

# SOCIAL WORK & CHRISTIANITY

JOURNAL OF THE NORTH AMERICAN ASSOCIATION  
OF CHRISTIANS IN SOCIAL WORK

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## **SPECIAL ISSUE: SPIRITUALITY AND TRAUMA**

### **INTRODUCTION TO SPECIAL ISSUE**

Introduction: Special Issue on Spirituality and Trauma

### **ARTICLES**

Spirituality as a Potential Resource for Coping with Trauma

After Trauma: Family Relationships and the Road to Healing

The Role of Spirituality in Helping African American Women with Histories of Trauma and Substance Abuse Heal and Recover

Trauma, Religion, and Social Support among African American Women

Reflections on Collective Trauma, Faith, and Service Delivery to Victims of Terrorism and Natural Disaster: Insights from Six National Studies

Religious Coping Strategies Among Traumatized African Refugees in the United States: A Systematic Review

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Field Test of a Peer Support Pilot Project Serving Federal Employees Deployed to a Major Disaster



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# SOCIAL WORK & CHRISTIANITY

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*Social Work & Christianity* (SWC) is a refereed journal published quarterly in March, June, September, and December by the North American Association of Christians in Social Work (NACSW) to support and encourage the growth of social workers in the ethical integration of Christian faith and professional practice. SWC welcomes articles, shorter contributions, book reviews, and letters which deal with issues related to the integration of faith and professional social work practice and other professional concerns which have relevance to Christianity.

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## SPIRITUALITY AND TRAUMA

# Introduction: Special Issue on Spirituality and Trauma

*Mary Van Hook, Leola Dyrud Furman, & Perry W. Benson*

*This special issue addresses the role of trauma in the lives of individuals, families, and communities and pathways to healing. Articles address a wide range of life experiences, cultural aspects, and contexts. Articles also highlight the potential interaction between trauma and spirituality or religion.*

SADLY, EVENTS THAT CREATE TRAUMA ARE AN EVER-PRESENT REALITY IN THIS world. Desperate people are fleeing the ravages of war and terrorism. Communities are being devastated by fire, floods, and other natural disasters. Children and adults are struggling with the pain of family violence. People are caught up in neighborhood or random acts of violence. Many of the individuals, families, and communities that social workers are engaged with have been victims of one or more events that contribute to trauma. As a result, professionals working with people and communities that have been traumatized must contend with the impact of vicarious trauma. In view of the pervasive presence of trauma, it is essential for social workers to have an understanding of the nature of trauma, ways in which it expresses itself, and potential ways to promote healing. Issues of spirituality and religion can emerge in the trauma experience, both in terms of ways in which they can be impacted by trauma and as possible sources of healing.

This special issue is designed to help social workers further their understanding of trauma, ways in which it is experienced, and potential sources of healing. The articles in this issue also address the role that spirituality and religion can play in the trauma experience. They provide a multifaceted lens by which trauma can be understood. The following articles address trauma as experienced at the levels of individuals, families, organizations, and communities as well as vicarious trauma.

“Spirituality as a Potential Resource for Coping with Trauma” by Mary Van Hook introduces the concept of trauma in terms of its impact and potential sources of healing with an emphasis on upon the role of spirituality. T. Laine Scales and April Scales use a personal narrative approach in “After Trauma: Family Relationships and the Road to Healing” to describe how trauma impacts development and human relationships and ways in which healing can occur.

Culture influences the life course and ways in which trauma can be experienced. Two articles draw upon research to examine this from the perspective of American women. In “The Role of Spirituality in Helping African American Women with Histories of Trauma and Substance Abuse Heal and Recover,” Joan Marie Blakey and Jewell Brazelton use a case study method. Sharon Johnson, Sha-Lai Williams, and Joseph Pickard in “Trauma, Religion, and Social Support among African American Women,” identify how traumatized women turn to religion and social support to cope.

