Psychological Trauma
The Need for a Pastoral Response

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Accounts of the effects of traumatic events have been documented over the history of humankind. Post-traumatic stress is an expected reaction to an abnormally stressful situation and represents a significant public health concern that warrants attention. Religious faith is a primary way that people successfully cope with the negative effects of traumatic experiences.

Traumatic events shatter the sense of connection between individual and community, creating a crisis of faith.
Judith Lewis Herman, Trauma and Recovery

It was midday when twenty-five year-old Patricia was brought unconscious to the emergency room. She, her husband, and their fifteen month-old son had just come home from a summer vacation. Larry, her husband, was an officer at the nearby Air Force Base. When they returned to their apartment, Patricia decided to go out to get some groceries. She went alone in the family car while Larry stayed home with the baby. In order to get to the store, she had to get on the highway and travel two exits. As she left the on-ramp, her car was struck on the left side by an oil delivery truck.

From the accident site Patricia was taken unconscious to the nearest emergency room. The hospital chaplain met Larry while he was still in the reception...
area. The young officer had been raised as a Southern Baptist in rural Texas but had not been involved in religion since his youth. Nevertheless, he was receptive to the chaplain’s interest in him and his wife.

The hospital chaplain had been alerted at the time of Patricia’s admission and was in the treatment area when her condition was assessed. This was very comforting to Larry and helped to establish a relationship between him and the chaplain. “I’m sure everything’s going to be all right with Patricia because you were there to say some prayers for her. God is going to listen to you.”

The neurosurgeon was not very communicative. His responses to Larry’s insistent questions were guarded, and it was clear that his judgments about Patricia’s condition were not optimistic. Should she ever regain consciousness, it would be impossible to predict the extent of her brain damage. Larry harbored hostile feelings toward the surgeon and was quick to ventilate them to his trusted confidant. The chaplain listened to the young husband as he described his frustrations with the hospital staff. “She’s going to get better despite what the doctor keeps saying.”

“We got married even though our families objected. Patricia was pregnant and we decided to marry, although we had intended to do so even before we knew about the baby. Her family did not come to the wedding, except one of her sisters. This really hurt both of us. We haven’t been very religious, though we both believe in God. Do you think God is punishing us for our lives?”

Patricia’s condition did not improve. Nonetheless, Larry kept his hopes alive, frequently entering her cubicle in the ICU, holding her hand and through his tears telling her how much he loved her, needed her, and wanted her to wake up and get better. Larry clung to the hope for a miracle.

At eleven o’clock on the sixteenth day of her hospitalization, Patricia died. Larry was not at the hospital, but was telephoned and asked to return. The chaplain was with Patricia when she died and remained at the bedside until her husband arrived. When Larry entered the unit, he bent down and embraced the body of his wife, kissing her and sobbing deeply. After a few moments of silent embrace, he looked up at the chaplain and threw his arms around his neck and wept.

For weeks after the funeral service, the grieving man could not work and spent most of his time detached and withdrawn. Larry was plagued with insomnia and disturbing nightmares about his wife’s accident. He had outbursts of rage, and could not concentrate. Prior to the accident he was active and upbeat; now he had lost interest in all activities. He constantly blamed himself for his

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wife's death and took little comfort in family or friends. Larry experienced a severe psychological trauma, which developed into post-traumatic stress disorder (PTSD).

**Many Suffer From Psychological Trauma**

Chaplains and community-based clergy need the skills to recognize and assist those who come to them for counsel in the aftermath of traumatic events. Many of these persons may be suffering what mental health professionals have identified as PTSD. The word “trauma” comes from a Greek root meaning “wound.” In much the same way that a physical blow may wound the body, bringing disability and pain, a psychological trauma can overwhelm the thoughts and feelings of a person and bring sustained suffering.

Graphic accounts of the effects of extreme stress on human beings have been documented in literature since Homer’s *Odyssey* and Samuel Pepys’ diary of the disastrous London fire of 1666. In the nineteenth century, Freud recognized the effects of psychological trauma in childhood, but it was only in the wake of the devastating wars of the twentieth century, particularly the return of Vietnam War veterans to the United States, that a scientific model was developed to understand the symptoms that result from extreme stress (Van der Kolk). Recently, the PTSD model for understanding psychological trauma has been applied to understand reactions to catastrophic accidents, natural disasters, and criminal victimization (Herman).

