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# TRAUMA OF THE HEART: AUGMENTING THE FAMILY PARADIGM TO STEM THE SPREAD OF HIV/AIDS AND TO FACILITATE HEALING AND RECOVERY IN THE WAKE OF HIV/AIDS

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*This article briefly reflects on the HIV/AIDS epidemic in the African American community. The article suggests an alternative paradigm that views the high-risk behaviors that contribute to the spread of the virus as a reaction to ‘trauma of the heart’ as opposed to viewing the epidemic solely in terms of a lack of HIV and sexually transmitted disease awareness. It further suggests a pastoral intervention of expanding the paradigm of family beyond the classical nuclear construct to family as a system of individuals committed to embracing and ‘adopting’ individuals who have experienced trauma of the heart. This augmented understanding of family might provide an alternative to the high-risk behaviors that individuals may engage in during the search for affirmation, which all too often may contribute to the spread of sexually transmitted diseases.*

KEYWORDS: HIV/AIDS, trauma, family, African American, church, infidelity

## REIMAGINING THE CONTEXT OF HIV/AIDS

When one considers the rate and manner in which HIV/AIDS is ravaging the African American community, it is troubling at best, and devastating at worst. In a 2014 report published by the Center for Disease Control (CDC), African Americans of 13 years of age and older accounted for approximately 44% of all new HIV infections in 2010, while representing no more than 12% of the U.S. population. In particular, men and women accounted for 70% and 29%, respectively, of those infected among African Americans in 2010.

The CDC estimates that compared to other demographic groups, the rate of HIV infection for African American men is 7×, 3×, and 2× that of white men, African American women, and Latino men, respectively. Among African American men, those who report as gay, bisexual, or men who have sex with men represented

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over 70% of new infections in 2010 and over a third of new infections among men across all cultures who report as gay and bisexual. What is even more disturbing is that African American male youths between the ages of 13 and 24, while only representing a fraction of the U.S. population, lead the rate of infection among any subgroup of bisexual and gay men. Among African American women infected in 2010, 87% of the cases resulted from heterosexual contact. More astounding than the disproportionality found among African American males are the rates of infection for African American women compared to other groups. Black women are infected at 20x and 5x the rates of white women and Hispanic women, respectively.

The call for HIV/AIDS awareness from numerous not-for-profit and government organizations has grown significantly over the last decade within the African American community. Many of those efforts have focused on educating faith communities and religious leaders about HIV/AIDS, about healthy sexual practices, general health information as it pertains to the contraction and spread of HIV/AIDS, the importance of getting tested, and the possibilities of healthy living after contracting HIV. The preponderance of responses to HIV/AIDS awareness in the African American community focuses on cognitive awareness. As with any epistemological approach that prioritizes the noetic, the underlying presupposition (whether one realizes it or not) is that if people are cognitively aware or cognitively 'know' something, they will act in a corresponding way. Much of the work done in the African American community to stem the tide of the HIV/AIDS epidemic has assumed that people were not aware of the factors that led to the spread and contraction of HIV/AIDS, and that if people acquired such information, they would alter their behavior patterns in such a way that would impair the spread of the deadly virus. However, my clinical experience with individuals whose lives have been traumatized by this deadly virus suggests otherwise.

Many individuals I interacted with in the pastoral and therapeutic encounter were very knowledgeable about the HIV/AIDS epidemic. Not a single person in my clinical or pastoral experience who was infected by HIV/AIDS, by their own admission, was unaware of the possibility of contraction due to high-risk or imprudent practices. Nevertheless, a common narrative was a disbelief that 'they' could contract the HIV virus. Moreover, in my pastoral and clinical experience, it is not uncommon to encounter individuals who are not infected with HIV (or at least are unaware of their serostatus) who also are fully aware of the dangers and risks that make them susceptible to sexually transmitted diseases, yet still remain ambivalent, at best, as it pertains to maintaining a healthy lifestyle.

