton: Princeton Univ., 1990), 53, quoted in Serene Jones, *Feminist Theory and Christian Theology: Cartographies of Grace, Guides to Theological Inquiry* (Minneapolis: Fortress Press, 2000), 79.

Today we know that leprosy is a treatable disease mainly caused by bacteria.⁵¹ However, during the middle ages leprosy was a defining marginal location. Lepers were isolated in sanatoria communities. For thousands of years, leprosy has effected humanity; and in ancient eras, people were separated into leper colonies because of the belief that leprosy was highly contagious. In the medieval period, the social perception of leprosy was generally one of fear.⁵² People with leprosy were generally viewed as unclean, untrustworthy, morally corrupt, and were often required to wear clothing to identify them as such.⁵³ As the disease of leprosy disappeared, structures implemented to support communities of lepers were left vacant from the fourteenth to seventeenth centuries.⁵⁴ While the illness of leprosy disappeared, the social value and images attached to people with leprosy remained. Yet this social energy of fear and exclusion were left dangling without a recipient. Foucault's proposal is that people experiencing madness were placed into the institutional and social roles left vacant by the lepers.

In the Medieval era, those experiencing madness were allowed to roam and interact with society. However, a new way of viewing those with madness emerges in the Renaissance through a literary composition known as the Ship of Fools. These ships transported those

⁵¹ Charles Patrick Davis, MD, PhD, "Leprosy (Hansen's Disease)," MedicineNet.com, accessed April 1, 2017, <http://www.medicinenet.com/leprosy/article.htm>.

⁵² Jacques Le Goff, ed., *The Medieval World* (London: Collins & Brown, 1990), 20.

⁵³ Herbert C Covey, "People with Leprosy (Hansen's Disease) during the Middle Ages," *The Social Science Journal* 38, no. 2 (June 2001): 315–321.

⁵⁴ Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Vintage Books, 1988, 1965), 3.

declared mad by society from place to place.⁵⁵ Within a century, confinement on ships was replaced by confinement in hospitals as madness became equated with unreason.

In time, the criminal and those with “deranged minds” would assume the social role left vacant by the leper.⁵⁶ As we watch the language of madness emerge, we arrive at the seventeenth-century where houses of confinement were established for the poor, the unemployed, prisoners, and the insane.⁵⁷ Foucault proposes that the social fear and anxiety that was once held by the lepers was now transferred to different people groups including those culturally defined as insane. Concern over the disease of the body from leprosy is replaced with concern over transforming understandings of dis-ease of the mind through shifting definitions of madness.

During the Renaissance, madness was equated with an imagery of transcendence. However, during the Classical Age we see for the first time understandings of madness as condemnations of idleness.⁵⁸ During this movement in history, confinement was a police matter and, therefore, was considered a correctional and moral institution that Foucault claims as, “the underside of the bourgeoisie’s great dream and great preoccupation in the classical age: the laws of the State and the laws of the heart are at last identical.”⁵⁹ Foucault also argues that madness appeared to fill the place in society once held by religious enthusiasm. As the Age of Reason takes hold, we now have two vacant social roles that madness fills: the role of the leper

⁵⁵ Foucault, 8.

⁵⁶ *Ibid.*, 7.

⁵⁷ *Ibid.*, 39.

⁵⁸ *Ibid.*, 58.

⁵⁹ *Ibid.*, 171.

and the role of the religious enthusiast. Unreason and “the passions” became linked with madness. The end of the eighteenth-century creates the institution of the asylum. As we move into the nineteenth-century, the patient-doctor relationship becomes the performative relationship in the treatment of madness which established with medicalization of mental illness. With the medicalization of mental illness, we have a movement into Freudian psychoanalysis, and eventually the creation of the DSM.⁶⁰

As we move from the nineteenth to twentieth century, the language of madness shifts to constructs of “normal and abnormal,” and “sick and well.” However, the marginalized social positions have been established from the vacant marginalized social positions left when leprosy disappeared. Therefore, the language of mental health was constructed around previously established marginalized identities and mental un-wellness becomes an illness-based identity from which one must “get better.”

Feminist Theologian, Rosemary Radford Ruether, builds on Foucault’s argument by suggesting that the marginal identity of mental illness not only emerged from the social placeholder left vacant by the lepers, but also that the institutional methods of confining those labeled with mental illness were informed by the practice of slavery in America.⁶¹

Paupers, including those with mental illness, were put up for public auction by the town or county. Townspeople could then bid for them, with the auctioned people awarded to the lowest bidder, ensuring that the municipality would only pay the least for care. Those who took such people in for a fee could then use them any way they wanted, primarily as unpaid labor. Farmers particularly were on the lookout for able-bodied poor people, including the more docile among “the retarded” or “mentally ill,” who could be used for farm labor.⁶²

⁶⁰ Paula J. Caplan, *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal* (Reading, Mass.: Addison-Wesley, 1995), 41.

⁶¹ Rosemary Radford Ruether, *Many Forms of Madness: A Family's Struggle With Mental Illness and the Mental Health System*, 1 edition. (Minneapolis: Fortress Press, 2010), 139.

⁶² Ruether, 139.

Poorhouses were also another form for institutional confinement throughout the eighteenth century. Stemming from England's "poor laws," poor houses were intended as a mixture of charity and punishment bringing together indigent populations:

...orphaned children, pregnant girls thrown out by their families, women fleeing from domestic violence, poor widows and the elderly, people with physical handicaps and those with mental illness, drunks and petty thieves, able-bodied people down on their luck, and people too poor to heat their homes in the winter who used the poor house for seasonal housing. It became the source of many other institutions in American life: jails, nursing homes, orphanages, domestic-violence shelters, homes for unwed mothers, mental hospitals, and today the homeless shelter, as different groups were separated out into specialized institutions.⁶³

Forced labor and confinement served to further reify the marginal locations of those experiencing mental illness. Centuries of history show both the European and American struggle to define normalcy and to confine those who were deemed abnormal. Often those labeled as mentally ill have intersectional places of marginality such as poverty, differing physical and cognitive abilities, race, gender, and in the case of Fred, gender orientation.

⁶³ Reuther, 141.

WHAT IS NORMAL?

A brief review of this concept of madness illustrates how madness evolves from a state of whimsical transcendence to a construct of moral depravity and unreason, and into an illness of the mind supported by scientific study. Every era has its own way of defining what constitutes normal and abnormal. Throughout the centuries, this construct of normalcy has been guided by understandings of race, class, gender, and heteronormativity. According to clinical and research psychologist Paula J. Caplan, “Historical changes reflect the kaleidoscope of ways that normality can be defined.”⁶⁴ Centuries ago, people we would label today as mentally ill were viewed as “innocent children of God” and sometimes venerated.⁶⁵ As history suggests religion developed an understanding of mental illness that included demon possession. For religion, mental illness was caused by demon possession and those considered possessed were beaten and/or burned at the stake.⁶⁶ In later eras, those considered mentally ill were put on public display, given asylum, or sold as slaves.⁶⁷ Caplan refers to Thomas Szasz’s observation about the nature of mental health by quoting:

The notion of mental illness is used today chiefly to obscure and ‘explain away’ problems in personal and social relationships just as the notion of witchcraft was used for the same purpose in the early Middle Ages until well past the Renaissance.⁶⁸

⁶⁴. Caplan, 40.

⁶⁵. Ibid.

⁶⁶ Ibid.

⁶⁷ Ibid., 41.

⁶⁸. Ibid., 40.