Christson Adedoyin, Caroline Bobbie, and associates draw upon existing literature to identify ways in which traumatized refugees from Africa used spirituality to cope with their trauma in “Religious Coping Strategies Among Traumatized African Refugees: A Review of the Literature.” Leola Furman, Perry Benson, Bernard Moss, Torill Danbolt, Einar Vetvik, and Edward Canda address responses to people who have been victims of terrorism and natural disasters internationally. In “Reflections on Collective Trauma, Faith, and Service Delivery to Victims of Terrorism and Natural Disaster: Insights from Six National Studies,” the authors draw on their own experience as well as research to identify ways in which spirituality-based strategies can help people.

In “Lessons Learned from Disaster: Behavioral Health for Social Workers and Congregations,” James Ellor and Sara Dolan examine the impact community disasters and the complex path to recovery, including the role of emotional/health efforts and the religious community. Jon Wallace addresses the potential for trauma experienced by those who address the traumatic experienced of others in “Field Test of Peer Support for Pilot Project Serving Federal Employee Deployed to a Major Disaster.”

This issue serves as a valuable resource for social workers because many of the individuals, families, and community they serve have experienced life events that create trauma. The articles in this issue describe the impact of trauma as well as potential paths to healing. Christian social workers will find the emphasis on the roles of spirituality and religion in this process especially relevant. ❖

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# Spirituality as a Potential Resource for Coping with Trauma

Mary Patricia Van Hook

*Many of the people seeking help from social workers have experienced trauma as result of a variety of life circumstances. Consequently, it is important for social workers to have an understanding of trauma. This paper addresses ways in which trauma is experienced, potential interactions between trauma and spirituality, and possibilities for promoting healing.*

**T**RAUMA OCCURS WHEN A PERSON FACES A POTENTIAL THREAT TO LIFE, a threatening and dangerous experience outside the usual human experience, and events that are overwhelming and make people feel powerless and afraid. Traumatic events have the power to inspire helplessness and terror (Herman, 1997, p. 34). Traumatic events can represent a single event or can be part of an ongoing pattern of events and actions by others. Unfortunately, the numbers of people facing death in the theater of war (both military and civilians), refugees fleeing danger, daily news reports of people facing threats of being murdered or raped, and hidden stories of children being seriously abused in various ways all indicate that the experience of trauma is more widespread than we might wish. As social workers, our work serves as a constant reminder of trauma in the lives of people and their families. As a result, we risk vicarious trauma as our work lives are filled with the stories of danger and evil.

## **The Impact of Trauma**

Our bodies, minds (thoughts and memories), and emotions are an integrated system. Trauma affects all three individually and disrupts the

integration of these systems. Trauma can also have an impact on our interpersonal and spiritual lives. While some of the characteristics are part of the syndrome, Post Traumatic Stress Disorder, typically only about 10% of trauma survivors go on to have PTSD (Peres, Moreira-Almeida, Nasello & Koenig, 2007). For a more complete discussion of PTSD, see Scales & Scales in this issue.

## **Bodies**

Trauma impacts the body in various ways (Herman, 1997, Perry & Pollard, 1998; Anda, Felitti, Bremner, Walker, Whitfield, Perry, Dube, & Giles, 2006):

- Potential physical damage created by the traumatic event
- Body memory of the trauma
- Sense of loss of body integrity
- Rush of stress-related hormones
- Neurobiological impact with impact on emotional, cognitive and behavioral coping

While trauma can have a neurobiological impact at all ages, it is especially influential for young children because it can influence the trajectory of their lives (Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Anda, Felitti, Bremner, Walker, Whitfield, Perry, Dube, & Giles, 2006). The brain is organized during development through genetic potential and life history. While trauma can cause sensitization within the mature brain, during development it can determine the functioning capacity of the person's brain. Children who have been traumatized (unlike other children) are frequently at a baseline state of low-level fear—responding by using either a hyperarousal or a dissociated adaptation. The child's emotional, behavioral, and cognitive functioning will reflect this (often regressed) state (Perry, et al, 1995).