Younge *et al.* (2010) conducted a study among 196 low-income African American women to assess their perceptions of contracting HIV. The authors note that 'heterosexual intercourse has surpassed intravenous drug use to become the leading cause of HIV transmission for African American women' (p. 51). Despite this danger, 'research has suggested that perceptions of HIV risk among this population are not elevated compared to those of other groups' (p. 50). Of the 196 respondents in this study, 'in spite of their own and their partners' involvement with multiple partners, only 19% ( $n = 37$ ) of participants reported consistently using condoms in the past 3 months' (p. 60). It is important to note at this point that a rush to judgment that intimates that the poor health practices are related to socioeconomic practices is ill-founded and without sufficient empirical evidence.

In a separate study that incorporated African American women across the socioeconomic spectrum (i.e., colleges, universities, faith-based organizations, etc.), Cornielle *et al.* (2008) conducted a study among 325 participants to examine possible correlations between age and condom usage. While test results did not yield any material correlation, the authors noted that 'younger women, compared to older women, were more likely to report using condoms in their current and past sexual relationships' and that 'younger women were also more likely to perceive that their partners had favorable attitudes toward condoms' (p. 229). The authors go on to conclude that because older women perceived that their partners had a negative attitude towards condom usage, 'older sexually active heterosexual women may be at higher risk than younger women for sexually transmitted infections associated with the lack of condom use' (p. 229).

Most studies suggest that more education is needed to change behavior; however, high-risk behaviors that increase the risk of contracting HIV do not necessarily reflect a lack of knowledge or awareness related to healthy practices. Consequently, this may not be the most helpful conceptualization of the problem. This calls into question the age old axiom that if people 'know' better they will 'do' better. Cognitive dissonance in this instance suggests that in order to alleviate the anxiety (or dissonance) caused by engaging in high risk behaviors (that conflicts with what one cognitively knows about HIV transmission) one simply alters their thinking (ergo HIV is about 'other' people or the risk of contraction is insignificant). Altering one's thinking represents the path of least resistance, as altering relational, cultural, and social behavior may prove to be more difficult at best, or alienating at worst. How might one account for phenomena where the individual(s) is aware of potential harm on the one hand, but behaves in a way 'as if' one has no knowledge of such harm? It is as if the individual psychically splits such that one part of the individual behaves in a way that is inconsistent with what one 'knows' on the other half of the psychic split. It seems that a person on one side of the psychic split engages in high-risk sexual practices that are inconsistent with the other side of the psyche that is fully aware of the dangers of contracting HIV and other sexually transmitted diseases. Splits usually occur in response to a trauma, as it defensively shields the injured person from confronting realities that they may experience as threatening to their sense of identity and selfhood.

In his now-famous analysis of Mr. Z, Kohut (1979) conceptualizes a psychic vertical split as opposed to a traditional Freudian horizontal split, where painful information or trauma that the ego may experience as threatening is repressed into the unconscious. In the vertical split, threatening information or experiences are not repressed and unavailable to the conscious, but rather are disavowed and separated by a psychological wall that protects the subject from the potential annihilation anxiety that is represented by the threat or injurious experience. The result is that the individual behaves in seemingly contradictory ways depending on what side of the split is being enacted. In the case of Mr. Z, aspects of his mother that were threatening or harmful to Mr. Z's self were split off psychically in order to protect the aspects of Mr. Z's mother that were nourishing to his selfhood. Knowledge that a caregiver, lover, or any other person who should provide love and nourishment was also the one who inflicted hurt and harm would be intolerable to hold in the psychogenic structure of any traumatized individual or person in a fragile emotional state. For Kohut, then, the vertical split is in response to a narcissistic personality disorder

caused by insufficient empathic affirmation by childhood caregivers, typically referred to as self-objects in the self-psychological schema.

Instead of theorizing on the disproportionate spread of HIV in the African American community as a result of a lack of education and awareness, consider that it could possibly be a response to a particular kind of trauma: a trauma of the heart. On one side of the split is a versed articulation of HIV/AIDS awareness and the tenants of maintaining a healthy lifestyle. On the other side of the vertical split are imprudent relational and sexual practices that increase the risk of contracting HIV or other sexually transmitted diseases. On this side of the vertical split, people behave 'as if' they have no risk of contracting the virus from their partner(s).

