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Brief Report

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## Posttraumatic Stress, Mental Health Professionals, and the Clergy: A Need for Collaboration, Training, and Research

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*This article addresses the need for improved clergy-mental health professional collaboration in the assessment and treatment of posttraumatic stress disorder (PTSD). Tens of millions of North Americans with personal problems seek the counsel of clergy. There is an absence of research on the function of clergy as helpers with the traumatized and on the psychological dynamics of religious coping among the traumatized. Psychological trauma presents the mental health and religious communities with unique opportunities to work together in the best interest of those they serve.*

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**KEY WORDS:** PTSD; clergy; religion; spirituality.

One March evening a tornado swept into the town of Greenville, South Carolina hurling trees, smashing homes and inflicting severe injuries. Coloring the trees the next morning were not spring cherry blossoms but tufts of pink insulation from the ravaged homes in the religiously conservative, Protestant community. The area Mental Health Center interviewed residents who came for federal disaster relief to see if any suffered PTSD.

Of the 116 respondents, 69 people or 59% qualified for a diagnosis of acute PTSD, 19 of whom had a severe form. Not one of these people, however, came to the Mental Health Center for help. At a 15-month follow-up 43% were still suffering with the disorder. (Larson & Larson, 1992, p. 3)

How many people could have been provided with early intervention and appropriate care if the clergy in this highly religious area had been trained in the recognition of posttraumatic stress disorder (PTSD), and how to assist those suffering to find mental health services? Suppose the religious community felt mental health specialists had an understanding of and appreciation for religious interpretative meaning when faced with suffering

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and were willing to work with clergy as colleagues throughout the clinical treatment? What if the area mental health community had developed linkage with religious leaders through educational events and receptive dialogue prior to the disaster? These questions are further reinforced when we discover that a research study conducted in South Carolina, 3 years after the first study, found that almost three out of four survivors of hurricane "Hugo" indicated that they used religion as a coping strategy in the aftermath of that disaster (Weinrich, Hardin, & Johnson, 1990).

Rabbis, priests, and pastors serve as front-line community mental health workers. Caring for people who are suffering psychological trauma is a significant part of pastoral work. It is important that members of the clergy and mental health professionals find means to work together more effectively to better serve traumatized people. As a beginning, it is essential that we train clergy in the recognition of PTSD and acute stress disorder (ASD), since tens of millions of Americans, particularly ethnic minorities, call upon clergy for help in times of personal crisis (Chalfant et al., 1990; Mollica, Streets, Boscarino, & Redlich, 1986; Veroff, Kulka, & Douvan, 1981). Likewise, it is important for mental health professionals to recognize the vital role that the religious community may play in screening and follow-up care of trauma survivors (Weaver, 1993).

One study found that a clergy member was just as likely as a mental health specialist to have a severely mentally distressed person ask her or him for assistance (Hohmann & Larson, 1993). People in "crisis" involving the "death of someone close" reported almost five times more likelihood to seek the aid of a clergyperson (54%) than all other mental health sources combined (11%) (Veroff et al., 1981). Persons at the highest socioeconomic level are the only group in society more likely to seek out a mental health professional for help than a clergyperson (Hohmann & Larson, 1993). According to the United States Department of Labor (1992), there are approximately 312,000 Jewish and Christian clergy serving congregations in the United States (4,000 rabbis, 53,000 Catholic priests, and 255,000 Protestant pastors). These clergy are engaged in counseling and other mental health services at an average rate of about 9.5 hr per week (Weaver, 1995). Annually, this adds to 148.2 million hr of mental health services, a volume equivalent in time to each of the 38,000 members of the American Psychiatric Association (APA, 1993) delivering services at the rate of 78 hr per week. This estimate does not take into account the nearly 100,000 nuns in full-time religious vocation in the Roman Catholic Church (Ebaugh, 1993) or clergy and religious workers from other religious traditions (e.g., Christian Orthodox, Buddhism, Hinduism, and Islam) in the United States, about whom it appears we have no research data regarding counseling knowledge or activity.

