

FAITH GROUP LEADERS AND TRAUMA: THE DIFFERENCE THAT CAN MAKE THE DIFFERENCE?

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Abstract: Traumatic events are very much a part of everyday life; they are neither new nor rare. The care of faith group members suffering from psychological trauma is a significant component of pastoral care and yet little attention has been paid to this complex area. This article details the results of a collaborative study between mental health and faith group leaders and between NHS Tayside and NHS Fife, which examines the role of faith and belief group leaders in working with people who have been subjected to trauma. The first part of this article details questions of interest to chaplains and faith group leaders, such as: the relationship between the faith group leaders and mental health personnel, and what training was available to faith and belief group leaders? Following completion of the study a consultation day was held by the Department of Spiritual Care in NHS Tayside (in November 2008) at which the collated results were presented. The faith group leaders, chaplains and health personnel who were present were able to give their responses to the results of the survey; those responses constitute the second part of this article.

Keywords, trauma, faith and belief group leaders, spiritual and religious care

Introduction

The total care of individuals after traumatic events necessitates that their physical, psychological and spiritual needs are attended to. Our knowledge of how to maximise the physical care of trauma victims has advanced more significantly over recent years than their psychological care and the spiritual care of trauma survivors has been largely neglected by mental health personal and researchers.

There is compelling evidence that traumatic experience triggers a psychological response, and that for a great majority of individuals this will comprise a normal and time-limited reaction. For some individuals, a combination of factors may provoke more serious reactions such as depression or post-traumatic stress disorder (PTSD).

Complicating the picture still further is the fact that clinically there is no easily discernable boundary between a normal and abnormal response to trauma, making any distinction difficult even for the expert in psychological disorders and therefore nigh on impossible for the interested and perhaps even gifted amateur.

In discussing trauma it is vital to clarify what constitutes a traumatic event. Involvement in a disas-

ter, prolonged combat exposure or suffering horrific burn injuries can readily be seen to be severe traumatic events, but the commonplace trauma such as an assault, accident at work or a road traffic collision may be accompanied by the perception of threat to life or the threat of serious injury; the individual may thus respond with fear, helplessness or horror and later development of significant psychological disorders.

Whilst we may believe some traumas to be so inherently awful that psychological distress will be inevitable, it should be remembered that no type of traumatic event invariably leads to the development of a psychological disorder. Individuals can be remarkably resilient and whilst we must be alert to distress we should not simply assume the individuals will have problems coping.

Moreover, it is clear that psychiatric or psychological symptoms are only part of the potential effects, with impairment of social or occupational function or the shattering of assumptions about the world (i.e., its

safety or justness) important to consider (Janoff-Bulman;1985, 1989, 1992). Positive effects after trauma has also been reported, for example approximately two thirds of the survivors of Piper Alpha disaster described positive sequelae such as feeling closer to their family (Hull et al, 2002). These positive effects are increasingly being empirically studied (Linley & Joseph, 2004). Factors significantly associated with growth after adversity such as trauma include: existential openness (Calhoun et al, 2000); intrinsic religiousness (Park et al, 1996), and religious participation (for example, Keonig 1998).

It is known that faith group leaders are commonly called upon to counsel individuals with mental health problems (Larson et al, 1998), including trauma (Weaver, Koenig and Ochberg, 1996; Lount and Hargie, 1997). Some groups, for example black Americans, people with strong religious affiliation, people from lower socio-economic group, and people with serious mental illness are more likely to attend clergy as first resort than others (Husaini, Moore and Cain, 1994; Weaver, Koenig and Ochberg, 1996; Larson et al, 1998).

Indeed, significant numbers of people with mental health problems use faith group leaders rather than mental health professionals (Sorgard and Sorensen, 1996). Some faith group leaders may lack confidence in counselling for mental health problems, and previous work has suggested that differences in confidence and practice within the faith and belief groups relate principally to training, rather than orientation or experience (Manning and Crawford, 1996; Winger and Hunsberger, 1988; Strickland, Welshiner and Sarvela, 1998). Training increases both skills and readiness on behalf of the faith

group leaders to refer to mental health services (Kim-Goh, 1993), and clergy seem more open minded about using mental health services than vice versa (McMinn et al, 1998; Manning and Crawford, 1996).