In general, the psychological literature suggests that trauma can lead to the onset of a psychical split in order to protect the 'self' from threatening information (most often about a significant other) that could precipitate the decompensation of self-hood. Kilborne (1999) asserts the near impossibility of being able to address trauma in the therapeutic encounter without addressing the psychological phenomenon of splitting. Describing the split as an unconscious reaction that 'scrambles experience so as to separate out and render unintelligible unwanted emotions,' Kilborne suggests that suffering, pain, harm, and disillusionment at the hands of significant others or caregivers is the cause of the split. He notes that 'the shame of feeling that one is again turning for help to the very person who inflicts harm splinters the world in part because one cannot separate expectations of help from sadistically inflicted injury at the hands of one and the same person' (p. 386).

## TRAUMA OF THE HEART

The spread of HIV/AIDS in the African American community, I am suggesting in part, is a reaction to affective or emotional disillusionment, or what I have termed 'trauma of the heart'. Trauma of the heart is conceptualized as emotional devastation that stems from the experience of infidelity in any intimate relationship where a covenant, not just marriage, has been established. The covenantal, interpersonal intimacy need not be limited to sexual relationships, but could include close friendships, or any other relationship with a partner, family member, or person whereby the nature of the relationship in and of itself was based on its exclusivity and an expectation of fidelity. The violation of such relationships can be traumatic. In my clinical and pastoral experience with persons with HIV/AIDS, a narrative of emotional and relational betrayal by family, friends, and lovers was a common theme.

Stolorow's (2007) work on emotional trauma is useful in this instance. For Stolorow, painful events or tragedies that occur from childhood and throughout life need not be traumatic in and of themselves. The onset of trauma occurs when an individual (child or adult) is unable to find a safe intersubjective dyad or space to process the agonizing feelings and emotion that stem from painful events or tragedies. For Stolorow, the presence of painful feelings is not the problem. It is the lack of a relational space to locate painful feelings that is traumatic. Consequently, the actual precipitating event or tragedy, no matter how immaterial or tragic, is not as important as what one does with the resulting affect. As such, trauma could reflect the cumulative effect of perceivably minor incidents over an extended period

of time, or a catastrophic loss. In either event, finding an emotional home is critical. Stolorow concludes that ‘it is the absence of adequate attunement and responsiveness to the child’s painful emotional reactions that renders them unendurable and thus a source of traumatic states...trauma is constituted in an intersubjective context in which severe emotional pain cannot find a relational home’ (p. 10). What is more telling, however, is the impact that early childhood trauma (as defined by Stolorow) can have on how one experiences trauma throughout the lifecycle:

Retraumatization later in life occurs when there is a close repetition of the original trauma, a confirmation of the organizing principles that crystallized from the original trauma, or a loss of an emotional bond that has been a source of alternative ways of organizing experience, without which the old principles are pulled back into the fore. (p. 11)

As it pertains to HIV/AIDS, trauma of the heart can reflect a retraumatization that has its roots in early life. Infidelity of relationship by one’s partner can indeed reflect a retraumatization that is emblematic of past experiences where one cannot find sufficient ‘attunement’ for the emotional turmoil that results from the painful experience of discovering that one’s partner has violated the boundaries of the relationship. The response to this trauma can result in a kind of psychic split, whereby the longing to find a relational home and affective attunement trumps one’s cognition as it pertains to HIV/AIDS awareness. In the vertical split that stems from trauma of the heart, the desire for emotional comfort and attunement is operationalized, while the awareness of contracting a sexually transmitted disease through imprudent or high-risk behavior is disavowed.

To this end, understanding and approaching relational infidelity as trauma is an important area for pastoral theology. To be sure, one of the most common topics that I encounter in my pastoral and clinical experience is the issue of relationships, love, partnership, and the potential for finding the ‘right one’. This does not seem to be an area that is taken seriously (in terms of scholarly reflection and research) in pastoral theology. At best, writing tends to be limited to marriage itself. Yet, between 2008 and 2011, the CDC’s HIV Surveillance Report (2011) shows that the highest rates of HIV infection occur in age groups between 20 and 44 years, the range that corresponds to Erikson’s (1994) life cycle stage where the search and experience of intimacy is the paramount psychological task. Pastoral theology, then, must confront the issue of relational infidelity. The material impact of ignoring the trauma of infidelity can be devastating.