The brain develops its functions and organization in a process reflecting survival needs. It is use dependent. Experience (in this case, trauma) provides the organizing framework for a child. The traumatized child experiences over-activation of important neural systems during sensitive periods of development (Perry, et al, 1995). The response pattern persists. Following the acute trauma experience, these systems of the brain will be reactivated when the child is exposed to specific reminders of the traumatic event and later when the child just thinks or dreams about the event or anything related to it. As a result, even though the child is no longer facing the traumatic event, the stress response apparatus of the child's brain is activated over and over again. Because the brain plays such an important part in other systems of the child's body and life, these functions too are influenced and deregulated—with the consequent behaviors of motor hyperactivity, anxiety, and impulsivity. The child becomes overly

sensitized, lives in a state of ongoing fear, and reacts to ordinary stressors with being threatened to being terrorized (Perry, et al, 1995). This creates an increased state of vulnerability for adults who experience trauma and were traumatized as children.

Trauma in childhood is reflected in dysregulation of the sympathetic nervous systems, increased cortisol (stress response) and norepinephrine levels in children (Anda, et al, 2006). “The sensitivity and organization of stress response neurochemical systems are related to developmental experience with stress” (Perry & Pollard, 1998, p. 39).

Studies reveal an increased pathway to a variety of long-term, behavior, health, and social problems (Anda, et al, 2006).

In adults, the neurobiological impact of trauma can make it difficult to process trauma both cognitively and emotionally. Smaller hippocampal volume and decreased activation that disrupts its fundamental role in the process of synthesizing, integrating, learning, and evaluating experience can produce fragmentation of the traumatic experience. Changes in the process within the brain can impact the trauma experience by impacting the cognitive synthesis involved in emotional memories and long term memories, obstructing the cognitive synthesis process, creating defects in the extinction of response to fear and emotional regulation, and by creating problems in relating personal experience into communicable language (Perez, et al, 2007).

### **Cognitions**

“Traumatic events destroy the victim’s fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of creation” (Herman, 1997, p. 51). The following reflect some of the thoughts and cognitive processes that can prompted by the experience of trauma (Herman, 1997; Perry, et al., 1995):

- Views world as a dangerous place
- Impacts the sense of meaning
- Disrupts trust in the fairness of life, in God, in other people
- Raises the question of “Why me?”
- Raises issues of self blame or lack of self worth (belief that one is deserving of punishment or mistreatment—damaged goods (Children especially likely to experience self blame)
- Disrupts memories—no memories, or fragmented memories
- Poses difficulty in processing and describing traumatic event in an organized manner

- Vacillates between intrusive memories and lack of memory for logical narrative in terms of the experience
- Alters state of consciousness—dissociation from body, and situation, trance like state.

### **Emotions**

As a result of trauma, people can experience some of the following emotional responses (Herman, 1997; Perry, et al, 1995):

- A threat of annihilation
- A sense of fear, helplessness, being out of control
- An agitated state (what will happen next?)
- Numbing—sense of just going through the motions
- Reoccurrence of prior traumatic symptoms with new traumas
- Flight/fight response (emotions, body responses)

As a result of these responses, trauma also has an impact on one's interpersonal and spiritual life.

### **Interpersonal life**

There is great variation in the effects on interpersonal relationships of one's response to trauma, depending on the type of trauma (for example, rape or tornado), the meaning attributed to it, and the age when the trauma was experienced. Some of the impacts on a person's interpersonal life can include (Herman, 1997 Anda, et al, 2006):

- People may call into question basic human relationships—shattering their basic sense of trust and connections
- People who have been traumatized by people can begin to distrust other people also
- People can seek a first resource for source of comfort and protection (God, parents). Failure to receive protection can create further sense of abandonment
- "People can withdraw from close relationships and seek them desperately" (Herman, 1997, p. 560)
- People can fear abandonment or being attacked
- People can fear their own inability to control their own anger (Harris, 1998)
- People can feel that they are without value in relationships
- Children who have been traumatized in early years can have problems in establishing basic trust and sense of self worth that makes them especially vulnerable

Research has linked extensive trauma experience in childhood with increased risk for adult life issues that affect interpersonal relationships—risky sexual behavior, anger control, alcohol and other drug use, aggressiveness against intimate partners, anxiety and depression (Anda, et al, 2006).