Post-traumatic stress disorder is a normal reaction to an abnormally stressful situation (Lifton). PTSD is not a sign of being “emotionally weak” or mentally ill. Those exposed to the shock effect of extreme stress will find their ordinary coping processes overwhelmed. PTSD is diagnosed when an experience occurs involving actual or threatened death or serious injury or a threat to the physical well-being of self or others if the response is one of intense fear, helplessness, or horror (American Psychiatric Association). The traumatic event is re-experienced in specific ways, such as recurrent and intrusive distressing recollections or dreams of it. Additionally, a person often persistently avoids situations associated with the trauma and has general emotional numbness. Hypervigilance and irritability also may be experienced. PTSD becomes the diagnosis when these symptoms persist for more than a month and create significant impairment in a person’s functioning.
Religious belief and practice are traditional ways through which many develop personal values and their beliefs about meaning and purpose. With psychological trauma, an individual’s sense of order and continuity of life is shattered. Questions of meaning and purpose emerge as a person experiences a loss of control over his or her destiny. Religious faith is a primary coping strategy for many suffering from psychological trauma (Weaver, Koenig, and Ochberg).

A recent study (Astin, Lawrence and Foy) found evidence suggesting that religiously committed women who are battered suffer less severe PTSD symptoms than those without such commitment and that religious involvement of a couple reduces the risk of domestic violence (Ellison, Bartkowski, and Anderson). This finding is consistent with research related to combat veterans which discovered that those experiencing psychiatric problems or PTSD attend religious services less frequently than those not experiencing them (Watson, Kucala, Manifold, Juba and Vassar).

A study has examined the effects of stress in the wake of the terror and destruction caused by a class IV hurricane (Hugo) in South Carolina on sixty-one nursing students and ten faculty involved in disaster relief. After three weeks of work, three-quarters of those examined reported that religion was a primary positive coping strategy (Weinrich, Hardin and Johnson). In a separate study, researchers investigated religious coping methods used by 225 individuals who experienced the devastating impact of a major midwestern flood. Frequent prayer and worship attendance were associated with better mental health (Smith, Pargament, Brant and Oliver).

In addition to offering the social support of community, nurturing religion provides a healing means of addressing a traumatic experience. Faith can facilitate faster and more effective recovery (Pargament). In a long-term study of 124 parents who lost a child to sudden infant death syndrome, it was found that greater religious participation was related to increased emotional support by others and increased meaning found in the loss (McIntosh, Silver and Wortman). This is no small finding, given the high level of trauma that follows the sudden death of a child. Religion appeared to provide for these parents an effective means to make sense of the loss that enhanced well-being, lowered distress, and facilitated recovery.
In a well-designed study of persons grieving the death of a family member or very close friend, it was discovered that there is a strong link between the ability to make sense of the loss through religious belief and practice and positive psychological adjustment (Davis, Nolen-Hocksema and Larson). In a third investigation, fathers of children being treated for cancer in a hospital clinic were asked about various methods of coping. Among twenty-nine different strategies used, prayer was both the most common and most helpful for the fathers (Cayse).

Seeking Clergy Counsel

Clergy, vowed religious, and healthcare chaplains are in an ideal position to recognize and assist those suffering from psychological trauma (Weaver, 1995). There are 353,000 Christian and Jewish clergy serving congregations in the United States (4,000 rabbis; 49,000 Catholic priests; and 300,000 Protestant ministers, according to the U.S. Department of Labor, 1998). In addition there are 92,107 sisters and 6,578 brothers in religious orders nationwide (Stark and Finke). These are among the most trusted professionals in society (Gallup and Lindsay). They are often in long-term relationships with individuals and their families, providing ongoing contacts in which they can observe changes in behavior that can assist in the assessment and treating of PTSD. Surveys by the National Institute of Mental Health found that clergy are more likely than psychologists and psychiatrists combined to have a person with a mental health diagnosis see them for assistance (Hohmann and Larson). It should be noted that more than ten thousand of these clergy serve as professional healthcare chaplains working closely with medical professionals.

Ethnic minority persons are more likely to receive pastoral assistance in times of crisis and psychological trauma than European-Americans. African-American pastors are much more likely to go into the community and seek out people in crisis than their non-African-American colleagues. Many urban churches offer community outreach programs for those in need, including services to persons who suffer from conditions that place them at risk for PTSD. Among those conditions are homelessness, hunger, substance abuse, child abuse, domestic violence, AIDS, and imprisonment. Similarly, Mexican-Americans are more than twice as likely to seek help with personal problems from clergy than from psychologists and psychiatrists combined (Chalfant et al.). In fact, that study found that the degree of identification with Mexican ethnicity was strongly related to seeking pastoral help as a primary resource.