It has been well documented that clergy respond to persons exposed to a wide range of extreme stressors that can precipitate PTSD. Publications have reported clergy responding to natural disasters (Chinnici, 1985), catastrophic accidents (Lindy, Grace, & Green, 1981), criminal assault including rape (Golding, Siegel, Sorenson, Burham, & Stein, 1989), spouse battering (Bowker & Maurer, 1987), child abuse (Weaver, 1992), elder abuse (Pratt, Koval, & Lloyd, 1983), and human-created disasters including death camps (Cohen, 1989), war (Jacob, 1983) and torture (Lernoux, 1980).

Studies conducted in hospitalized patients undergoing acute or worsening physical illness have reported that about 25% spontaneously indicate religion as the most important factor that enables them to cope; furthermore, these studies indicate that there is a significant inverse relationship between the use of religion as a coping behavior and affective symptoms both cross-sectionally and longitudinally (Koenig et al., 1992; Pressman, Lyons, Larson, & Strain, 1990). This is particularly true for older women, over 50% of whom may use religion as a coping behavior during times of stress (Koenig, George, & Siegler, 1988) and for African Americans (Conway, 1985; Krause & Tran, 1989).

Despite the abundant evidence that clergy are extensively involved with the care of persons exposed to traumatic stress and that religion is a primary coping strategy for many persons in times of stress, there is an absence of published research in the mental health literature on the role of clergy in response to persons suffering traumatic stress. A computer search using the Psychological Literature Index Data Base (1/74-12/93) revealed 1,583 citations with posttraumatic stress disorder in the text, only one of which (Wick, 1985) addressed the role of clergy (rabbi, priest, minister, or pastor). Two articles cross-referenced PTSD and religion, one investigating the coping styles of natural disaster survivors (Weinrich, Hardin, & Johnson, 1990) and the other, long-term stress among combat veterans (Green, Lindy, & Grace, 1988). Both articles found religion to be a primary coping strategy for people suffering psychological trauma.

When referencing "posttraumatic stress disorder" in the Psychological Literature Index Data Base for Book Chapters and Books (1/87 to 12/93) 333 citations appear. Of these only two PTSD textbooks made reference to clergy as possible helpers for persons suffering PTSD (Figley, 1989; Williams, 1987), and one book had two useful chapters on the pastoral care of Holocaust survivors by rabbis (Cohen, 1989; Skolnik, 1989). The absence of research into the role of clergy as helper with the psychologically traumatized contributes to the isolation of clergy from the mental health network in which they play a pivotal role.

Further, clergy appear to be inadequately trained to appropriately recognize the symptoms of someone who is in emotional distress. Domino (1990) found, in a geographically representative sample of 157 American clergy, that Protestant, Catholic, and Jewish clergy demonstrated about the same knowledge level of the symptoms of emotional distress (such as depression and anxiety) as a group of college undergraduates in an introductory psychology class. These findings are further reinforced by research demonstrating that even experienced clergy are woefully unprepared to assess for suicide potential in persons at risk. When compared to psychiatrists, psychologists, social workers, and marriage and family therapists, clergy scored significantly lower on the ability to assess for suicide lethality (Domino, 1985; Swain & Domino, 1986).

Referral skills are, of course, closely related to evaluation skills since evaluation of a problem guides the course of action. Meylink and Gorsuch (1987) reviewed all research involving the referral patterns among clergy in the 20 years between 1963 and 1983. They found that clergy referred less than 10% of those coming to them with problems to mental health specialists. A more recent study of urban rabbis (Ingram & Lowe, 1989) revealed a similar pattern. It has been estimated that improved referral and evaluation skills could increase clergy referrals by almost three times the current rate (Lee, 1976). To be fair, most clergy receive little training in making a referral and identify financial considerations of the counselee as a chief reason for not making more mental health referrals (Virkler, 1979).