### **Spirituality**

Spirituality involves people's sense of meaning, morality, and their relationship to the transcendent and world around them. For many people, spirituality is experienced as part of one's religion. Thus the spirituality and sense of meaning regarding life experiences of a Christian, a Muslim, Buddhist, or a Hindu, for example, are likely influenced by the nature of the particular person's religious tradition. Trauma calls into question assumptions about the world and spiritual life. It raises ultimate questions of life and purpose. While trauma and related suffering inevitably raise spiritual issues, the impact of spirituality in the life of the person who has been traumatized varies widely. Trauma can potentially influence spirituality in the following ways (Bryant-Davis, Ellis, Burke-Maynard, Moon, Counts, & Anderson, 2012; Farley, 2007):

- People can experience a crisis of faith—how could God have let this happen to me (and others) (Bryant-Davis, Ellis, Burke-Maynard, Moon, Counts, Anderson, 2012)
- People can turn to God or spiritual life for comfort, hope, and meaning
- People can find comfort/people can feel abandoned
- People can ask questions about the meaning of life
- People can sometimes search for new meanings and purpose in their life
- People can feel violated at the very core of their being, their sense of their spiritual self

Studies have linked trauma with both an increase in spirituality and religion (a catalyst for spiritual growth) as well as a weakening of religious faith and spirituality. The following section gives examples of ways in which some traumatic life events influenced people's spirituality. The diversity of responses reflected in these studies means that one cannot make assumptions about an individual person and must assess each person individually. Response to spirituality/religion can also involve positive and negative coping strategies described subsequently.

**Acts of terrorist violence:** Among those experiencing the Sept 11, 2001 attack, 78% reported no difference in religion, 11% described religion as more important, and 10% described as religion as less important. The extent of loss and exposure to trauma influenced this impact. Parents who lost children were especially likely to report a decreased importance of religion

(Seirmarco, Neria, Insel, Kiper, Doruk, Gross & Litz, 2012). People's response to the Oklahoma City bombing varied with positive religious coping associated with growth and negative religious coping associated with an increase in PTSD (Pergament et al, 1998 as cited in Smith, 2004).

**Natural disasters:** African American survivors of Hurricane Katrina described a positive response for some—especially religious or spiritual practices with God who gives strength. It was negative for those who reappraised their faith in negative ways—If God really loves us, why is he letting people die in this way? (MHum, Bell, Pyles, & Runnels, 2011; Hrostolwski & Rehner, 2012).

**War:** The experience of killing people and failing to prevent the death of fellow soldiers weakened religious faith—(associated with greater use of VA MH facilities to seek sense of meaning) (Perez, Moreira-Almeida, Naello, & Koenig, 2007). Among Vietnam veterans suffering PTSD, the majority (74%) reported difficulty reconciling their religious beliefs with the traumatic events in Vietnam; 51% said that they had abandoned their religious faith in Vietnam (Dresher and Foy, 1995, as cited in Smith, 2004). Soldiers who experienced greater combat trauma were more likely to use spiritual/religious coping but it did not lessen their PTSD symptoms relative to other coping strategies (Green, Lindly, & Grace, 1988 as cited in Smith, 2004).