We decided to survey faith leaders in Tayside to ascertain the frequency with which they came across members of their congregation suffering from trauma, to determine how equipped they felt to respond, and to open a dialogue which would, it was hoped, lead to improved responses.

Method

The project gained full ethical approval from the research ethics committee. A questionnaire was designed and sent by post and email to faith group leaders identified through the NHS Tayside's Department of Spiritual Care directory of faith and belief group leaders, faith group offices, the internet and the phone book. Two rounds of questionnaires were sent and the results were collated using MS Excel and then presented to a selected focus group for discussion.

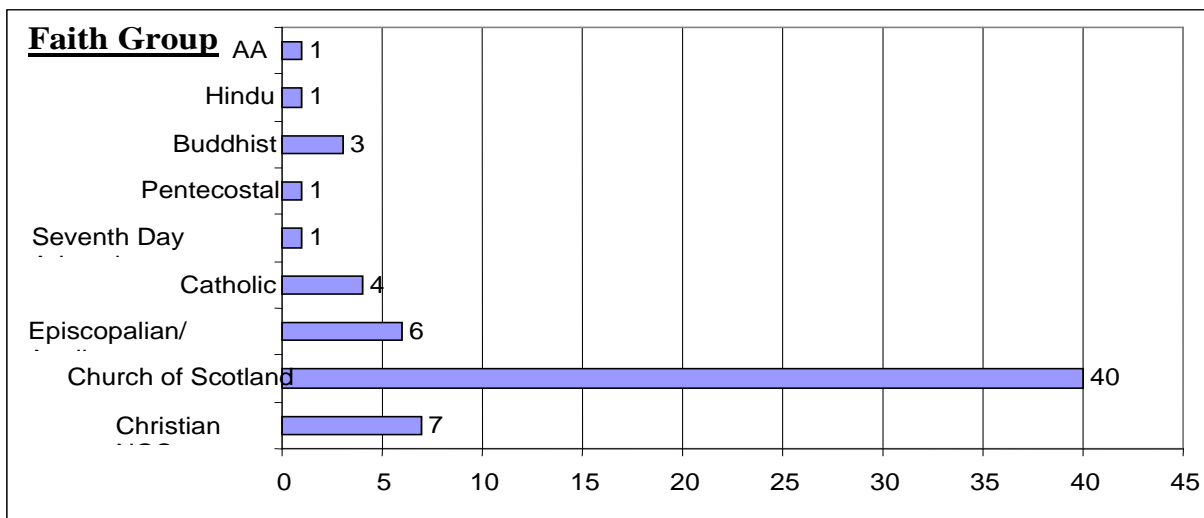
Results

180 surveys were sent by post and by email and 64 responded in a manner amenable to analysis. Those excluded include blank forms, no experience of trauma and undelivered forms. The faith and belief groups canvassed were those represented in NHS Tayside, which correlates with a relative degree of accuracy to the national spread of faith and belief groups as found in the 2001 census. Census material is reproduced here with kind consent of the General Register Office of Scotland.

Table 1:

Percentage of people stating religion by council area. [General Register Office of Scotland, from the 2001 Census of Population]					
	All Tayside	Angus	Dundee City	Perth & Kinross	Scotland
Church of Scotland	45.34	53.91	34.95	49.68	42.40
Roman Catholic	11.87	5.90	20.24	7.64	15.88
Other Christian	7.47	6.86	6.67	8.83	6.81
Buddhist	0.12	0.08	0.17	0.11	0.13
Hindu	0.13	0.04	0.26	0.05	0.11
Jewish	0.03	0.03	0.04	0.03	0.13
Muslim	0.87	0.18	1.98	0.23	0.84
Sikh	0.06	0.02	0.14	0.02	0.13
Another Religion	0.54	0.39	0.66	0.53	0.53
None	28.49	27.98	29.11	28.22	27.55
Not answered	5.08	4.61	5.78	4.68	5.49