A clear example of the need to train clergy about PTSD is revealed in the numbers of women who seek the assistance of clergy as a result of spousal assault. Alsdurf (1985) surveyed 5,700 Protestant clergy in the United States and Canada and found that 84% of the respondents had counseled battered wives in the course of their pastoral work. In a survey of 1000 battered women, Bowker and Maurer (1987) discovered that one in three of these women received help from the clergy and one in ten of the battering husbands were counseled by a member of the clergy. Clergy were seen by the battered women as slightly more effective helpers than medical personnel and significantly less effective than social services, police, lawyers, shelters, and women's groups. Mental health training of clergy regarding marital violence and its aftermath would presumably be an important preventive mental health strategy.

Many pastors understand the limits of their skills and are prepared to take part in additional mental health training. In a national study on the pastoral counseling skills of Protestant clergy, researchers found that 37% of the almost 2,000 pastors studied agreed that "the

overall quality of pastoral counseling is poor" (Orthner, 1986, p. 53). In four separate studies, a majority of clergy reported that they had attended one or more workshops or seminars related to mental health issues, and a significant number of the continuing education events were sponsored by a mental health discipline (Abramczyk, 1981; Orthner, 1986; Rupert & Rogers, 1985; Wright, 1984). Canadian clergy who had attended a mental health continuing education event in the year prior to the study made three times as many referrals as nonattenders (Wright, 1984).

Because of the negative attitude of some mental health professionals toward religion and spirituality (Ellis, 1980; Freud, 1927), and the clergy (Meloy, 1986) the potential role of religion and clergy in helping traumatized persons reestablish a sense of meaning and coherence in their shattered world is frequently overlooked. It is not surprising that psychiatrists refer patients to clergy less frequently than do other medical specialties (Koenig, Bearson, Hover, & Travis, 1991). This trend is largely due to a lack of education about what clergy can do to help and the powerful role that religion can play in helping persons put their lives back together after a trauma. The clergy have much to teach mental health professionals about helping people whose faith and trust in a benign universe has been shattered by their traumatic experiences. Thus, there is a need to open much more of a dialogue between clinicians and spiritual healers.

Clergy are in a particularly helpful position to recognize PTSD and assist persons in seeking specialized care. Pastors are often in long-term relationships with individuals and their families, giving them ongoing contacts in which they can observe changes in behavior that may greatly assist in the assessment of PTSD. They are visible and available caregivers who offer a sense of continuity with centuries of human history, a feeling of being a part of something greater than oneself and an established pattern of responding to crises. Undoubtedly persons in distress go to clergy in such large numbers because accompanying the traumatic experience for many individuals is a "crisis of faith" (Ochberg, 1988; van der Kolk, 1987). Clergy have specialized training in philosophical and theological issues that directly relate to these life-crisis questions. Clergy are also in a unique position of trust in which they can assist persons in reconnecting to support systems available through their faith communities. With effective training in PTSD diagnostic and referral networking skills clergy could make a much more significant contribution to preventive mental health in North America.

### Recommendations

1. Research is needed to better understand the role of clergy as helpers with the traumatized. Important questions to be addressed are: How much do clergy know about PTSD? Do clergy have training on PTSD in seminary or postseminary continuing education? How much knowledge do clergy have about community resources available to the traumatized? How often do clergy refer traumatized persons to a mental health specialist? How often do clergy have mental health specialists refer traumatized persons to them for spiritual care? What spiritual resources for healing are utilized by clergy when working with the traumatized?

2. More information is needed about attitudes of mental health professionals toward clergy and what role, if any, they perceive that clergy might play. What personal and professional characteristics predict whether clinicians view clergy as potential allies and collaborators, as playing a minimal role, a competitive role, or even a harmful role in this area? What are some fears that mental health professionals have about working with clergy, and how often are such fears justified? Such research may help to identify barriers that prevent mental health professionals and clergy from working together in helping the traumatized victim.