## TRAUMA OF THE HEART AND PASTORAL CARE

Pastoral care in the area of infidelity is among the most challenging for caregivers today. Olmstead, Blick, and Mills (2009) postulate relational infidelity as being one of the most strenuous challenges in the therapeutic encounter, arguing that ‘given the difficulty with which therapists rate the treatment of infidelity and its perceived detrimental impact, additional research on how therapists treat extramarital relationships is of great import’ (2009, pp. 48–49). Additionally, responding to infidelity in a pastoral care modality is further complicated by the challenges presented at various stages of the couple’s life cycle, social and economic contexts, each

partner's mythologies on marriage and its sanctity (or exclusivity), and each partner's family of origin. I am advocating for a pastoral approach that treats all instances of relational infidelity.

Clinical research suggests that not all acts of infidelity are the same, with various categories impacting the marriage in different ways. Glass and Wright (1992) locate extramarital affairs into three categories: (1) third-party relationships with strong emotional connections but no sexual intercourse; (2) sex without strong emotional ties; and (3) strong emotional ties integrated with sex. Atwood and Seifer (1997) identify three additional typologies of infidelity, including parallel, traditional, and recreational extramarital affairs. Traditional affairs are conducted in secrecy and understood to be in violation of the marital arrangement, whereas parallel and recreational affairs are known by the offended spouse but are implicitly and explicitly condoned by the spouse, respectively. In observing infidelity by men who are in the transitional phase of launching children, Carter and McGoldrick (2005) observe that because 'men are raised in a culture in which pornography is often their introduction to sexuality, there is a natural tendency to objectify women. There is certainly no one way to deal clinically with a man's affair, but it should be emphasized that the necessity of his facing his own responsibility and the ways in which the affair reflects some sense of failure in his life is a vital element in treatment' (p. 137). As such, it is of great importance that the pastoral caregiver's interpretive lens for examining causes and complexities of infidelity be more substantive and expansive than a few propositional biblical positions on sin.

Identifying and understanding the social construct and imaginary in which infidelity flourishes are of great importance for the pastoral clinician. Traditional subscriptions to the biblical text where Jesus prays 'I do not ask that you take them out of the world, but that you keep them from the evil one...they are not of the world, just as I am not of the world' (John 17:15-17 ESV) may inadvertently cause pastoral caregivers embrace a hermeneutic lens of 'being in the world but not of the world' and overlook how the extramarital imagination is truly constructed by the larger society.

On balance, Glass and Wright (1992) observe that more men than women believe that infidelity is justified with correspondingly lesser feelings of guilt. In contrast, more women than men tend to believe that any sort of extra-dyadic association is inappropriate to the relationship. Research has found that women are less likely to pursue extramarital affairs without a correspondingly strong emotional attachment or motive related to love (Glass & Wright, 1992, p. 368).

When pastoral clinicians overlook the socially constructed impact of infidelity, they run the risk of being oblivious to a system of enablers that fuel the individual's propensity towards infidelity and extramarital affairs. This notion is not foreign to the biblical text as well. In speaking of external factors that can influence individual behavior, Paul notes that 'though we walk in the flesh, we are not waging war according to the flesh. For the weapons of our warfare are not of the flesh but have divine power to destroy strongholds. We destroy arguments and every lofty opinion raised against the knowledge of God, and take every thought captive to obey Christ, being ready to punish every disobedience, when your obedience is complete' (II Corinthians 10:3-6 ESV). If pastoral clinicians desire to influence personal behavior, examination of social constructs is pertinent.

Based on this premise, Atwood and Seifer (1997) recommend social construction couple therapy, where the couple's understandings of extramarital affairs is assessed



and challenged. The couple's past meaning systems must be uncovered. The end goal of social construction couple therapy, as it relates to trauma of the heart, is to break up 'the meaning that the problem holds for them and questioning their marital script. This is achieved through the use of techniques like metaphors, reframes, etc., that amplify the couple's process and by finding exceptions to the couple's process (deconstruction), thereby providing seeds (reconstruction) for transformation' (Atwood & Seifer, 1997, p. 67).