If normalcy is a construct culturally bound to time and space, then how are the terms mental health and mental illness defined today? According to *Random House Webster's Dictionary*, mental health is defined as, “psychological wellbeing and satisfactory adjustment to society and to the ordinary demands of life.”⁶⁹ Mental illness is defined as, “any of the various forms of psychosis or severe neurosis.” Caplan also notes that the terms mental disorder and mental disease are listed as synonyms for mental illness and, “according to a parenthetical note, the term mental illness didn’t even come into general use until between 1960 and 1965.”⁷⁰

Notice the binary-constructed language emerging: normal vs. abnormal; illness, disease, disorder vs. wellness. Remember that the grounding assumptions for this writing are in the postmodern view of reality that proposes: 1) Realities are socially constructed, 2) Realities are constituted through language, 3) Realities are organized and maintained through narrative, and 4) There are no essential truths.⁷¹ The concept that language helps constitute reality is crucial to understanding how binary constructs such as *illness/wellness* help reinforce the marginalized identity of those suffering with socially defined mental illness. In an attempt to create a different reality that eases mental illness out of the shadows of marginality, I will use the term soul-suffering for the remainder of this writing. By naming psychic turmoil in terms of soul-suffering, we begin to move away from identities of illness and toward identities of healing and/or wellness.

Because healing in the context of soul-suffering cannot rely upon cure, the initial moves toward healing typically rest primarily on the attitudes and actions of the sufferers, not professionals. Thus we begin with changes that most survivors undertake on the way toward healing-turning points, acceptance of the need

⁶⁹ Ibid., 43.

⁷⁰ Ibid.

⁷¹ Freedman and Combs, 46.

for healing and the initiation of the personal healing work that makes long-term recovery possible and sustainable.⁷²

Fred's psychiatric diagnosis of Major Depressive Disorder with suicidal ideation, Generalized Anxiety Disorder, and possible chemical dependency issues can be helpful in describing his specific kind of soul-suffering. However, this diagnosis tends to focus on pathology rather than a more wide-range distress. With the construct of mental health located in a position of social marginality, how do we begin to make sense of the soul-suffering experienced by LGBTQ persons?

The DSM

Fred's diagnosis of Major Depressive Disorder (MDD) is, "by far the most commonly treated mental health condition in psychiatric medicine, comprising nearly forty percent of all diagnosis. According to the Professor of Sociology at Rutgers University Allan V. Horwitz states:

MDD is claimed to be the most important threat to public health of any mental health condition; the often-cited World Health Organization report indicates that depression is the leading cause of disability for 15 to 44 year olds and by 2020 will trail only heart disease as the most disabling condition among all age groups worldwide. Finally, depression has become the most emblematic mental illness in the broader culture, suggesting that an "Age of Depression" has replaced the "Age of Anxiety."⁷³

The rise of the mental health field helped reframe people suffering from MDD from social "misfits" to people who had genuine biological disorders. Horwitz argues that the prominence of depression is due to the ways the DSM-II diagnostic criteria incorporate,

⁷² Greider, 221.

⁷³ Allan V. Horwitz, "The DSM-5 and the Continuing Transformation of Normal Sadness Into Depressive Disorder," *Emotion Review* (2015): 209.

“mild and transient as well as severe and chronic symptoms.”⁷⁴ Depression therefore, encompassed not only the melancholic conditions that had previously characterized it, but also normal responses to common stressors. Caplan suggests that much of what is currently being labeled as mental illness would, “more appropriately be called problems in living.”⁷⁵ I would complexify this statement further to include problems of living within systems of cultural imperialism, racism, sexism, and heterosexism which will be explored later in this writing.

When conceptualizing the word *better*, we set our understanding within some sort of framework for how we understand normalcy. However, we must ask the question collectively, “Who defines normal and normal compared to whom?”⁷⁶ Arbiters of normalcy often place people into categories for political, economical, and emotionally charged reasons while, “pretending that they are operating in a solidly scientific way.”⁷⁷ In the case of Fred, the conditions of normalcy he must measure up to are those of a white, heterosexual, cisgendered male.

While I am arguing for an understanding of mental health that includes the particularities of the social location and experiences of LBGTQ persons through a framework

⁷⁴ A full review of the constructs of the DSM is beyond the scope of this paper. Numerous authors who have tackled the issues of DSM construction have written extensively about the political, economic, and gendered constructions of the DSM. The guiding assumptions this paper works from are the premises established by Horwitz, Caplan, and Vanderstein. These premises include: 1) the diagnostic criteria defined within the DSM that have been constructed politically, economically, through heteronormative, patriarchal, cisgendered, Caucasian constructs; and 2) biological and scientific understandings of mental wellness are based on an understanding of normalcy defined from specific social locations of power.

⁷⁵ Caplan, xxvii.

⁷⁶ Ibid., 45.

⁷⁷ Ibid., xxvii.

of feminist theology, I do not want to disregard understandings of wellness that omit our biological realities.

I am certain as a scientist that biological factors have an important influence on behavior....I am convinced that biological factors may predispose some individuals toward developing mental illness, but there is more to biology than neurotransmitters and brain chemistry. While I believe in the importance of biological factors, I am equally convinced that the way all biological factors are expressed in behavior and mental states depend equally on social and psychological variables.⁷⁸

However, which biological factors effect mental states are not as clear as some scientific claims would lead us to believe. Even though neuropsychologist Elliot S. Valenstein acknowledges that we experience biological realities that effect mental wellness, he also states, “Biochemical theories of mental disorders are at present floundering, although only few are willing to admit it.”⁷⁹ While Valenstein argues against biomedical theories being the predominant causal factor, he does propose that social interactions can initiate physiological changes that would not otherwise take place in isolation; therefore, setting up the premise that social factors produce biological responses.

It is an error to assume that every disorder exists solely within the gene-coded biochemistry of a patient, as many are social in origin. A physician has to treat the patient, but if every problem is “medicalized” to the point that only physiological causes are looked for, much that is critical may be missed.... Explaining how physical events are related to mental events ultimately requires confronting the age-old conundrum, the “mind-body” problem.⁸⁰

Let us think briefly about the phrase “mental illness.” In medical models of care the word *mental* refers to the organ of the brain; generally, not the concept of the mind. *Illness* refers to a state of un-wellness. However, in most cases, mental un-wellness can only be

⁷⁸ Elliot S. Valenstein, *Blaming the Brain: The Truth About Drugs and Mental Health* (New York: Free Press, 2000), 6.

⁷⁹Valenstein, 124

⁸⁰ Ibid., 139.

measured in the context of one's behavior and its agreed upon social meaning.⁸¹ French philosopher, Jacques Derrida, proposes that meaning is not carried in a word by itself but, "by the word in relation to its context. Therefore, the precise meaning of any word is always somewhat indeterminate and potentially different."⁸² I am not arguing that the meaning of the term *mentally ill* is always negative. For many people, obtaining a mental illness diagnosis offers the potential to free them from personal narratives of moral and/or religious failings.⁸³ It gives a sense of belonging to a new community to which we can relate, and it provides a new jumping off point for our narratives. Theologian Monica A. Coleman's diagnosis of Biopolar II provided her with new ways to relate to herself, to God, and to the world by providing new pieces for her own narrative.

There's something to be said for knowing and naming the condition... The naming helped me feel sane. Hearing myself described on paper, so well, down to little details, suggested that the happy, studious, successful part of me was not just a lie, a facade or mask that I wore to hide my depressions. Rather, happiness was part of who I was as well... The name "Bipolar II" officially said that I was more than depression... It helped to have a label, but I was the same person with the word as I was before.⁸⁴

What I am arguing for are theories and practices that hold the tension between constructed understandings of the concept of mental illness that acknowledge both helpful and restrictive assumptions. In Fred's case, (as well as the LGBTQ community on whole) I also would argue

⁸¹ In these cases, I am scoping this statement primarily to affective disorders. There are conditions such as schizophrenia and other psychotic disorders that have diagnostic criteria that can be possibly based on more scientific criteria. And this paper does not address those with traumatic brain injury. I would argue that conditions such as psychotic disorders have biological roots. However, one's wellness is still defined in socially constructed ways which can be both helpful and restrictive.

⁸² Jacques Derrida, *Limited, Inc.* (Evanston, IL: University of Illinois Press, 1988), quoted in Jill Freedman and Gene Combs, *Narrative Therapy: The Social Construction of Preferred Realities* (New York: A Norton Professional Book, 1996), 29.

⁸³ Robert H. Albers, William Meller, and Steven D. Thurber, *Ministry with Persons with Mental Illness and Their Families* (Minneapolis: Fortress Press, 2012), 29.