Clergy are most often called upon in crisis situations associated with grief, depression or trauma reactions, such as personal illness or injury, death of a spouse or close family member, divorce or marital separation, serious change in
the health of a family member, death of a close friend (Fairchild; Weaver, Preston and Jerome). People in “crisis” involving the “death of someone close” reported almost five times more likelihood of seeking the aid of a clergyperson (54 percent) than all other mental health sources combined (11 percent) (Veroff, Kulka and Douvan). Further highlighting the prominent role that clergy play in community mental health, the U.S. Surgeon General’s 2000 Report on Mental Health found that each year one in six adults and one in five children obtain mental health services either from a healthcare provider, the clergy, a social services agency, or a school (Satcher).

Both pastoral care and mental health publications have found that clergy respond with pastoral care and counsel to persons exposed to a wide range of extreme stressors (Dykstra). They document responses to natural disasters such as floods (Smith et al.) and tornadoes (Chinnici), catastrophic accidents (Black), child abuse (Weaver, 1992), elder abuse, and human-created disasters including death camps (Cohen), war (Zimmerman and Weber) and torture (Lernoux).

Researchers have found that one in five adults (700,000 survivors) who are victimized in a violent crime (e.g., rape, robbery, assault) seek the counsel of a clergyperson. This is the same number who seek help from all categories of mental health professionals combined or a medical doctor (Norris, Kaniasty and Scheer). It is also estimated that 1.8 million women are physically abused each year by husbands or intimate partners (Branner, Bradshaw, Hamlin, Fogarty, and Colligan). A national survey of one thousand battered wives found that one in three received help from clergy, and one in ten of their husbands were counseled by clergy (Bowker).

Often a person suffering from PTSD will have additional symptoms, particularly major depression or substance abuse. These problems may be the first means by which clergy and other religious professionals will recognize that someone has suffered a psychological trauma. Major depressions, which occur in about half the people who develop PTSD (Kessler et al.), are usually associated with a predominantly sad mood, hopeless feelings, very pessimistic thinking, loss of the ability to experience pleasure, pronounced and continual sleep disturbance, significant agitation or restlessness, suicidal thoughts and attempts, and the loss of self-worth (Weaver, 1993). Self-medication with alcohol and illicit drugs at first may allay PTSD symptoms, such as sleep disturbance and anxiety, but with time they exacerbate the distress. A comprehensive study of Vietnam veterans found that 75 percent of those with PTSD developed alcohol abuse or dependence (Kulka et al.).
Clergy are accessible helpers within communities that offer a sense of continuity with centuries of human history and an experience of being a part of something greater than oneself. They are visible and available leaders in communities that have a language of faith and hope. Rabbis, priests, ministers and vowed religious are also in a unique position of trust in which they can assist persons in connecting to support systems available through their faith communities and beyond (Weaver, Revilla and Koenig). Undoubtedly, persons in distress go to clergy in large numbers because accompanying the stressful state for many individuals are questions of meaning and purpose uniquely addressed by religion.

**Conclusion**

Faith communities can offer both social support and a healing means of addressing a traumatic event. Rabbis, priests, and ministers are in a unique position of trust in which they can assist persons in the aftermath of psychological trauma. They need effective skills to recognize the signs of PTSD and information about how best to respond.

The interventions made by the hospital chaplain with Larry during the hours immediately following the accident in which Patricia sustained her fatal injuries, contributed significantly to the way he managed the stress and its psychological consequences. The sustained relationship with the chaplain during the extended crisis helped Larry to gradually absorb the reality that his wife would not recover and that he would need to prepare himself and his son for life without her. The pastoral counsel and support helped the young officer regain emotional equilibrium in the face of a catastrophic loss. Without destroying his psychological defenses, the chaplain was able to work with his denial of the seriousness of Patricia’s injuries and begin to address his anger and guilt. Larry’s hostile reactions to other hospital professionals were linked to his sense of powerlessness in the face of this catastrophe. The chaplain provided a safe haven, as Larry began the difficult process of regrouping and reorganizing his life. Competent pastoral interventions, especially those at the onset of the crisis, can weaken the effects of PTSD and increase the likelihood of a positive prognosis.

**Note**

1 This article is dedicated to the co-founder of the Catholic Worker, Dorothy Day, who gave her life to the ministry of the poor. We wish to express our gratitude to The Rev. Carolyn L. Stapleton, D. Min., Eileen Gorey, R.N., and Lisa Matsumoto, M.LIS., Head Librarian at Hawaii State Hospital, for their generous help in the development of this project.
References