Figure 1:



Respondents

Responses were received from the above faith and belief groups (with NOS being 'no other statement', where the respondent did not give any identification of denomination or group other than

'Christian'). The responders identified their own faith or belief and the research team have placed these into nine categories, six of which would be classed broadly as Christian. Three respondents described themselves as Buddhist, one Hindu and one as be-

longing to the belief group of Alcoholics Anonymous. There was an age range from 30 to 79 years, and 78.1% were male. Figures 2 and 3 demonstrate

a closer breakdown of their age ranges and a breakdown of the years of service reported by the respondents.

Figure 2:

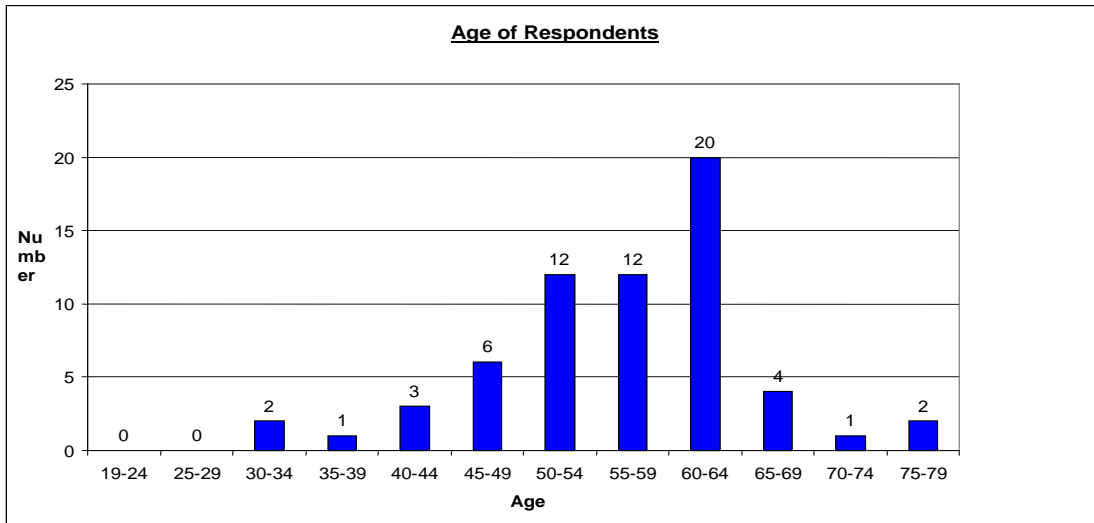
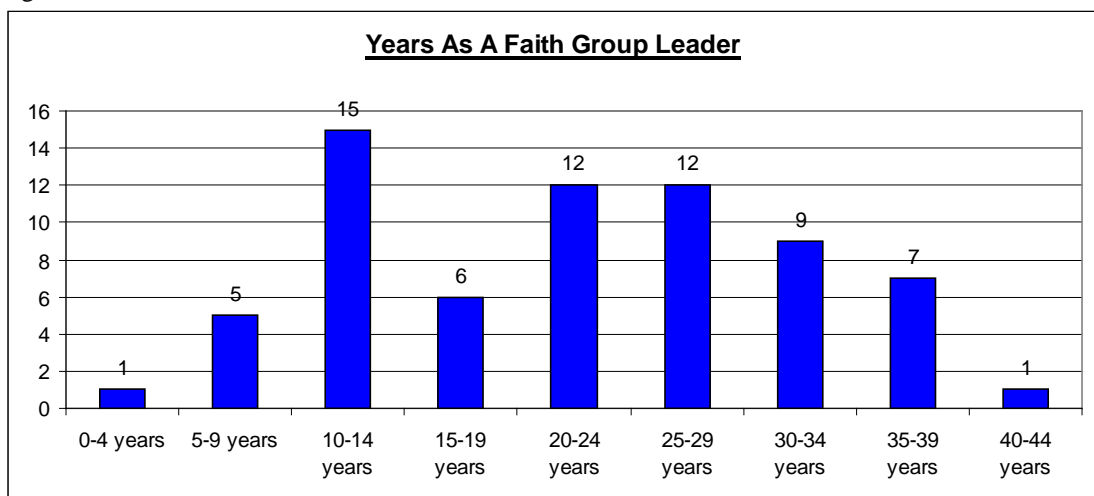