**Children who have been abused:** Religious faith is severely damaged for some, while others turn to faith and spirituality as way to cope and heal (Walker, Reese, Hughes, Troski, 2010; Bryant-Davis, Ellis, Burke-Maynard, Moon, Courts, & Anderson, 2012). Several studies of women who had been sexually abused as children reported being helped by having a relationship with a benevolent God or higher power (Bryant-Davis & Wong, 2013). Female members of the Church of Latter Day Saints who had been sexually abused in childhood reported the healing that came from supportive members of their church and a sense of meaning provided by their faith (Valentine & Feinauer, 1993). African American women and women who had experienced or witnessed violence as children reported coping using spirituality/religion (rituals—especially prayer, beliefs, pastoral counseling, and involvement in the church organization) (Bryant-Davis, 2005). For women who had experienced trauma earlier and now have mental health and substance abuse issues, an increase in trauma experiences, especially sexual abuse as a child, was associated with greater use of negative religious coping efforts. Having a view of God as punishing increased distress. Positive religious coping helped reduce trauma (Fallot & Heckman, 2005). Among African American men who experienced childhood violence, 55% used spirituality as a way of coping (Bryant-Davis. et. al. 2010). Children who were abused by religious leaders described confusion and anger toward God and religious leaders—especially when told that God will show his anger if they tell (Bryant-Davis, et al, 2012).

**Refugees:** Spiritual life as Muslims and religious leaders were essential sources of support for Kozovar Albanians feeling the dangers of war (Gozdziak, 2002). Buddhist values were helpful in healing for Cambodian refugees (Bryant-Davis & Wong, 2013). For a more complete discussion of the role of spirituality in the role of coping with trauma for African refugees, see Adedoyin and Bobbie, “Light at the End of the Tunnel: Religion and Spirituality as Coping Resources of Traumatized African Refugees: A Review of the Literature” in this volume.

**People Who Lost Loved Ones Due to a Traumatic Death:** Some people reported losing any of their faith in God (blame for the tragedy) while others found comfort and new meaning in life through religion or spiritual beliefs and practices. People were comforted by their belief in life after death. People with strong religious or spiritual ties were the most likely to have a positive response. Members of African-Caribbean groups were especially likely to report these ties (Chapple, Swift, & Ziebland, 2011).

### **The Role of Spirituality in Helping People Cope with Trauma**

Spirituality can both contribute to resiliency (the ability to bounce back after hardship) and can intensify the pain and distress. The concept of healing is important here. Healing is the process of becoming whole or finding some way to adapt and compensate for losses (Walsh, 1999). It recognizes that people can heal emotionally and spiritually even though they cannot undo the traumatic event that occurred. The woman cannot undo the rape, the soldier cannot undo the battle carnage, the mother cannot undo the damage to family and home by the tornado, the child cannot reverse her parent's murder or suicide, but healing in the life of the person can take place. Walsh describes spirituality as being able to give meaning to a precarious situation, having faith that there is some greater purpose or force at work, and finding solace and strength in these outlooks (1999).

Pargament and Brandt (1998) describe religion as helping to address the problem of human insufficiency (certainly affirmed during trauma). When people are pushed to realize their fundamental vulnerability, religion offers them some solutions including spiritual support, explanations for difficult life events, and a sense of control.

### **Positive Religious Coping Strategies**

Positive religious coping strategies appear to help promote healing and reduce the impact of trauma. Negative religious coping strategies are associated with an increase in distress. Research has identified some of these coping strategies. Understanding the nature of these coping strategies and their roles in coping offers clues for potential help through spirituality in addressing trauma or contributing to distress. The following are based on

the work of Pargament (e.g., Pargament, Koenig, Tarakeshwar & Hahn, 2004). This research emphasizes spirituality with a religious dimension. Many studies have drawn from his works and other studies closely reflect these concepts.

Positive spiritual coping strategies include the following (Fallot & Heckman, 2005; Perez, et. al, 2007; Smith, 2004):

- Looked for a stronger connection with God (spiritual connection)
- Sought God's love and care (seeking spiritual support)
- Sought help from God in letting go of my anger (religious forgiveness)
- Tried to put my plans into action together with God (collaborative religious coping)
- Tried to see how God might be trying to strengthen me in this situation (benevolent religious reappraisal)
- Asked forgiveness for my sins (religious purification)
- Focused on religion to stop worrying about my problems (religious focus).