⁸⁴ Monica A Coleman, *Bipolar Faith: A Black Woman's Journey in Depression and Faith*, 2016., 325-326.

for ways of deconstructing our colonialists culture as a diagnostic method of assessing a person's flourishing. A cultural analysis is often required when assessing wellness issues.⁸⁵

In her work, *Decolonizing Trauma Work*, Renee Linklater asserts that, "Many of the difficulties in applying psychiatric assessment to Indigenous people arise from a Eurocentric misunderstanding of behaviors and responses."⁸⁶ While Linklater's work falls within the scope of trauma work with Indigenous communities, I do believe she offers useful frameworks that can also be mapped onto our work within LGBTQ communities who experience colonial trauma. Linklater defines this trauma as Eurocentric, and I would add heteronormative. While diagnosis can provide a point of relation for individuals, a weakness of diagnostic models is that the model fails to recognize trauma that results from colonialization.

Using psychiatric diagnoses varied among the practitioners. Generally, those who used the diagnoses did so because they were working in mainstream settings or were case managing clients that were accessing mainstream services. Practitioners used diagnostic language with caution as it was clearly recognized that psychiatric labelling has implications on how a client sees themselves. It was also recognized that diagnoses contribute to the formation of an identity based on a pathological diagnosis rather than a validated lived experience. Of most importance is the understanding that psychiatry does not account for the multitude of injuries that have resulted from colonization; in fact, psychiatry often exacerbates colonial trauma by using systematic assessments and administering treatment, particularly in an institutional setting.⁸⁷

The realities we inhabit are brought forth in the language we use and kept alive by the stories that we live. Narrative Therapist, Michael White, writes that cultural stories determine the shape of our individual narratives.⁸⁸ Fred's cultural story takes root in a heteronormative, patriarchal, and religious culture that does not afford him ways to celebrate his difference and to construct a personal narrative around his preferred reality. Fred enters his narrative

⁸⁵ Renee Linklater, *Decolonizing Trauma Work: Indigenous Stories and Strategies* (Halifax: Fernwood Publishing, 2014), 125.

⁸⁶ Linklater, 122.

⁸⁷ Ibid., 131.

⁸⁸ Freedman and Combs, 32.

through stories of violence, marginalization, exploitation, and oppression. How do we understand the interplay between one's biology and social construction in ways that are meaningful for individuals like Fred? From a theological perspective we can ask, "What is salvific for Fred?" Before we can answer this question, we must first deconstruct the spaces where Fred experiences a marginalized sense of self.

FEMINIST THEORY

While there are many theories, or lenses, at our disposal to engage Fred on the spectrum of his experience of soul-suffering, this paper leverages feminist theory to help deconstruct the layers of Fred's psychic-turmoil. I find feminist theory helpful with constructing a theoretical approach to LGBTQ mental health issues for two primary reasons. First, feminist theory addresses areas of socially constructed oppression experienced by women that I believe intersect with the lives of LGBTQ persons. Second, when addressing the needs of SGL men, we must acknowledge the ways in which these men are stereotypically feminized.

In order to connect Fred's experience to a woman's marginality, we must understand how feminist theory seeks to deconstruct the marginality of women by exposing the privilege of patriarchy.⁸⁹ When I speak about marginality, I am using this term in a way that seeks to expose unequal power distributions between individuals and groups, and how these configurations of power disadvantage certain groups.

Feminism is far more than a movement to achieve equal rights, individual freedom, and economic and social equity for middle class White women. Instead a feminist perspective demands a critical analysis of structures and ideologies that brand people as inferior or superior according to various traits of human nature, whether gender, sexual orientation, class, color, age, physical ability, and so forth. Feminism

⁸⁹. It is important to note that most feminists will reject a monolithic understanding of patriarchy because it deflects the effects of racism, classism, sexism, heterosexism, and ageism on the lives of women. The term patriarchy is derived from the Latin *patriarchia* meaning "rule of the father." However in contemporary feminist language patriarchy tends to mean "the rule of men over women." Jones asserts, "Using a single word to describe this grand web of oppressive forces served the rhetorical function of suggesting that male domination had a long history and stretched across national and cultural boundaries, touching every facet of life....Like many feminist terms, it means different things to different theorists. Recent theorists have made a concerted effort to use it more precisely (Jones 77-78)." For the purposes of this paper, I use the term patriarchy to define the ways in which the power differential between women and men oppress women and LGBTQ persons.

strives to eradicate sexism and related exploitative classificatory systems and to allow those silenced to join in the cultural activity of defining reality.⁹⁰

We live in world of binary constructions such as male/female, gay/straight, black/white, rich/poor and so forth. The binary gender system allows for one set of choices: A person must self-identify as either male or female, lest one risk the cultural criticism arising from identifying with a gender that falls outside of our constructed binary.⁹¹ Once a person identifies as female, the distinction between her biological sex and her gendered female role becomes blurred. One must also note that definitions of femininity are constructed around what it means to be “male” and how women function in relation to a man’s desire. Queer Theologian, Virginia Mollenkott, further claims that, “society in the United States depends on gender roles not only to maintain androcentric control but also support capitalism.”⁹² This tie in of gender roles in support of capitalism reinforces McClure’s previously identified second premise on the emergence of individualism: the creation of a free market economy is one stream that fed into multiple reasons for the rise of individualism.⁹³

We do not have to dig deeply in order to determine how female identities are defined in our contemporary culture. Women are labeled as more relational than men, more emotional, nurturing, sensitive, and submissive. The emotional attributes of women are supported by physical understandings of femininity such as long hair, wearing makeup, jewelry, and more. Certain Christian theologies of gender have placed the women’s job in the home raising

⁹⁰ Bonnie J. Miller-McLemore and Brita L. Gill-Austern, *Feminist and Womanist Pastoral Theology* (Nashville: Abingdon Press, 1999), 79.

⁹¹ Virginia R. Mollenkott, *Omnigender: A Trans-Religious Approach* (Cleveland, Ohio: Pilgrim Press, 2001), 20.

⁹²Mollenkott, 19.

⁹³ McClure, *Moving Beyond Individualism in Pastoral Care and Counseling*, 25.

children. In this job she is viewed as subordinate to men. Ancient Christian theologies have placed woman as the bearer of original sin, and sex was either for procreation and/or an exhibition of power. The ancient practice of making women property echoed into the twentieth century practice of denying women voting rights, creating inequitable pay structures, and carrying forward the embedded understanding that women's bodies were about maintaining sexual accessibility to men.

Feminist theologian, Serene Jones, broadly defines women's oppression as, "dynamic forces, both personal and social, that diminish or deny the flourishing of women."⁹⁴ Drawing once again on Iris Young's earlier work, oppression embodies the five faces of *exploitation*, *marginalization*, *powerlessness*, *cultural imperialism*, and *violence*. Jones uses the following definitions based on Young's work to construct her framework of oppression:⁹⁵

Marginalization	Marginals are the people the system [labor]...cannot or will not use. Marginalization is perhaps the most dangerous form of oppression. A whole category of people are expelled from useful participation in social life and thus potentially subjected to severe material deprivation and even exterminations.
Powerlessness	Powerlessness is the inhibition on the development of one's capacities, lack of decision-making power in one's working life, and exposure to disrespectful treatment because of the status one occupies.
Cultural Imperialism	To experience cultural imperialism means to experience how the dominant meanings of a society render the particular perspective of one's group invisible at the same time as they stereotype one's group and mark it out as the Other.
Violence	Includes less severe incidents of harassment, intimidation, or ridicule simply for the purpose of degrading, humiliating, or stigmatizing group members...violence is a social practice that approaches legitimacy.

⁹⁴ Iris Marion Young, *Justice and the Politics of Difference* (Princeton: Princeton Univ., 1990), 53, quoted in Serene Jones, *Feminist Theory and Christian Theology: Cartographies of Grace, Guides to Theological Inquiry* (Minneapolis: Fortress Press, 2000), 75.

⁹⁵ Jones, 71.

