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Spirituality and Trauma: The Role of Clergy in the Treatment of Posttraumatic Stress Disorder

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ABSTRACT: An increased awareness of the spiritual aspects of health and illness has recently led to changes in psychiatry residency training as well as hospital accreditation requirements. The spiritual impact of trauma has been an area of particular interest, as trauma evokes certain existential questions and crises. It is estimated that from 5–11% of trauma survivors will go on to develop posttraumatic stress disorder (PTSD). Given the spiritual challenges of the experience of trauma, patients with PTSD could benefit from spiritual assessment and intervention as part of their overall treatment plan, and clergy can be utilized to perform this. The literature exploring the spiritual impact of trauma and the use of clergy in the treatment of trauma survivors is reviewed. The methods used by three chaplains in a residential treatment program for PTSD at one facility are described and discussed. Both the literature and the experiences of the clergy suggest that exploration of trauma-related existential conflicts in patients with PTSD is beneficial. However, there is a notable dearth of controlled scientific studies evaluating the effectiveness of spiritual interventions with this treatment population. The need for controlled studies to verify the usefulness of spiritual assessment and intervention in patients with PTSD is noted, and a more rigorous analysis of how clergy can best serve this treatment population is encouraged.

KEY WORDS: trauma; posttraumatic stress disorder; spirituality; religion; clergy; psychotherapy.

Introduction

There has been interest recently in the spiritual aspects of health and illness. Some assert that physicians have not adequately addressed patients' spiritual needs. This has coincided with research that has shown that spiritual

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beliefs and religious behaviors can contribute to improved coping with illness, as well as improved health outcomes (1,2,3). The American Psychiatric Association has called for greater sensitivity to spiritual issues in psychiatric practice (4). To support this goal, the Accreditation Council on Graduate Medical Education requested that spiritual and religious issues be part of psychiatry residency training, and the Joint Commission on Accreditation of Healthcare Organizations requires that a spiritual assessment be performed on patients receiving behavioral health services (5,6)

It is generally agreed that life-threatening events and psychological trauma can prompt spiritual questioning. Trauma can include experience of combat, a natural disaster or terrorist attack, sexual assault, or any experiences where individuals fear that their life or psychological integrity are threatened. The lack of control, combined with the violent and sometimes hostile nature of the traumatic event, invites a process of existential questioning on the part of the victim. Questions such as, "Why me?," and "How could God let this happen?" are often asked by the victim. These are spiritual questions, and victims might go to their clergy for help in dealing with their traumatic experiences. Some individuals will develop a mental disorder at some point after these experiences.

Although there is considerable variation depending on gender, race, and the type of trauma, it has been estimated that 5–11% of trauma victims will develop posttraumatic stress disorder (PTSD) (7). PTSD is an anxiety disorder including three symptom clusters: reexperiencing the trauma through nightmares, flashbacks, or intrusive memories; autonomic hyperactivity, such as exaggerated startle response, night sweats, and irritability; and avoidance symptoms, including social isolation, restricted range of emotion, and absence of intimacy in relationships (8).

Because the experience of trauma often evokes spiritual issues, the use of clergy in the assessment and treatment of patients with PTSD should be explored. Clergy are specially trained to work with people regarding faith in God, religious teachings, and the reconciling of personal experiences with spiritual expectations. Clergy are also able to help patients connect to support systems available to them through faith communities during and after treatment (9).

The purpose of this article is to review the literature regarding the spiritual aspects of trauma, and to describe one facility's use of clergy in the treatment of PTSD. The article assesses the strengths and weakness of the work of three different chaplains, and concludes with recommendations for future research.

Literature review

Review of the literature on spirituality and trauma over the past 15 years produced articles from a variety of disciplines. Many articles have stressed

the importance of distinguishing between spirituality and religion. In the family therapy literature, Neil Adams asserts, for instance, "there is a background spirituality to many peoples' world views, and the process of extracting meaning and positivity from trauma and suffering can be viewed as a spiritual process, whether or not this is tied to religion or conscious process" (10).