Figure 3:



Contact with traumatised individuals

90% of the faith group leaders reported that they had been approached by a member of their faith group regarding trauma, with 70.3% having been approached on a “drop in basis”.

Training

The survey asked what training was available, prior to qualification, for faith and belief group leaders. The possible types of training were divided into mental health training and counselling-type training. Sixty two per cent of respondents had had some degree of training; 38% had none. Table 2 demon-

strates which type of training the respondent stated that they had undertaken. The right hand columns describe those with neither mental health or coun-

selling training and those who described themselves as having taken both types of training.

Table 2:

Number of Respondents with Training relevant to dealing with trauma, by faith group.						
Faith Group	Mental Health Training (%)	No Mental Health Training (%)	Counselling Training (%)	No counselling training (%)	Neither *	Both**
Christian NOS	2 (29)	5 (71)	4 (57)	3 (43)	3 (43)	2 (29)
Church of Scotland	18 (45)	22 (55)	23 (57)	17 (42)	13 (32)	14 (35)
Episcopalian	2 (33)	4 (66)	3 (50)	3 (50)	2 (33)	1 (17)
Catholic	0 (0)	4 (100)	2 (50)	2 (50)	2 (50)	0 (0)
Seventh Day Adventist	1 (100)	0 (0)	1 (100)	0 (0)	0 (0)	1 (100)
Pentecostal	0	1	1	0	0	0
Buddhist	0 (0)	3 (100)	0 (0)	3 (100)	2 (67)	0 (0)
Hindu	0 (0)	1 (1)	0 (0)	1 (100)	1 (100)	0 (0)
Alcoholics Anonymous	1 (100)	0 (0)	1 (100)	0 (0)	0 (0)	1 (100)
TOTALS	24 (37)	40 (62)	35 (55)	29 (45)	23 (36)	19 (30)

* neither MH nor Counselling ** both MH and Counselling

Spiritual or Religious Care and Counselling

It is clear from some of the open text responses that spiritual or religious care and counselling were considered to be different. A sample of open text comments are noted below. One respondent with counselling skills said that when talking to mental health professionals,

“I have had to insist that individuals be ‘checked out’. Only when I have stated that I am an accred-

ited counsellor, as opposed to a minister has what I have said been taken seriously.”

Another wrote,
“I am concerned with aspects of confidentiality. I would not say I counsel as such.”

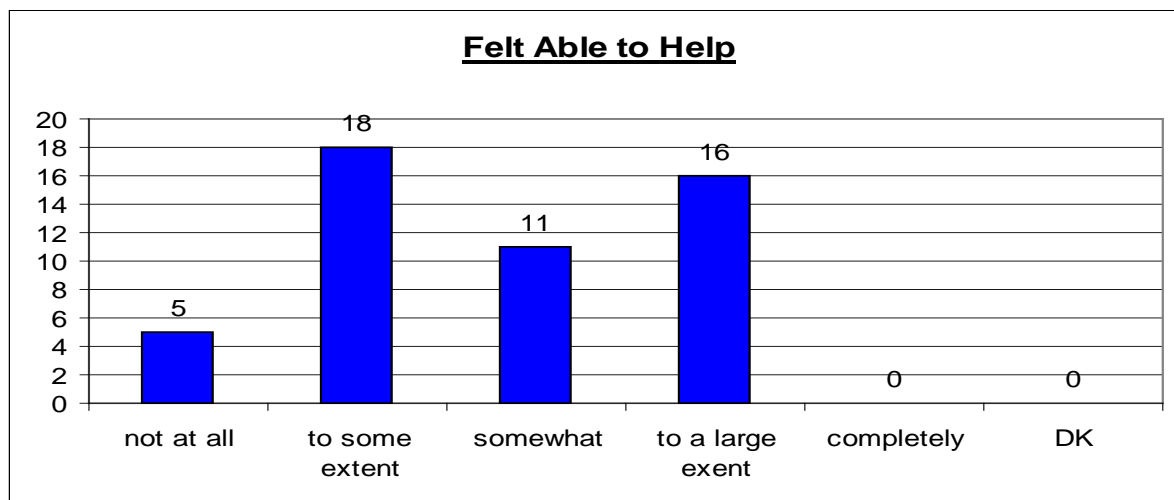
A third respondent felt that this distinction was also made in the minds of those seeking help for their trauma-experiences from a faith or belief group leader:

“People contacting their parish minister are not looking for ‘counselling’. The approach is more informal

and more equal. They are expecting a minister to listen, above all, but there is often an opportunity to give the person reassurance, comfort or a new way

of looking at things, which can include the option of seeking professional help, from a psychiatrist, for example.”

Figure 4:



The number of respondents endorsing each of the categories are shown in Figure 4, with only 5 (4%) believing they were not at all able to help. (DK=Don't Know)

Discussion

Whilst faith and belief group leaders may often come to their vocations later in life it was clear from our respondents that the majority had served for sufficient time for the results of our questionnaire to be representative of the broad scope of work which they might be expected to meet in a career as a faith or belief group leader.

It is clear that dealing with trauma, and with the responses of individuals to traumatic events, is an expected part of the working life of a faith group leader. The type and duration of training varied considerably with some faith and belief group leaders clearly coming to their current role from social work or a similar career where mental health and counselling training was more widely provided. There was no correlation between number of years as a faith or belief group leader and the amount of training that had been undergone, with no clear pattern emerging supporting the idea that there is an improvement in the type or volume of training available over the past 45 years.

It is important to clarify what the faith and belief group leaders themselves considered to be training in mental health. A lack of clarity as to what constitutes this training is demonstrated by only three of the respondents listing practical theology lectures as giving mental health training, although a majority of the Church of Scotland Ministers, who comprised 40 out of 64 respondents, would have taken training of this type. Further research would be required to determine how uniform the presentation of mental health material in practical theology courses has been over the past 45 years, in the four divinity faculties or schools in Scotland. Moreover, it is not clear whether respondents considered there to be a distinction between training and education. Faith group leaders have university education but this does not equate to mental health training.

A comparison can be found with the findings published by Mowat and Swinton in their report, 'What do Chaplains Do?' The authors interviewed 44 full-time chaplains of whom seven had a counselling qualification, and 14 of whom held a Bachelor of Divinity degree, which would involve some practical

theology components. Whilst Mowat and Swinton found 14% to have counselling training our survey had a considerably higher percentage of counselling training (55%).

Equally, one respondent who was British Association for Counselling and Psychotherapy (BACP) registered commented that:

"[Counselling is] specialised work, many ministers would not have the skills; I have had to pick up the pieces of people's previous contact. [I] have to pay for supervision."

Moreover the support systems, such as supervision, that are available for counsellors are not available for this faith and belief group leader; this is a clear risk for those undertaking this often difficult work. A comparative analysis of the availability of supervision and other forms of support for faith and belief group leaders was outside the scope of this study but represents an opportunity for further research. Even so faith and belief group leaders seem to consider that they use skills from 'counselling training' to inform their pastoral or spiritual religious care; not to provide counselling *per se*.

The identification of training needs amongst faith and belief group leaders does not diminish the considerable skills that they were able to bring to the assistance of people who had traumatic experiences. The potential for the immediacy of their input as a contrast to the often delayed input from mental health services further amplifies the potential influence their input upon the adaptation of individuals to adverse and traumatic life events. Bateson wrote of the difference that makes the difference and contextualising input for individuals which is appropriate to their belief system as opposed to input which jars with their beliefs is more likely to be the appropriately unusual difference that's makes a difference (Bateson, 1972).