How does feminist theory help assess the marginalization of LGBTQ persons? Since gender expression is a performative construct through which we express our identities, feminist theory aids in deconstructing the heteronormative bias encountered by persons with LGBTQ identities. While these five faces of oppression are not meant to capture every form of oppression experienced by women, I believe they are a suitable framework to trace Fred's lived experience as a same-gendered loving male in our culture.

Returning to Fred, viewing his experience through feminist theory highlights areas of Jones' understanding of oppression.⁹⁶ Fred is a same-gendered loving, cisgendered male in his mid-twenties. Let us try to make our composite case study believable by wondering what a possible encounter might look like with Fred. In my imagination, upon meeting Fred, I might be struck by his demeanor and physical appearance that demonstrates the constructed gender binary. Maybe Fred is tall and slender with a porcelain complexion, jet black hair, and clear turquoise eyes. He is both culturally definable as masculinely handsome and femininely beautiful. Perhaps he is soft spoken with a voice most would place on the more feminine end of the gendered spectrum. His mannerisms are neither completely definable by constructed masculinity, nor are they completely definable by constructed femininity. Fred's socially inscribed identity is rooted in a vast chasm between the binary masculine and feminine gender constructions.

Imagine further, that Fred began his narrative by sharing stories about being bullied as child. He recounted being beaten up on the playground by a group of boys. The physical violence Fred encountered was also accompanied by the use of demeaning language. He was

⁹⁶ Since Fred is a composite case study, this description of Fred is amalgam of physical traits used to compile this composite case study.

repeatedly insulted in ways that reflect cultural understandings of weakness and shame that continue to demean and objectify female bodies. It is important to realize the use of language in this part of Fred's narrative. Heterosexual males have used derogatory language about female bodies to insult the masculinity of other men. If a male is perceived as weak he is called a sissy or the derogatory word pertaining to female genitalia; both are demeaning remarks regarding the constructed nature and anatomy of women. The cultural message received by this type of bullying is that being male is the preferred reality over being female. From an early age, Fred was given derogatory cultural message about constructed femininity. Also, his perceived "gayness" was tied to his self-described sense of presenting a more feminine physical presence; therefore, he was called a faggot and mama's boy. As a child, Fred learned that a male identity was constructed around understandings of not being female. His understanding of being male and gay was guided by misogyny. Fred learned that being "female" means being weak. Therefore, being same-gendered loving is equated with femininity, and establishing Fred's identity in the weakness and shame of the feminine.⁹⁷ Our language creates our cultural realities of what it means to be male and female:

Boys and men are also pressured into gender conformity through name-calling, but in their case, the name-calling ("sissy," "weakling," "queen") teaches contempt for the feminine as that which is weak,

⁹⁷Ancient understandings of sexuality were built upon exchanges of power. While understandings of homosexual orientations as we understand them had not been constructed, to engage in same sex activities that permitted a male to be penetrated by another male were not socially acceptable. To penetrate was a male activity of power. However to be the one penetrated was passive activity associated with being female. Therefore, to be penetrated moved a male closer in social location to a female who lacked power, status, and standing within her community. In his article *The Bible on Homosexuality: Exploring Its Meaning and Authority*, Kenneth Locke states that, "Within ancient Jewish society men and women were assigned distinct gender roles, the transgression of which was perceived as a serious threat to Judaism. The male gender was regarded as the active, while the female was thought of as the passive. In ancient Jewish eyes the only way two men could have sex with each other was if one took on the passive role, that is allowed himself to be anally penetrated by his partner. This, however, was considered a threat to the very fabric of Jewish identity, because it blurred the important distinction between male and female that Jews regarded as part of the bedrock of their society. Sexual contact between two men mirrored the active/passive roles between masculine and feminine. By allowing himself to be penetrated anally, the passive male lost his manly honor and transgressed the given gender boundaries (Locke 134)."

dependent, or passive. Thus gender control of females is achieved by extolling “masculine” virtues but placing them beyond the reach of “real women,” while gender control of men is achieved by degrading “femininity” so that no “real man” would ever want to be associated with it. Consider: Successful women are often complimented as having the minds of men or possessing manly strength, but to call a man “womanly” is a degrading insult. Women cannot win.”⁹⁸

Fred also recalled sitting alone in the cafeteria hoping someone would sit next to him, yet everyone passed him by. He could not decide what was worse: kids laughing at him while they walked passed him, or kids who never acknowledged his existence. He might have asked himself, “Is it better to be seen even if you’re seen as something bad than to be invisible? At least, if they were laughing at me and beating me up, I was seen. I wasn’t understood, but I was seen.” Throughout his childhood, Fred experienced the marginalization, powerlessness, and violent faces of oppression.

After coming-out to his parents at the age of fifteen, Fred’s father, on the advice of their minister, decided to send him to reparative therapy.⁹⁹ His mother was against it and supported her son. She was overruled by men as her male minister explained to her that the husband was the head of the household and laid out for her “God’s plan” for an obedient wife. The experience of Fred’s mother with sexism in both her interpersonal relationship with her husband and with her religious institution created a sense of marginalization and powerlessness concerning care for her son. While undergoing reparative therapy, Fred shared with me various therapy techniques which I would label “violent.” Since he was a good looking young man, the organization charged with curing him attempted to provoke him into giving testimonials for their company. They offered compensation in exchange for his claims of “being cured.” I would label this experience as “exploitation.”

⁹⁸ Mollenkott, 20.

⁹⁹ See earlier footnote about Reparative (or Conversion) therapy.

When revealing to his parents that reparative therapy did not cure him of his homosexuality, Fred was punched by his father and taken to his minister to explain himself as a failure. In subsequent interactions with his minister, he suffered emotional and sexual abuse; therefore, further solidifying Fred's experience of oppression through violence, exploitation, powerlessness, and marginalization. Fast forward through Fred's story: he experienced multiple job losses (which Fred filtered through his narrative of oppression), physical assault, and the Orlando Pulse Nightclub shooting during which one of his best friends was shot and killed. In the context of intense soul-suffering, I imagine Fred could have expressed his intense emotion the following way:¹⁰⁰

You know I could almost bear this life knowing my best friend and a few others were in it with me. But I'm so tired. I'm tired of being a failure. I'm tired of being abused and trying to live in a culture that doesn't want me. I'm tired of knowing that God loves everyone else but me. And I'm even a worse human being because I was mad at my friend for dying before I did. So, I thought if I could drink enough and take enough pills it would end it all. But I couldn't even do that right because here I am, locked up because I'm crazy. I'm in here because I'm suppose to get better. But I don't know if I want to. I don't even know what better is suppose to be.

Notice Fred uses the word *better*. What does *better* look like for someone like Fred whose life is informed by experiences of cultural imperialism expressed in forms of marginalization, exploitation, and violence? After all, it was the cultural imperialist heteronormative notion of *better* that forced Fred into reparative therapy as a teenager. *Better* meant curing him of his homosexuality, and violent methods were used in the pursuit of *better*. As an adult, Fred is not certain what *better* means for him. However, the mental health field understands this concept of better as a reduction or elimination of Fred's symptoms as defined by the DSM. This concept of better is steeped in heteronormative, patriarchal, cultural meanings that can

¹⁰⁰ Remember that Fred is a composite case study. Fred's statements are an amalgam of statements that come from experience but not a real person.

be measured against the constructions of the DSM. The theological frameworks that guided Fred as a child, as well as the reparative therapy he encountered, consider the condition of homosexuality as an illness from which Fred must get better. However, it is important to note that in 1974 the American Psychological Association removed the diagnosis of homosexuality as mental disorder from the DSM III.¹⁰¹

Understanding the language construction of gender dynamics is paramount to deconstructing LGBTQ experiences of marginality in our culture. Lesbian women are often classified as either “butch” or “fem.” “Butch” women present more socially defined masculine appearances and mannerisms while “fem” woman present more socially defined feminized appearances and mannerisms. Same-gendered loving (SGL) men can be described as otters, bears, nellies, or fems with each descriptor defining his level of socially defined masculinity or femininity. LGBTQ persons are defined by the amount of “maleness” they do or do not possess.¹⁰²

When a same-gendered loving man comes-out he automatically moves down in social status because of his perceived feminization. If being male equals privilege in our society and being female equals disadvantage, then a male identity that embodies social expressions of the feminine moves to a location of marginality because of the ways femininity is constructed and devalued.