Viewing relationships harmed by infidelity through a systems lens may also prove useful to the pastoral caregiver, especially in terms of the analysis of potential triangles. The basic premise underlying a systems approach is that both parties in the marriage or relationship contributed, in varying degrees, to the extramarital affair in question. By analyzing the triangle(s), the therapeutic process identifies a third party that has been introduced to the marital dyad in an effort to offload the prevailing conflict, tension, and pressure in the marriage. Characterizing triangles in African American marriages, Wimberly (1997) explicates the effects of unchecked anxiety in the dyad. The result is that 'a third party is drawn into the pained marital relationship in order to stabilize the dyad. This process of drawing a third party into the relationship to lessen the anxiety is called triangulation. Triangles function to externalize the marital dyad conflict. This means that the anxiety internal to the marital dyad gets pushed outside itself' (Wimberly, 1997, p. 105).

A systems analysis helps to expose the psychological splitting and projective identification that can run rampant in marital conflict. In infidelity, both partners will be predisposed to split off the worst of themselves and project it onto the other spouse. Progress towards remediation will be hampered, as both people in the dyad are unable to see how they have contributed to the turmoil. Systematizing the extramarital affair, Geurin, Fay, Burden, and Kautto (1987) note the importance of crystalizing the triangulation process, whereby a third party is introduced into the relationship in an effort to alleviate the stress and tension within the original relational dyad. The offending person is depicted as seeking a place of refuge from the pain of the relational dyad. The offended person is depicted as being overly committed to other activities that reduce the empathic availability to the offending person. For Geurin *et al.*, 'if both parties can accept responsibility, then they can move toward changing the parts they played' (p. 67). Pastoral interventions and therapeutic goals should aim to shift each person's position in the triangle such that individual responsibility is accepted.

Without balance, a pastoral approach to systematizing the extra-relational affair can inadvertently serve to appease the one who has committed the adulterous act. Such appeasement will only make the aggressor in the relationship more aggressive. One of the primary dangers in the psychodynamic construct of systems, splitting, projection, and projective identification is that it has the potential to lay the groundwork for the offending partner to suggest, 'You made me feel or act this way!'

A safe pastoral environment that fosters robust conversation is needed. The conversation must include an authentic confession of violations by the offending party. Carter and McGoldrick (2005) note that 'what is worse than the affair itself...is the protective web of lies,' and 'the betrayed spouse begins to question the entire history of the relationship.' They observe that 'the betrayer and the betrayed rarely see eye to eye on how much talking is needed...For a myriad of reasons, it is difficult for the betrayer to be truthful' (Carter & McGoldrick, 2005, pp. 387-388).

I have also observed that when providing care to couples who have been devastated by infidelity, affect trumps cognition at every juncture. Oppenheimer observes that the recovery tasks the victim must undertake are made easier when the cheating spouse voluntarily confesses the infidelity versus the adulterous acts being accidentally discovered.

Affect cannot be underestimated in the healing and remediation process. When affect is overlooked, the offended party's ability to forgive is undermined. Too many pastors and clinicians erroneously place forgiveness in cognition, when it is more appropriately located in the entirety of one's existence. It is ill advised for pastoral caregivers to reduce forgiveness to a simple theological or intellectual proposition. Suggesting to the offended spouse that they would be better off by forgiving does not facilitate the process. While forgiving the offender is psychologically healthy for the offended party, the pastoral encounter must engender a safe space whereby restorative creativity is cultivated. Kluwer and Karremans (2009) conducted a quantitative study on affect and forgiveness in relation to infidelity. They summarize their findings by observing that, in the case of relationships with strong commitment, positive affect is highly correlated with the ability to forgive (Kluwer & Karremans, 2009, p. 1318). If an unbalanced systems approach in the pastoral intervention results in the offended party feeling worse because the horror of their position is not duly empathized with in the pastoral encounter, forgiveness that leads to a restoration of self is highly unlikely.