Other writers have asserted the need to recognize spirituality as a dimension of all human beings and family systems, providing a system of thought that gives meaning to experience. Mary Jo Barrett describes how patients recovering from trauma found exploration of their spirituality helpful (11). She treated individuals who had experienced physical violence or sexual abuse, and found that they were radically changed by the trauma, losing a sense of innocence and trust. They saw the world as dangerous, feeling perpetually vulnerable. Fear, anger, and self-blame pervaded their attitudes, and treatment was oriented towards this negative self-concept and world-view.

Ellen Bass and Laura Davis, in their guide for women survivors of sexual abuse, devote one chapter to the spiritual aspects of trauma (12). They describe a woman who lost her faith in God when she shared her history of childhood violence with her minister, who told her she should not be angry at God. She felt misunderstood and became alienated from God. These writers acknowledge that organized religion has sometimes failed to provide support and protection to victims of child sexual abuse, but they also acknowledge that many trauma survivors find strength and hope in religious beliefs and rituals.

In the nursing literature, Janice Humphreys studied women who experienced domestic violence (13). The women rated their levels of distress by answering a symptom questionnaire, and spirituality was measured using the Spirituality Perspectives Scale (14). *Consider:* Humphreys found that women who scored higher on the spirituality scale had fewer repeated unpleasant thoughts and outbursts of temper.

Roger Fallot studied female trauma survivors with chronic mental illness and found that 58% said religion was "very" or "extremely important" to them (15). For some, their ability to be in relationship with God led to improved ability to be in supportive relationships with others, and some felt called to help other trauma survivors.

In literature that blends the disciplines of medicine, psychology, and pastoral counseling, several articles describe the effect of trauma on spiritual belief systems and faith. John Wilson and Thomas Moran state that religious faith can be an essential part of one's personality and identity and that trauma can leave an individual's spiritual domain shattered and disorganized (16). The victim's belief system can be usurped, leading to disturbing questions, such as, "What kind of God would allow this to happen?," and, "What kind of world is this?," contributing to the isolation and despair many patients with PTSD experience. Wilson and Moran point out that clinicians working with trauma survivors should create an environment where they can

reexamine and alter their spiritual beliefs to accommodate their traumatic experiences.

Working with men with combat-related trauma, Larry Decker observes that some veterans developed the symptoms of PTSD and some did not, despite exposure to comparable levels of trauma (17). Some individuals were able to integrate their traumatic experiences without the development of pathology, and he explains how internally-based systems of belief, such as mysticism, might provide some trauma survivors with the resilience to overcome and integrate trauma. Decker goes on to explore trauma as an influence in the spiritual development of the individual (18). While for some individuals trauma results in deterioration of personality and beliefs, he notes that for many, it precipitates a personal exploration that results in an expanded and more meaningful perspective on existence. Other authors have reported similar findings (19,20). The use of clergy might help individuals navigate these mixed waters of psychiatric illness and spiritual despair.

The need for the involvement of clergy in the treatment of trauma survivors is now being recognized. Andrew Weaver and colleagues point out that clergy are often the first point of contact for people struggling with the aftermath of trauma (9). While some clergy have training in mental health counseling, many do not. Likewise, many mental health professionals have little training in evaluating the spiritual concerns of patients. The need for cross-professional training for psychiatrists and clergy is further asserted by Carolyn Grame and colleagues, who cite examples of programs already in place to facilitate dialogue (21).

The 12 steps of Alcoholics Anonymous form one program that brings spirituality into the treatment of mental illness. It has long been a part of treatment programs for addictions. Substance abuse disorders can occur with PTSD, since some individuals self-medicate feelings of guilt, despair, and hyperarousal with drugs or alcohol. Hani Raoul Khouzam and Perla Kissmeyer describe a case of a veteran with PTSD and a history of alcohol abuse who developed a major depressive episode which responded to fluoxetine (22). With the resolution of his depressive symptoms came feelings of guilt about surviving in Vietnam while many of his comrades perished, which precipitated relapse. As part of his treatment for alcohol abuse, he attended Alcoholics Anonymous (AA) groups daily. It was in AA that his feelings of survivor guilt abated; he reported that he had had a "spiritual awakening" as a result of this program. The authors note that the antidepressant relieved certain symptoms of depression and PTSD, but that it was a spiritual program that relieved his survivor guilt.