¹⁰¹ Caplan, 56.

¹⁰² I am using the acronym LGBTQ in this instance to refer to the spectrum of queer identities that encompass the lesbian, gay, bi-sexual, transgender, and questioning community. Same-gender loving individuals are included in this statement. However, it is important to note that all LGBTQ people are defined by the levels of maleness they do or do not possess.

Conversely, one could posit that if a same-gendered loving man loses social approval and power because of his socially inscribed femininity, then a woman who embodies a same-gendered loving identity could gain social standing by stepping into socially ascribed and stereotypical masculine gendered roles. However, while reversing this argument makes sense on a rhetorical level, its lived expression does not bear the fruit of this conclusion. A woman with a SGL identity causes a few disturbances on the continuum of gender relations that push her into marginal spaces. First, by declaring her same-gendered loving identity she revokes male sexual access to her body; therefore, removing (or at the very least minimizing) the male-female gender sexual politics within relational dynamics. Since female bodies are seen as both explicit and implicit sexual commodities of men, removing or minimizing the variance of sexual politics decreases both a woman's social power and status. Second, women who present identities more consistent with social understandings of masculine expressions are viewed outside the spectrum of what it means to be feminine, therefore decreasing her social availability to be sexualized by men. The female body must remain feminine in order to maintain sexual viability which, in turn, maintains male power over and access to female bodies. However, because SGL men are stereotypically feminized, I believe a SGL man takes a longer, harder fall down the social ladder when he comes out than a same-gender loving woman. Yet it is important to understand that both SGL men and women are vulnerable to marginalization and violence built around social understandings of femininity.

VIOLENCE

In the previous section, I touched briefly on Jones' understanding of violence in conjunction with feminist theory. Jones defines violence as:

Including less severe incidents of harassment, intimidation, or ridicule simply for the purpose of degrading, humiliating, or stigmatizing group members...violence is a social practice that approaches legitimacy."¹⁰³

Feminist process theologian Marjorie Suchocki posits that, "Violence has many forms existing along a continuum from obvious to subtle, but at its base, violence is the destruction of well-being."¹⁰⁴ I think it is important to linger upon this word *violence* in order to tease out a spectrum of violence that often goes overlooked by society in general and pastoral theologians and practitioners more specifically.

First, let me say that I hesitate to define violence around a metaphor of a linear spectrum. This language runs the risk of suggesting that the term *spectrum* denotes graduating levels of intensity such as the goodness or badness of whatever construct that is placed within the metaphor of *spectrum*. Specifically, using the term *spectrum of violence* risks implying that certain forms of violence are more permissible than others or less damaging. Instead, I appreciate Suchocki's words of *obvious* and *subtle* to help set a framework for her operational definition of violence. For the remainder of this writing, I will work with Suchocki's definition of violence as the destruction of well-being. While I recognize the limitations of using the

¹⁰³ Jones, 79.

¹⁰⁴ Greider, 9.

metaphor of *spectrum* to describe destructions of well-being as violent, the metaphor of *spectrum* can be useful in deconstructing different types of violence.

Let us look briefly at violence on a spectrum. I propose this perspective not as a way of absolutizing or concretizing gradations of violence, but rather as a way of flattening out the concept. This allows us to look at the spectrum of violence through a deconstructive lens before returning to a richer more nuanced understanding of violence that includes the interrelated web of intersectionality where racism, classism, heterosexism, ageism, ableism, and patriarchy collide to form our living-human web.¹⁰⁵ I will anchor this concept of violence between the poles of physical violence and microaggression.

The easiest forms of violence to identify and describe are various forms of physical violence. Physical violence often results in physical injury. Fred was hospitalized with injuries resulting from the physical violence of a hate crime. He spoke tentatively and shamefully about the physical abuse he suffered at the hands of his father and minister. He spoke with rage about the death of his best friend who died as a result of the physical violence during the Pulse Nightclub shooting. We can see the wounds caused by physical violence. However, physical violence also comes in the form of sexual violence such rape, child molestation, and incest where physical wounding can be less visible yet still experienced. I am not suggesting that physical violence does not cause emotional, psychological, and spiritual wounds. In acts of

¹⁰⁵ I elude to this metaphor as violence as a web as a way of leveraging pastoral theologian Bonnie Miller-McLemore's construction of the "living human web." In her work *The Living Human Web: Pastoral Theology at the Turn of the Century*, McLemore proposes the metaphor of living human web to describe the "interconnectivity of selfhood." McLemore quotes Catherine Keller when she states, "While aware of the limits of any one metaphor in a metaphysics of relationality, the image of the web 'claims the status of an all-embracing image, a metaphor of metaphors, not out of any imperialism, but because, as a metaphor of interconnection itself, the web can link lightly in its notes an open multiplicity of images (McLemore 17)." I weave into McLemore's metaphor of a living human web an understanding of violence that is intertwined with the fabric of humanity expressed in our social selves.

physical violence our bodies bleed and are broken, our souls bleed and often feel broken, and our psyches bleed and feel fractured. We know physical violence. Since external wounds are overt, it is easy to identify them.

Microaggressions on the other hand are subtle, harder to identify acts. All of us are guilty of forms of microaggression at one time or another. In their book, *Microaggressions in Ministry: Confronting the Hidden Violence of Everyday Church*, Cody Sanders and Angela Yarber build on the work of psychologist Derald Sue who defines microaggressions as, “brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership.” Sanders and Yarber state:

It is equally important to consider how microaggressions derive their power to harm through the citation of larger racist, sexist, heterosexist, and genderist/transphobic social discourses. Thus, microaggressive speech operates as a linguistic tool of oppressive force reflecting hegemonic “values, biases, assumptions, and stereotypes that have been strongly culturally inculcated into our beliefs, attitudes, and behaviors.”¹⁰⁶

Based on pedagogical theorist Henry Giroux, Sanders and Yarber further nuance this concept of microaggression into three distinct categories: insult, invalidation, and assault.¹⁰⁷ This construct of microinsult, microinvalidation, and microassault serves to legitimize oppressive beliefs, attitudes, and behaviors based on the target’s race, gender, class, sexual orientation, or gender identity.¹⁰⁸ Sanders and Yarber define microinsults, microinvalidation, and microassault in the following ways:¹⁰⁹

¹⁰⁶ Sanders, Cody J.; Yarber, Angela (2015-11-17). *Microaggressions in Ministry: Confronting the Hidden Violence of Everyday Church* (Kindle Locations 252-255). Westminster John Knox Press. Kindle Edition.

¹⁰⁷ Sanders and Yarber, Kindle Locations 252-255.

¹⁰⁸ Ibid.

¹⁰⁹ Ibid.

Microinsult	communicate stereotypes, rudeness, insensitivity toward the embodiment of human difference, such as race, gender, sexual orientation, or gender identity.
Microinvalidation	serve to deny the validity of personal experiences for racial minorities, women, and LGBTQ persons by imposing reality on these marginalized groups. Microinvalidations invalidate, negate, or exclude thoughts, feelings, and experiential realities of targeted parties. The potential for harm rests in the microinvalidation's ability to subtly define reality outside the conscious awareness or deliberate intention of those in the privileged majority groups in ways that uphold their unquestioned privilege while marginalizing others.
Microassault	Rather than the unintentionally and lack of perpetrator awareness characteristic of microinsults and microinvalidations, microassaults are most often conscious and deliberate and intend to communicate a demeaning attack or inflict harm based on a target's racial, gender, or sexual group identity. These communications most resemble older forms of racism and sexism in their very deliberate and overt communication of denigration.

Breaking down microaggression in this way carves out social space which we can use to provide language to describe Fred's experiences as a child, as an adolescent, and as an adult. For example: every time Fred heard his church talk about love, marriage and relationship yet excluded the ways he experienced same-gendered love he encountered microinsults and microinvalidation. Every time Fred was demeaned and shamed for his perceived feminine presentation, he encountered overt microassaults.