3. Research is needed to investigate the function of religion as a coping strategy for trauma survivors. More than 50 published studies over the past 15 years have consistently demonstrated a positive association between religious commitment and mental health (Koenig, 1995). Religiously involved persons have lower rates of depression, anxiety, alcoholism, and suicide; higher life satisfaction and greater well-being; and adapt better to the rigors of physical illness and disability. Furthermore, religious persons perceive themselves as less disabled and experience less pain than do those with similar health problems but without a strong faith in God (Koenig, 1994). Do persons with psychological trauma benefit from religious coping? Does religion have a buffering or "cocoon" effect for some persons so that they are at lowered risk of PTSD or have more rapid recovery?

4. Information needs to be designed for clergy and religious caregivers explaining the signs of PTSD as well as how to best support and connect trauma survivors to the larger network of specialized helpers. This is an educational project that the International Society for Traumatic Stress Studies and the American Association of Pastoral Counselors could develop together. Such information needs to be made available to all clergy but especially those in the inner city impacted by epidemic levels of violence. In a random sample of young adults in Detroit, Breslau, Davis,

Andreski, and Peterson (1991) found that 4 out of 10 had been exposed to a traumatic event that qualified as a PTSD stressor. The rate of PTSD in this exposed group of urban young adults was 24%.

In many places in the United States, clergy are the only professionals who live in the inner city. Many helping professionals live in the suburbs and commute to their jobs. Pastors need collegial/collaborative relationships with mental health professionals to diminish the isolation that can place them at risk of "helper burnout" when working with the traumatized (David Foy, personal communication, March, 22, 1994).

5. Mental health professionals can play an important role in educating clergy about the first signs of PTSD, to enable them to screen more effectively members of their congregation for this disorder. Providing educational programs directed toward community clergy and chaplains can help to fill the gap that many have in their training in this area. Including a clergyperson as part of the health care team is a practical way to educate and train clergy to become more proficient in the diagnosis of PTSD and the range of treatments that are now available.

6. Although most clergy receive some training in counseling (Weaver, 1995), very few mental health specialists receive training in any aspect of religion. A survey of clinical psychologists who were members of the APA revealed that only 5% had religious or spiritual issues addressed in their professional training (Shafranske & Malony, 1990). When members of the American Association of Directors of Psychiatric Residency Training were asked if their program had a course on any aspect of religion, 19% endorsed "occasionally" and 12% stated "frequently or always." (Sansone, Khatain, & Rodenhauer, 1990). Care of the traumatized offers a creative opportunity in which mental health specialists and the religious community can learn from one another. Contemporary mental health care of the traumatized requires cultural sensitivity and diverse understandings of suffering, healing and spirituality and a receptive dialogue with religious professionals.

For the past 28 years, the Case Western Reserve University School of Medicine has sponsored a program for parish-based clergy employing group clinical supervision based on actual pastoral experiences. They focus their program on "self awareness, interviewing, psychological evaluation, referral and brief acute crisis counseling," with a two year, weekly clinical case design. This program has trained a significant portion of the clergy in the Cleveland, Ohio area and is a model that could be effectively used in many mental health settings with benefits to all vocations involved (Rabbi Milton Matz, personal communication, March 15, 1993).

## Conclusion

Despite limitations in training, clergy act as front-line mental health workers for millions of Americans, many of whom have suffered psychological trauma. Americans have very high rates of church, temple, and mosque involvement and there is strong empirical evidence that faith involvement has positive benefits for many of these people. Although most clergy receive some training in counseling very few mental health specialists receive training in any aspect of religion or spirituality. Clergy indicate a high interest in mental health continuing education. Contemporary mental health professionals need to appreciate diverse religious understandings of healing and spirituality when working with the traumatized and develop a creative dialogue with religious communities.

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