Mental Health staff benefit from supervision and support structures that might be useful for faith group leaders and liaison between the two groups would benefit both groups, and benefit the distressed individual even more. The results of this study and the consultation process are that it is necessary to provide further mental health training thus increasing confidence in skills present and augmenting skills. As one respondent commented,

"there should be more training and close links between professional groups".

Consultation

On 25th November 2008 a conference was held by the Department of Spiritual Care, NHS Tayside, at which the authors presented the above research findings. There were 21 conference participants most of whom were hospital chaplains. Also represented was a BACP registered counsellor, a senior NHS manager, and chaplaincy volunteers. The participants were divided into four groups and asked to respond to the findings. Two of the questions related to the training available:

I there anything I have learned today I can add to my toolbox for dealing with trauma?

What would be a helpful way to get more tools for dealing with trauma?

Taking these two questions together, the participants made the following observations:

The ordinary things we do have value naturally;

There is use in having a plan; the objective is recovery;

Importance of the family to those experiencing various responses to trauma;

Ritual linked to ability to express distress, funerals, and the role of the undertaker is important;

There are no cowards or heroes, no professionals or patients. We share a common humanity;

There is trauma in bad news being broken;

Pastoral response not overtly religious, whether chaplain or faith or belief group leader;

It is easy to underestimate the faith or belief group leader's role in presence, holding or touching a traumatised person.

And they identified the following requirements of faith group leaders:

Training only takes us so far; we just have to do it.

Expectations frame experience. If we don't know what is coming next [when called in] then we just have to turn up.

Minimising the drama rather than maximising the drama

Practising the art of dialogue between the professionals, whether that be working with other clergy, CPNs, or GPs etc.

The need for joint training between hospital staff and ministry teams

The need to challenge health professionals and to communicate with health professionals

Taking time to be a reflective practitioner acknowledging the need for and good use of Spiritual Direction or pastoral supervision

The need for wider co-operation between faith group leaders and psychiatry was recently highlighted in an editorial in the *British Journal of Psychiatry* (Leavey and King, 2007). It is a clear outcome of this research that there is a desire on the part of some faith and belief group leaders to participate in multidisciplinary working. Respondents to the survey also highlighted the specialist role of hospital chaplains in this regard, as is demonstrated by the following comment:

“As a chaplain I was regularly used by mental health care staff. They knew me as an individual and not as a ‘perceived role’. As a minister of religion, GPs learned to trust my way of working and began to respect me BUT because of my therapeutic training as opposed to my ministerial background. Working with trauma victims is draining, time-consuming but necessary, a privilege to be able to assist, sometimes costly to myself (i.e. my emotional health). Rewarding.

It could be inferred that the mutual values of chaplaincy and faith and belief group leaders enable these groups to link together and perhaps it would be useful for chaplains in developing their practice to be aware of their potential role as a bridge between mental health professionals and faith and belief group leaders.

Finally, the participants stated that the conference had taught them about;

Coping strategies;
Life experience which gives tools for dealing with trauma;
Understanding better what is trauma;
The positive aspects of dealing with trauma.

Traumatic experiences do not always affect individuals in negative ways as noted above. In fact positive changes after traumatic experience has been noted in philosophical, religious and fictional texts since the earliest writings (Tedeschi & Calhoun, 1995). Positive change has been referred to in trauma literature as “adversarial growth” (Linley

& Joseph, 2004). The participants at the conference related their own experience of working with people who had experienced trauma that good can come, either fairly quickly in a feeling of joy to be alive, or in the longer term, through growing and developing afresh after a trauma experience.