Since language creates versions of reality, constructions of microaggression and its parts create a space that allows marginalized individuals to name hurt and injustice, and to further identify causes of soul-suffering. Yet, I wonder if this language goes far enough. Microaggression provides space for naming injury, but I wonder if it this term allows perpetrators of microaggression to wrestle with our own embedded-ness in ways that lead to more inclusion of those with marginalized race, class, ability, gender, gender orientation, gender identities.

Recalling our working definition of *better* discussed earlier in this paper, when assessing microaggression from the location of *better*, one could claim that an embedded understanding of *better* is one of many threads of complexity that feed into the language and action of microaggression. For example: Being heterosexual is *better* than being same-gender loving. Being male is *better* than being female. Being white is *better* than being a person of color. Being wealthy is *better* than being poor. Being American is *better* than being an immigrant. Being cisgendered is *better* than being transgendered. Certain expressions of Christianity are *better* than other expressions of Christianity or being Christian is *better* than not being Christian. This implicit construct of *better* helps establish status, power, and hierarchy that in turn continues to marginalize persons who are not on the preferred side of *better*. Those on the marginal side of *better* often experience diminished well-being and various forms of soul-suffering. If violence can be defined as the destruction of well-being and microaggressions are a way of naming certain overt and subtle causes of the destruction of well-being, then the language of microaggression is another way to name violence. If the pursuit of *better* diminishes and/or harms well-being, then the construct of *better* becomes violent; therefore, creating the term *violence of better*.

While the language of microaggression provides a space for those who are victims of *better* to name the causes of harm to their well-being, this language does not go far enough in returning the culpability to the perpetrators of the *violence of better*.

How do we understand Fred's soul-suffering in light of this concept, *violence of better*? Implicit assumptions lurking within medical models of mental health treatment rest in pathologizing the symptoms of soul-suffering and often the administration of medication.

While hospitalization and medication do not cure soul-suffering, many report enough relief from their symptom to make possible further healing work.¹¹⁰

Fred's experiences have been informed by both subtle and overt messages of *better*. Being male is *better* than being female which prevented Fred's mom from stopping Fred's father's decision to send him to reparative therapy. Instructed by their minister in the ways that woman should be submissive to men and that wives should obey their husbands, Fred's mother stayed silent and watched as her child entered into the violence of reparative therapy. His mom self-reported the fear she had of being beaten by his father and the shame she carried because she was powerless to stop Fred's father and his minister from sending Fred to reparative therapy. Her well-being was harmed by sexism reinforced by sexist theology. Fred's mother was also a victim of the *violence of better*. As a child, Fred was bullied by a group of boys. He was called names that are constructed to elicit shame and demean women's anatomy. He was ignored during lunchtime, and he was ignored by his father when he was in the hospital. Fred's well-being was harmed through these experiences of the *violence of better*.

Heterosexuality is *better* than homosexuality. Therefore, he was sent to reparative (conversion) therapy with the hope of being cured of his same-gender loving identity. However, some sectors of religion and culture have not caught up with the scientific understanding that being same-gender loving is not a condition from which one must be cured and same-gendered loving persons are placed in a category of "sin." This category of sin requires a conversion or a return to state of heterosexuality. Going to reparative therapy injured Fred's well-being. Fred's body and soul were injured by the *violence of better*.

¹¹⁰ Greider, 248.

Because sexism intersects with heterosexism, one night while walking down the street, Fred and his partner were attacked. While being beaten, the attacker screamed sexist insults in Fred's face. The wounds of Fred's body were treated in the hospital but the wounds to his soul went uncared for. And one summer night in Florida, because being heterosexual is *better* than being homosexual, a night club full of same-gendered loving people endured a mass shooting where over fifty people lost their lives; Fred's friend being one those individuals. A night club full of people were victims of extreme forms of the *violence of better*. Following the shooting, Fred believed that death was *better* than life and he decided to take his own life hoping to end his soul-suffering. Fred was further victimized by his own experience of the *violence of better*.

What does healing look like for LGBTQ people who are like this fictional case study, whose soul-suffering is steeped in the *violence of better*? How does pastoral theology respond to these constructions of *better* in ways that are helpful to LGBTQ people and their journey toward finding relief from soul-suffering?

CHALLENGES FOR PASTORAL CARE

There is a theological divide within Christianity which is implicitly constructed around this concept of *better*. Our current political climate is steeped in the constructions of a binary of *better*, and it seems to be getting even more rigid with each passing political event. As this rigidity increases, the chasm between our constructed theological binaries is becoming wider, deeper, emptier, and increasingly lonely. Currently, one can either be liberal or conservative. One either supports marriage equality or one stands against it. One can claim either Black Lives Matter or that All Lives Matter. Prochoice or Pro-life seem to be the only options available for women's reproductive rights. Within the construct of American nationalism one is either a Christian, or one is not. Certain expressions of Christianity assert that one is either going to heaven or to hell. Each pole of these binary constructions defines its own understandings of *better*.

Better is not neutral because the implicit theological convictions that inform our understandings of better are not neutral. The personal and the theological are political, and the political is theological, personal, and communal. Therefore, it is important that pastoral theologians and caregivers create intentional operational theologies that stand in the in-between spaces of Fred's intersectional marginalized identities. Neuger states:

All people have an operational theology that guides the formation of their value systems and their sense of purpose in life. For some, these theological groundings are hidden and unavailable to them. For others, they are very conscious and dynamic...Each pastoral counselor has her or his own themes, and it is the task of each counselor to articulate those clearly and carefully.¹¹¹

¹¹¹ Neuger, 57.

In rethinking this construction of *better*, I leverage the following theological themes from pastoral theologian Barbara McClure: 1) all of creation is to be valued equally, 2) all things are synergistically related to all other things, and 3) God is deeply entwined with God's creation and what happens in God's created order.¹¹² Within these themes, I understand the nature of God as liberative, process oriented, at times queer, and co-creative. I do not claim to be either a liberation, process, or queer theologian. Rather, I claim these theologies as multiple frameworks that inform how I engage myself, the world, and those seeking care.

Returning to our composite case study, the theological frameworks from which Fred's identity emerges carry with them understandings of sin and salvation that perpetuate, if not initiate, this *violence of better* paradigm. In the section on Feminist theory, we saw that the marginalization Fred experienced is informed by understandings of femininity that socially construct Fred's identity as "less than male." Fred was sent to reparative therapy because heterosexist theological understandings mandate a heterosexual identity. From childhood, Fred was given messages that he was sinful, or bad, and that his same-gender loving preferred reality was something from which he must get *better*. Fred understands his suffering in the context of a punishing God. Theologies that construct binary understandings of gender, gender orientation, and gender identity disrupt an individual and communal sense of well-being and perpetuate the *violence of better*.

¹¹² McClure, *Moving Beyond Individualism in Pastoral Care and Counseling*, 203.

Fred's experience of soul-suffering is personal, collective, historical, and theological.¹¹³ Using postmodern theory that informs the assumptions that we create the worlds we inhabit through our use of language, Freedman and Combs state:

Speaking isn't neutral or passive. Every time we speak, we bring forth a reality. Each time we share words we give legitimacy to the distinctions that those words bring forth. To talk about race is to legitimate race as a concept. Such legitimation tends to reify race or whatever other concepts we discuss, and we can easily forget that other concepts are equally possible and equally valid. The "logic" of language lends an air of logic to our perceptions and descriptions of the social world, and we have been socialized so as to confuse "logical" with "real."¹¹⁴

In a previous section, we imagined the possibility of Fred making the possible statement regarding his fictional circumstances :

You know I could almost bear this life knowing my best friend and a few others were in it with me. But I'm so tired. I'm tired of being a failure. I'm tired of being abused and trying to live in a culture that doesn't want me. I'm tired of knowing that God loves everyone else but me. And I'm even a more shitty human being because I was mad at my friend for dying before I did. So, I thought if I could drink enough and take enough pills it would end it all. But I couldn't even do that right because here I am... locked up because I'm crazy. I'm in here because I'm supposed to get better. But I don't know if I want to. I don't even know what better is supposed to be.