William P. Mahedy has written about the spiritual challenge of the traumatic combat experiences of Vietnam veterans (23). His experience in that war as a military chaplain, combined with his ministry training, allowed Mahedy to explore the spiritual quandaries that blocked the recovery of veterans from PTSD. He developed a program integrating the principles of AA with PTSD treatment, called, "The Spiritual Boot Camp for Combat Veterans" (24). As in

AA, this program focused on the individual's lack of control over circumstances and the recognition of some higher power, as well as on personal responsibility for one's thoughts, feelings and actions.

Mahedy's work is an early effort to understand the effects of trauma on combat veterans. Since then, many Veterans Administration treatment centers have provided spiritually-oriented programs for PTSD. A report from the Menlo Park VA Hospital describes a psychotherapy group entitled, "Values and Personal Growth: Paths to Inner Healing" (25). Medical, social work, and ministry professionals facilitated this group, and veterans were encouraged to explore their personal values and internal resources for spirituality and healing.

Chaplain involvement at the Dayton VA Medical Center

The Posttraumatic Stress Disorder Residential Rehabilitation Program (PRRP) at the Dayton VA Medical Center involved the chaplain service from its inception. Initially, chaplains conducted weekly bible study with the veterans. A new chief of the chaplain service was hired who had training in substance abuse disorders, and he eliminated the bible study and created a clinically-focused group. This group was called the Spirituality Group, and he was able to integrate into it the clinical methods of the PRRP treatment team.

Although he was well trained regarding the treatment of individuals with substance abuse disorders, the PTSD population was new to him. He relied on his understanding of general principles of spirituality, and over time, the spiritual issues particular to the PTSD population emerged, issues such as anger, letting-go, and forgiveness.

The PTSD symptoms of autonomic hyperactivity, avoidance, and reexperiencing can make tolerating and expressing anger difficult, and the Spirituality Group was helpful because it increased awareness of anger and the difficulties involved in managing it. The chaplain encouraged veterans to explore their own spiritual resources to help understand and channel their anger. The book *May I Hate God?* by Pierre Wolff proved useful to the group (26).

The spiritual concepts of forgiveness and acceptance pervaded the groups, and no particular spiritual stance was promoted. This created an environment of safety where veterans could start work in the group wherever they were spiritually, without fear of being judged "wrong." One significant effect of this group was that it facilitated the development of one-on-one relationships with the chaplain. Issues brought up in group often prompted feelings patients would rather discuss with the chaplain alone, and many patients sought him out for private consultation. Once processed individually, the patient could bring these insights to the group, which enriched the group dynamic and, by way of the chaplain, the clinical team, which gained an enhanced understanding of the patients.

After two to three years, the responsibilities of the chief of chaplain services demanded that he pass the group on to another chaplain. The next chaplain was chosen because of his experience as an army chaplain with two tours of Vietnam. He had less clinical training and drew more upon the military experience he shared with group members to facilitate therapeutic change. He structured the Spirituality Group around a discussion of C. S. Lewis' *The Four Loves* (27). Each group focused on one of the four loves as defined by Lewis. The chaplain chose this subject in order to encourage the veterans to reflect on their relationships with and responsibilities to other human beings. Trauma often disrupts these bonds, and contributes to the isolation, shame, and social dysfunction seen in patients with PTSD.

The first of Lewis's four loves is *storge*, generally termed "affection." Such love describes the comfortable familiarity often felt for family members. Such family relationships are often disrupted in trauma survivors, as the predictability of relationships is shattered when comrades are suddenly gone as a result of enemy fire. Typically, family members lament that this comfortable connection is no longer present when the veteran returns from war. Exploring this syndrome in group helped veterans access their feelings on these relationships and opened the door for change.

Discussion of *philia*, or friendship, tended to be positive. The veterans' remembrances of the comradeship they had with other men in their units revealed that this form of love still existed for these veterans. They understood the importance of loyalty and relying on each other to survive, and this type of love continued in their contemporary lives through their on-going association with other veterans.