## EXPANDING THE FAMILY PARADIGM

Trauma of the heart is a useful paradigm for understanding the disproportionate HIV rate of infection among African Americans. I am advocating a radical embracement of the family paradigm that decenters the primacy of the nuclear family to a conception of family that is based on a group of individuals where a traumatized subjectivity can find unconditional mutual and reciprocal affirmation of selfhood. Stolorow (2009) contends that emotional trauma is not accidental to the human project, but necessarily a part of one's very life. For Stolorow, 'emotional trauma is built into the basic constitution of human existence...in virtue of our finitude and the finitude of all those with whom we are deeply connected, the possibility of emotional trauma constantly impends and is ever present' (Stolorow 2009, p. 206). Because trauma of the heart is elemental to life itself, the conception of family that is solely based on genetic ties falls short of the potential healing and sustaining resources that one could find in a family system where kinship is based on a mutual commitment to the affirmation of personhood. In the scholarly literature on HIV/AIDS, as well as in my clinical interaction with clients traumatized by HIV/AIDS, it is not an uncommon narrative to encounter individuals for whom the contraction of HIV represents such an extreme stigma in their family of origin that the rejection and marginalization by the 'nuclear family' results in a double-trauma: the trauma of learning that one has contracted and must live with HIV for the rest of their lives and trauma of the heart related to being disparaged and rejected by a family system from which intimacy and acceptance were expected. Seen in this context, one cannot be too shocked to find that individuals, whether infected with HIV or not, take great risks in the search for emotional connection.

Decentering the primacy of the nuclear family to include family being defined as groups or systems of mutual and reciprocal emotional affirmation represents a viable pastoral care intervention and viable alternative to seeking out emotional attunement through high-risk and imprudent relational behaviors that are precipitated by trauma of the heart. Bengston (2001) challenges the commonly held myth that the value or importance of family is declining. Instead, it is suggested that the form of the nuclear family consisting of two biological parents with biological children is in decline. Bengston argues that ‘families are changing in both forms and meanings, expanding beyond the nuclear family structure to involve a variety of kin and nonkin relationships.’ Observing the tendency to pathologize the family structure of cultures that tend to exist at the margins, Bengston posits ‘diverse family forms are emerging, or at least being recognized for the first time, including the matriarchal structure of many African American families’ (p. 4).

It is at this ideological juncture of expanding the framework of what constitutes family that African American faith communities and culture can add tremendous resources to the field of pastoral theology. In my pastoral and clinical experience, I have often found it difficult to identify or distinguish biological families and/or relatives in the church or in the occasional therapeutic encounter. It is a common practice for people to refer to each other as brother, sister, mother, father, auntie, or uncle as a sign of endearment of emotional bond and there not be a biological connection at all. These references tend not to be just temporary or seasonal, but can last over a lifetime. I recall one clinical encounter with an HIV patient where the person brought several church members with them to the doctor visit. The clinical staff later recalled how ‘strange’ and ‘weird’ it was in the room, as the HIV patient and the church members would preference each other by ‘brother’ or ‘sister’ before referring to the person’s first name. As I heard this, I recall thinking that nothing seemed out of the ordinary to me. Such terms of endearment are normative in the African American tradition. One can see this dynamic play out in African American culture and literature from the times of slavery until the present.

The pastoral intervention that is called for in this paper requires a formal and radical departure from limiting family to a nuclear form. Sermons in the African American church community that denigrate and pathologize African American families serve no constructive purpose other than to reinforce communal and interpersonal self-hate and universalize a family structure that promotes individualism and renounces responsibility for the welfare of, and accountability to, relatives beyond one’s immediate logistical or geographical purview.

In the biblical record, Jesus argues for an understanding of family that is not simply based on genetic relation, but one that is based on kinship that recognizes the sovereignty of God and love of neighbor as the *imago Dei*. In John 19:26–27, Jesus, in the process of being executed by empire, spoke to his traumatized mother and the disciple ‘whom he loved standing nearby.’ At the point of death, Jesus’ pronouncement is both profound and prophetic when ‘he said to his mother, ‘Woman, behold, your son!’ Then he said to the disciple, ‘Behold, your mother!’ And from that hour the disciple took her to his own home.’ In this instance, we see the foundation of what family should represent: kinship that is based on a covenantal commitment to mutual and reciprocal affirmation of personhood.