Notice the reference to culture, God, sense of worth, hope placed in suicide, the relation to his diagnosis (he named himself crazy), and wondering about the concept of *better*. To simply pathologize Fred does nothing to recognize how he experiences the synergistic relationship between his biological, psychological, and social identities in light of his lived experience. This imaginary statement of Fred's invites many possibilities of wondering and wandering with him through his story.

Current trends in pastoral care are built upon an understanding of "non-judgmental presence" that incorporates psychological theory. The shift in leveraging psychological theory to engage pastoral care was intended to shift understandings of soul-suffering away from religious ideology that sorted soul-suffering into the categories of sin or some sort of moral

¹¹³ Linklater, 133.

¹¹⁴ Freedman and Combs, 29.

failing. However, while I find this move helpful I also find a growing tendency to pathologize those seeking care using the language of psychology. While this practice may be helpful at times, it risks missing the important deconstructive components that can locate soul-suffering within the social contexts of race, class, gender, gender identity, and gender orientation.

Pastoral practitioners have the opportunity to walk on unique ground with care-seekers. While our models of care benefit from the use of certain psychological theories, I propose that when psychological theories are leveraged too heavily, we miss the opportunity to move within the in-between spaces of various forms of soul-suffering.

While “being present” with care-seekers provides the potential to embody an understanding of a God who is present in the world, I wonder if understandings of “presence” go far enough in establishing a more nuanced practice of theology and care. How do we imbue our theological frameworks with understandings of hope and relational justice that help people like our composite case study move from an identity of illness to an identity of wellness?¹¹⁵ Notice that I use the language of wellness rather the language of cure. When we speak of soul-suffering or other forms of physical illness in terms of cure, we create a language grounded in constructs of deficit which reinforces this concept of *better* in ways that limit moving forward in our lives. In what does one hope in situations where no cure is available? Greider asserts that, “because healing in the context of soul-suffering cannot rely upon cure, the initial moves toward healing typically rest primarily on the attitudes and actions of the sufferers not the professionals. Greider understands healing as a part of an identity of wellness, and when

¹¹⁵ In her text *Much Madness Is Divinest Sense: Wisdom in Memoirs of Soul-Suffering*, Greider writes extensively about the difference between identities of illness and identities of wellness. One of the concepts she teases out is that an identity of wellness does not have to include what we understand as “cure.” Rather some of her memoirist speak of their healing as a journey, and a process of living into alternative ways of being that learn to accommodate soul-suffering.

framed within the language of wellness, we construct an avenue of understanding that allows one to imagine and define for themselves a state of wellness that may or may not include a cure.

Wellness and soul-suffering do not have to be mutually exclusive. Larry Kent Graham states, “Any paradigm in pastoral care is valid only to the degree that it reflects the concrete situation of persons who are facing crises and provides resources for positively responding to such crisis.”¹¹⁶ Therefore, frameworks of care for those experiencing various forms of soul-suffering that do not include addressing lived experience within concrete situations risk reifying a marginalized identity and maintains an identity rooted in the problem story. Rather than addressing Fred’s soul-suffering through the language of *better*, I propose looking to themes of hope and justice as two of many themes that can help move pastoral engagement away from the construct of *better* and toward a theological paradigm of “a synergistically connected, equally valued creation where God is deeply invested in the flourishing of all creation.”¹¹⁷

Hope

Most practitioners would assess that Fred attempted suicide because in his despair he lost hope. Hope is often understood as either something one possesses, or something that God possesses. Despair and hope are placed on this continuum of *better* by making hope the agent that makes despair better; therefore, creating another identity emerging from the space of

¹¹⁶ Larry Kent Graham and Rodney J. Hunter, eds., “From Relational Humanness to Relational Justice: Reconceiving Pastoral Care and Counseling,” in *Pastoral Care and Social Conflict*, ed. Pamela D. Couture and Rodney J Hunter (Nashville: Abingdon Press, 1995), 223.

¹¹⁷ McClure, *Moving Beyond Individualism in Pastoral Care and Counseling*, 203.

deficit. I do not want to imply that hopefulness is not an important component along the journey of soul-suffering. Rather, I want to reach for understandings of hope that externalize this concept in ways that invite a greater sense of agency in the midst of soul-suffering. In her work *Collaborating Hope: Joining the In Between Spaces*, pastoral theologian Joretta Marshall states:

The questions that surround our comprehension of Hope are multiple: is Hope a belief, a feeling, or an emotion? Is it a vision or a way of being? Is Hope something one willfully discovers or something one is offered as a gift? Is it a dynamic or an entity in and of itself? Does Hope arise from the internal world or is it something external to human beings? It is likely that Hope is all of these things, and more. I suspect we would all agree that Hope is more than learned optimism, nor can it be reduced to some form of resiliency or grit, although each of these is connected to the dynamism of Hope itself. While I believe that there is an “internal” social construction of Hope referred to as a feeling, emotion, or belief...I want to encourage us to not be so consumed by this vision that we miss a broader, and perhaps more nuanced and relational vision of Hope. Hope is a dynamic and ever-evolving “thing” that carries its own agency and emerges in the spaces between Hopelessness and possibility, despair and risk-taking potential, and injustice and justice-making.¹¹⁸

As we reimagine ways that hope emerges and informs our understanding of soul-suffering, I suggest that Fred did not lose hope. Instead, Fred used hope in ways that created a vision for his future that allowed for the hope of death to be the solution to his soul-suffering. For Fred, death was better than life; and he hoped for liberation from his life. Since Fred was not hopeless, the antidote for his despair is not found in generating or finding lost hope. By making hope an externalizing agent we open up what Marshall calls the “in between spaces.” In these in-between spaces, Fred can now explore undiscovered pieces of his narrative that construct his identity through a lens of hopefulness in ways that move his agency toward narratives of flourishing and his understanding of well-being. Marshall states:

While Hope is available to all, this asymmetry suggests that Hope might arise in the in-between spaces of more privilege and less privilege...It is not simply that Hopelessness and despair are individual feelings or expressions that arise in response to the daily experience of microaggressions; rather, Hope is created in the in-between spaces of our living and existence as cultural and religious people,

¹¹⁸ Joretta L. Marshall, “Collaborating Hope: Joining the In-Between Spaces,” *Journal of Pastoral Theology* 26, no. 2 (May 3, 2016): 80.

complete with unequal access to power and various degrees of awareness as we participate in these relational exchanges.¹¹⁹

Marshall's statement is crucial in understanding hope not as some state of personal optimism, but rather suggesting and understanding of hope as something that emerges from our experiences of asymmetries of power, such as microaggression. Hope is not a passive dynamic that happens to us, rather hope is born in these in-between spaces of our lived experiences that inform our soul-suffering. By reimagining hope as a relational living agent emerging from in-between space, we join in these spaces with a new ability to expand our vision of God's activity in the world. Marshall's collaborative hope allows us to decenter theologies of better as binary constructions and enter into visions of the kin-dom of God where hope seeps from the cracks of these in-between spaces and joins with humanity and creation in ways that encourage identities of wellness. Yet hope is but one of many entwined and interdependent theological themes necessary for pastoral engagement with Fred. Hope is not fulfilled in a restored feeling of hopefulness, rather hope can be a mobilizing agent that fuels relational justice.