The topic of *eros*, or, romantic and sexual love, was often met with embarrassed silence. To many veterans, it reminded them of their exploitation of women during the war. If unchecked, this form of "love" can lead to the use of prostitutes or even rape, which the chaos of war often allows. *Consider:* But such behaviors during peacetime are clearly understood to be criminal, and for combat veterans with PTSD, secrets such as those can keep honest testimony and expression locked up, which can impede progress.

Of all of Lewis' four loves, *agape* is the most spiritual. It describes the relationship we have with humankind in general, and involves an element of charity. Discussion of this kind of love prompts patients to look at existential issues, such as personal responsibility for what happens in the world. With trauma, personal responsibility is distorted due to the lack of control one feels when the trauma is happening. This confronts the patient with the disparity between what he wanted to happen and the tragic events that actually occurred. Here the veteran has the opportunity to face God or the "higher power" that determines fate.

Because this chaplain in question was unable to attend the weekly team meetings, a third chaplain was chosen to take over this group. This chaplain had certification as a clinical pastoral addiction counselor, spent 23 years in the army with one tour of Vietnam, then entered the priesthood after retiring

from the military. To the Spirituality Group he brought experience with the 12 steps of Alcoholics Anonymous (AA), and was familiar with the modification of these steps for use with combat veterans with PTSD (28,24). One concept of AA is the focus on the self, which helps veterans confront any preoccupation with blaming others for their problems.

Although many veterans do not believe in God, a basic concept of the 12 step program is that of a higher power. This concept can prompt discussions of fate and the feelings of powerlessness that often accompany trauma. The 12 step program involves a progressive format and the movement towards a healthier and more manageable life. Letting-go was an important concept in this chaplain's Spirituality Group. Veterans were encouraged to explore their past experiences but not to dwell on them.

This chaplain attended the weekly team meetings, and as a pastoral counselor, was able to share psychodynamic as well as spiritual insights. In this way, clergy contributed to providing a holistic approach to the assessment and treatment of patients in the PRRP program.

Summary

Awareness of spiritual issues in health and illness has prompted research and changes in teaching requirements for psychiatry residents. The spiritual aspects of trauma have been explored rather extensively. Review of the literature revealed studies from various disciplines, including family therapy, nursing, psychology, pastoral counseling, and medicine. The differences between religion and spirituality were defined in several articles. The effects of domestic violence seemed to be buffered by spiritual beliefs and practices, and the findings of another report suggested that the ability to be in relationship with God enhanced the ability of patients to be in relationship with others.

Some studies suggested that trauma, if adequately processed, can lead to spiritual growth and to a broader and more realistic view of life. Given the fact that trauma can result in both mental illness and spiritual crisis, the need for cross-training of professionals involved in treating patients with PTSD was reported in some articles reviewed.

The work by chaplains at the Dayton VA supported the assessment of the spiritual issues of trauma. The active involvement of chaplains on the treatment team allowed the team to provide more holistic care to the veterans. The arrangement also allowed for the education of team members by clergy regarding spirituality, and clergy learned about the treatment of PTSD and other mental disorders. Spiritual issues which arose in the Spirituality Group included forgiveness, letting-go, and anger at God. The use of spiritual resources to address these issues was explored.

Each of the three chaplains chose different methods in using a spiritual approach to the treatment of PTSD, and each approach revealed its own merits. The elimination of bible study from the group and the initiation of a

more clinical focus on the part of clergy was important. The exploration of the four loves of C. S. Lewis provided an environment, for example, where veterans could explore their relationships. Finally, the basic principles of the 12 steps of Alcoholics Anonymous, and its concept of a "higher power" offered a useful format for veterans to confront dysfunctional attitudes and try out new behaviors of relating to themselves, to God, and to their community.

Conclusion

Although there is a rather large body of literature that explores the spiritual aspects of trauma, and there is evidence that some institutions are currently utilizing clergy in the treatment of PTSD, there is a lack of studies that measure outcomes of programs that address the spiritual sequelae of trauma. Current literature suggests that treatment programs that include a spiritual component can help confront obstacles to recovery from PTSD. Studies are needed to determine if and how spiritual assessment and treatment improves the outcomes of patients with PTSD. The results of such studies can provide information regarding the relative effectiveness of different spiritual interventions, which can then be applied to the development of new, more effective PTSD treatment programs.

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