References

- BATESON G 1972 *Steps to an Ecology of the Mind* New York, Ballantine
- The General Register Office of Scotland, the 2001 Census of Population
- HUSAINI B A, MOORE S T and CAIN V A 1994 Psychiatric symptoms and help-seeking behaviour among the elderly: an analysis of racial and gender differences. *Journal of Gerontological Social Work* Vol. 21: 177-195.
- KIM-GOH M 1993 Conceptualisation of mental illness among Korean-American clergymen and implications for mental health service delivery. *Community Mental Health Journal* Vol. 29: 405-412.
- LARSON D B, HOHMANN A A, KESIBER L G, MEADOR K G, BOYD J H, MCSHERRY E 1988 *Hospital and Community Psychiatry* Vol. 39: 1064-1069.
- LEAVEY G and KING M 2007 The devil is in the detail: partnerships between psychiatry and faith based organisations. *British Journal of Psychiatry* Vol. 191, 97-98.
- LINLEY P A and JOSEPH S 2004 Positive Change Following Trauma and Adversity: A Review, *Journal of Traumatic Stress*, Vol 17, no 1, pp.11-21.
- LINLEY P A and JOSEPH S 2005 Positive and Negative Changes Following Occupational Death Exposure, *Journal of Traumatic Stress*, Vol 18, no 6, pp751-758
- LOUNT M and HARGIE O D 1997 The priest as counsellor: an investigation of critical incidents in the pastoral work of Catholic priests. *Counselling Psychology Quarterly* Vol 10 pp247-259.
- MANNON J P and CRAWFORD R L 1996 Clergy confidence to counsel and their willingness to refer to mental health professionals. *Family Therapy* Vol.23 pp213-231.
- MCMINN M R, CHADDOCK T P, EDWARDS L C and LIM B R K B. 1998 Psychologists collaborating with clergy. *Professional Psychology: Research and Practice*. Vol. 29 pp564-570.
- MOWAT H and SWINTON J 2005 What do Chaplains Do? The role of the Chaplain in Meeting the

spiritual needs of patients Mowat Research Limited, Aberdeen.

SORGARD K W and SORENSEN T 1996 The church and community psychiatry services in a region of Northern Norway. *Soc. Psychiatry and Psych. Epidemiology* Vol. 31 pp266-271.

TEDESCHI R G and CALHOUN L G 1995 Trauma and Transformation. Growing in the Aftermath of Suffering. Thousand Oaks, CA. Sage.

WEAVER A J, KOENIG H G, OCHBERG F M 1996 Post traumatic stress, mental health professionals, and the clergy: a need for collaboration, training and research. *Journal of traumatic stress*, Vol. 9 pp847 - 857.

WINGER D and HUNSBERGER B 1988 Clergy counselling practices, Christian orthodoxy and problem solving styles. *Journal of psychology and theology* Vol. 16 pp41-48.

SRICKLAND G A, WELSHINER K J and SARVELA P D 1998 Clergy perspectives and practices regarding intimate violence: a rural view. *Journal of Rural Health* Vol 14 pp305-311

JANOFF-BULMAN R 1985 The aftermath of victimisation: rebuilding shattered assumptions. In FIGLEY C R (ed.), *Trauma and its wake* (pp15-35). New York: Brunner/Mazel.

JANOFF-BULMAN R 1989 Assumptive worlds and the stress of traumatic events: applications of the schema construct. *Social Cognition*, Vol. 7 pp113-136.

JANOFF-BULMAN R 1992 Shattered assumptions: Towards a new psychology of trauma. New York: Free Press.

HULL A M, ALEXANDER D A and KLEIN S 2002 A long-term follow-up study of survivors of the Piper Alpha Oil Platform Disaster. *British Journal of Psychiatry*. Vol. 181 pp435-440.

CALHOUN L G, CANN A, TEDESCHI R G and MCMILLAN J 2000 A correlational test of the relationship between posttraumatic growth, religion, and cognitive processing. *Journal of Traumatic Stress*, Vol.13 pp521-527.

PARK C L, COHEN L H, and MURCH R 1996 Assessment and prediction of stress-related growth. *Journal of Personality*, Vol.64 pp71-105.

KEONIG H G, PARAGMENT K I and NIELSEN J 1998 Religious coping and health status in medically ill hospitalised older adults. *Journal of Nervous and Mental disease*, Vol.186 pp513-521.

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