In my clinical and pastoral experience with those who suffer from HIV/AIDS, the need to find a space to locate painful affect related to rejection and trauma of the

heart is critical to living a healthy life. Such familial hospitality is consistent with the biblical witness and is crucial to pastoral care. In her womanist project on the ministry and practice of hospitality, Westfield (2001) crystalizes the longstanding tradition of care and hospitality enacted by African American women for those who were broken and traumatized. Genetic connections to those they cared for was immaterial. It was the people's humanness that precipitated the care. She notes 'stranger-to-stranger hospitality continued when many African American women raised the children of women sold to other plantations, the children of the masters who raped them, and the children of the mistresses who brutalized them...in short, we learned to be hospitable in hostile environments' (p. 59).

### BIOGRAPHICAL NOTE

**Dr. Danjuma Gibson** is currently a lecturer of pastoral care at Calvin Theological Seminary in Grand Rapids, Michigan, and a psychotherapist at the Center for Religion and Psychotherapy in Chicago, Illinois. His research interests include how Black religious experience and expression intersects with psychoanalytic discourse in a way that is accretive to African American subjectivity and personhood.

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### REFERENCES

- Atwood, J. D., & Seifer, M. (1997). Extramarital affairs and constructed meanings: A social constructionist therapeutic approach. *The American Journal of Family Therapy*, 25(1), 55-75.
- Bengston, V. L. (2001). Beyond the nuclear family: the increasing importance of multigenerational bonds. *Journal of Marriage and Family*, 1-16.
- Centers for Disease Control and Prevention. (CDC, 2007-2010). Estimated HIV incidence among adults and adolescents in the United States. HIV Surveillance Supplemental Report 2012;17(4).
- Centers for Disease Control and Prevention. (CDC, 2011). HIV Surveillance Report, vol. 23.
- Carter, B., & McGoldrick, M. (2005). *The expanded family life cycle: Individual, family, and social perspectives*. New York: Allyn & Bacon.
- Corneille, M. A., Zyzanski, L. E., & Belgrave, F. Z. (2008). Age and HIV risk and protective behaviors among African American women. *Journal of Black Psychology*, 34(2), 217-233.
- Erikson, E. H. (1994). *Identity and the life cycle*. New York: W.W. Norton & Company, Inc.
- Geurin, P. J., Fay, L. F., Burden, S. L., & Kautto, J. G. (1987). *The evaluation and treatment of marital conflict*. New York: Basic Books.
- Glass, S. P., & Wright, T. L. (1992). Justifications for extramarital relationships: The associations between attitudes, behaviors, and gender. *The Journal of Sex Research*, 29(3), 361-387.
- Kilborne, B. (1999). When trauma strikes the soul: Shame, splitting, and psychic pain. *The American Journal of Psychoanalysis*, 59(4), 385-402.
- Kluwer, E. S., & Karremans, J. (2009). Unforgiving motivations following infidelity: Should we make peace with our past? *Journal of Social and Clinical Psychology*, 28(10), 1298-1325.
- Kohut, H. (1979). The two analyses of Mr Z. *The International Journal of Psychoanalysis*, 60, 3-27.
- Olmstead, S. B., Blick, R. W., & Mills, L. I. (2009). Helping couples work toward the forgiveness of marital infidelity: Therapists' perspectives. *The American Journal of Family Therapy*, 37, 48-66.
- Oppenheimer, M. (2007). Recovering from an extramarital relationship from a non-systemic approach. *American Journal of Psychotherapy*, 61(2), 181-190.
- Stolorow, R. D. (2007). *Trauma and human existence*. New York: Routledge.
- Stolorow, R. D. (2009). Identify and resurrective ideology in an age of trauma. *Psychoanalytic Psychology*, 26, 206-209.
- Westfield, L. N. (2001). *Dear sisters: A womanist practice of hospitality*. Cleveland: The Pilgrim Press.
- Wimberly, E. P. (1997). *Counseling African American marriages and families*. Louisville: Westminster John Knox Press. vol. 26.
- Younge, S. N., Salem, D., & Bybee, D. (2010). Risk revisited: The perception of HIV risk in a community sample of low-income African American women. *Journal of Black Psychology*, 36(1), 49-74.