Justice

As stated earlier, pastoral themes of presence emphasize the importance of showing up. However, if we only engage presence as a theme of care then we risk creating passive systems of care. Marshall states:

The popularized version of a potentially more passive stance in pastoral care shows up in an over-valuing of the power of "presence." This descriptor, in and of itself, is not all negative, for it emphasizes the importance of "showing up" as one active step toward engagement. Yet our over-emphasis on presence can also encourage a more passive engagement with moments in time, as well as an unwillingness to do more than "sit" in the in-between spaces. Those who venture into pastoral care

¹¹⁹ Marshall, 84.

with a collaborative perspective are more curious about how to make extra efforts to join others and, equally importantly, to be changed by these encounters. In collaborative work, the “not-knowingness” of another’s experience, as well as a recognition that there is more than one way to move forward to Hope, always invites an intentionality of energy and an openness to something not yet seen.¹²⁰

As we craft themes of hope as a mobilizing agent emerging from in-between spaces, what direction are we being mobilized toward? What does justice look like in context of Fred’s soul-suffering? Justice is the theme that pulls pastoral theology and care from the seat of passivity and into a decentered understanding of God’s action in the world and seeks to co-create the the kin-dom of God on earth as it is in heaven. It is important to understand that relational justice is not framed as a form of divine or human retribution on Fred’s behalf toward the systems and individuals who have caused trauma and harm. Relational justice is restorative. Graham proposes:

The centrality of the values of love, justice, and ecological partnership in his paradigm constitutes a fundamental shift from the individual to the communal....In this new paradigm I am suggesting, individual experience and fulfillment is affirmed and promoted, but it is taken up into a moral context greater than the horizons of selfhood. The consequences of conditions such as gender, class, race, and sexual orientation help to shape pastoral diagnosis and intervention.¹²¹

It is this theme of relational justice that returns Fred’s individual selfhood to a self-created in and restored to community. Justice is the theme that seeks to counteract individualism by promoting God’s intention for a flourishing creation in which everyone and everything have equal value. Justice also challenges constructions of *better* by separating the construct of *better* from the individual self and returning the culpability for *better* to culture, social systems, and institutions. If selves are socially and institutionally created, then we must ask,

¹²⁰ Marshall, 80.

¹²¹ Graham and Hunter, eds., “From Relational Humanness to Relational Justice: Reconceiving Pastoral Care and Counseling,” in *Pastoral Care and Social Conflict*, ed. Pamela D. Couture and Rodney J Hunter (Nashville: Abingdon Press, 1995), 230.

“What kinds of culture are people like our composite case study being restored to?” Graham proposes that symptomatic behavior occurs either overtly or covertly for the benefit of someone else or group that has power over the carrier of the symptoms, claiming that a victim social position is an unjust position.¹²² Individual symptoms have social and political dimensions that create unjust power relationships that serve the interest of somebody or something else.¹²³

Pastoral care from a relational justice paradigm cannot settle for the pretensions of a pseudo-objectivity and “value-free” neutrality as its ultimate *modus operandi*. Neither can it settle for liberating persons only from moralistic oppression of the ego or superego and ego ideal. Rather it must provide moral assessment of every aspect impinging upon the pastoral situation and help to fashion ethically accountable responses to it. In this model roles of pastor and prophet combine.¹²⁴

Fred’s symptoms labeled as Major Depressive Disorder and Generalized anxiety disorder emerge from social structures that promote heteronormative patriarchy. Therefore, pastoral engagement with Fred should continue long after providing care for Fred in ways that seek to equalize unjust asymmetries of power. As we equalize these asymmetries of power concerning race, class, and gender, we join with the co-creative and transforming power of God where hope is the agential power that activates and mobilizes justice-making pastoral theology and care.

¹²² Ibid.

¹²³ Ibid.

¹²⁴ Ibid., 233.

CONCLUSION

In this thesis, I have argued that LGBTQ individuals experiencing soul-suffering are caught in a web of the *violence of better*. By using a postmodern understanding about how language constructs reality, I established the framework necessary for understanding the construction of the *violence of better* in two ways. First, I grounded this writing in the use of Narrative Therapy that proposes: 1) Realities are socially constructed, 2) Realities are constituted through language, 3) Realities are organized and maintained through narrative, and 4) there are no essential truths.¹²⁵ Second, since language constructs reality, I explored various definitions of the concept of *better* and defined the term better for this paper. *Better* indicates a positive direction of advancement, wellness, or goodness. I suggested that *better* serves as a linguistic construction that promotes movement toward our preferred socially constructed states of being in the world. Through this concept of *better* we attempt to create a preferred self.¹²⁶

After establishing the framework for this paper in Narrative theory and defining the construct of *better*, I explored the history of madness. By using the work of Foucault, I suggested that the construct of mental health emerged centuries ago as a transfer of social energy once held by positions of marginality, such as the lepers, then moved into social confinement, and became regulated by the field of medicine. Therefore, the concept of mental illness is rooted in positions of marginality and disadvantage from its inception. After exploring the history of madness, I continued establishing the marginality of mental health by

¹²⁵ Freedman and Combs, 25-35

¹²⁶Ibid., 35.

exploring our current social understandings of normalcy and the constructions of the DSM. This exploration illuminated the use of binary language such as, normal/abnormal and sick/well. The DSM became the arbiter of normalcy as the field of mental health came under the purview of the scientific and medical industry.

In subsequent sections of this thesis, I advanced my argument of the *violence of better* by using Feminist theory to deconstruct the oppression experienced by women that intersect with the lives of SGL persons. When addressing the needs of SGL men, we must acknowledge the ways in which these men are stereotypically feminized and that this feminization leads to violence. By exploring the concept of violence as something that harms one's well-being, I also proposed that the language of microaggression provides a space for those who are victims of *better* to name the causes of harm to their well-being; but it does not go far enough in returning the culpability to the perpetrators of the *violence of better*.

Finally, I suggested understandings of hope and justice in light of this construct of the *violence of better*. While there are many theological implications undergirding theologies and practices of care, I suggested a re-visioning of hope and relational justice as two important components necessary for engaging LGTQ persons affected by the *violence of better*.

The grounding agent for this thesis is the composite case study of Fred. Fred is a fictional character comprising numerous encounters with LGBTQ persons who have experienced soul-suffering. What does care look like for LGBTQ persons with multiple experiences similar to those of our fictional case study? If we accept the proposition that mental illness is a transfer of energy throughout history from marginalized populations such as lepers, then it is important to understand that people with LGBTQ identities experiencing mental health issues

are stepping into a system born from the marginalized identity of mental health. Diagnostic models of care, while they can be helpful, are often restricted to explanations of mental illness derived from a lens of biological malfunction. While people are embodied creatures with biological predispositions; experiences of marginalization, oppression, and violence can inform our biological actions and reactions within systems of oppression. The construct of better often means a restoration to a cultural understanding of normalcy, and normalcy is defined economically and politically by dominant heteronormative, patriarchal power systems. The means through which individuals are seeking a state of better can often be violent in implicit and explicit ways on both macro and micro levels.

The *violence of better* came at the cost of Fred's mental, emotional, and spiritual well-being which perpetuated his soul-suffering. Our understanding of soul-suffering is incomplete until we understand the social and contextual realities constructing *better* for the individuals seeking care. Was Fred mentally ill? I propose that Fred was experiencing mental and emotion un-wellness resulting from his socially constructed reality; and his experiences of his reality affected his biological mind, his metaphorical mind, as well as his emotional and spiritual well-being. This state of un-wellness presented itself in ways that are definable by DSM diagnostic criteria.

I do not want to omit the possible ways that medical models of care can help ease certain symptoms of soul-suffering. However, the task of pastoral engagement should include understandings of the structural realities that influence individual and social wellbeing. These structural realities include the effects of living in the contexts of race, class, ability, gender, gender orientation, gender identity, and all the ways these identities intersect with one another.

Narrative models of care afford the opportunity for multiple realities to emerge for those experiencing soul-suffering. In these multiple realities, hope emerges from those in-between spaces and seeps through the fractures caused by the *violence of better* that is informed by heterosexism and patriarchy. Hope that emerges from a collaborative effort between the care-seeker, caregiver, communal spaces, and God provides an agential power necessary to seek and work toward a relational justice.

If God is so invested in this world that God gave us each other, then hope can seep through the cracks and fissures of the soul-suffering of these patients whose experience created the composite case study of Fred. With the hope they imbued in me, I will continue the theological work of creating a more just world where the *violence of better* recedes into more equitable power distributions that are theologically grounded in, “Your kin-dom come, Your will be done, on earth as it is in heaven.”

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