Some of the phrases used by African American survivors of Hurricane Katrina eloquently describe these positive coping strategies (Hrostolwski & Rehner, 2012; MHum, Bell, Pyles, Runnels, 2011).

***Collaboration and support:***

“So long as I got God on my side I can't give up.”

“Let God guide you and trust that He will lead you in the right direction.”

“He (the Lord) done give me the strength.”

***Sense of meaning in the event:***

“God ain't brought me this far to leave me hanging.”

“I see the hurricane as an act of God—so I took it in a positive way—brought families closer together, made us see what was more important.”

Spiritual and religious practices prayer, meditation, reading the Bible, attending church were extremely important positive coping strategies for survivors of the hurricane (MHum, et al., 2012; Tausch, Marks, Brown, Cherry, Frias, Williams, Melancon, & Sasser, 2011).

Religious coping can be part of developing a new meaning for the role of faith as reflected in this paraphrase of the response by a man whose brother was shot and killed.

I used to believe that my faith and God would protect us, would keep me safe...that is what I saw as my faith. So my faith was truly shaken through this experience. I now see things differently. Because what my faith taught me was

that I could overcome and handle this situation, I never ever felt that I was alone in it. God was with me through it (Chapple, et al., 2011, p. 10).

Relationships with spiritual leaders can help provide a path for spiritual healing, as expressed by an African American woman who had been sexually abused as a child.

I've been going every week to talk to my pastor here...and trying to search, you know, and heal some of the hurt—just to gain peace and to realize that...He has it in His hands. I know that counseling and therapy does work, but God is the actual answer (Bryant-Davis, 2005, p. 411).

### **Negative Religious or Spiritual Coping Strategies**

Negative religious/spiritual coping strategies can be illustrated by some of the following statements (Perez et al, 2007):

“I wondered if God had abandoned me?”

“I questioned God’s love for me.”

“I decided the Devil made this happen.”

“I felt punished by God.”

These thoughts increase the sense of being abandoned, of being without support, of being a worthless person. Trauma can destroy a sense of trust in God and the higher power—a contract has been broken (Smith, 2004). Religious leaders or others who view traumatic events (for the individual or the community) as part of God’s judgment further their sense of self-blame—the hurricane was God’s punishment for... (Smith, 2004).

Children who have been traumatized can have difficulty maintaining their religious and spiritual beliefs. If we understand a child’s sense of spirituality and relationship with God from an attachment theory that God will protect one, abuse to the child disrupts one’s spiritual trust and can “lead to a damaged view and relationship with the divine being” (Bryant-Davis, et al, 2012 p. 309). Children’s sense of the ultimate environment can shift to one of suffering, chaos, struggle, resistance, evil, and fear. This can lead to either an increase in their spiritual life or a rejection of religion and spirituality as a coping strategy. Children can come to believe that the higher power is out to judge, punish or condemn them, making them feel shame and guilt and have negative self-esteem. (Bryant-Davis, et al 2012). Children can feel unworthy of God’s help, feel tested by God, feel angry toward God, blame God for their suffering, and wonder how a loving and just God could allow this to happen (Bryant-Davis et al, 2012; Walker, Reese, Hughes, Troskie, 2010).

When young children experience trauma from parents, phrases like “God is your father, your heavenly father” can create negative and judgmental images of God shaped by the parent. Experiences with parents (both positive and negative) get transferred to their spiritual life.

The nature of religious thoughts and practices prior to trauma can influence the interaction of trauma and religion. People who have a strong relationship with their higher power prior to the trauma are more likely to benefit from their faith and to emerge with their beliefs intact while those with more tenuous or unstable religious attachments are more likely to lose their faith or be unable to benefit from them (Smith, 2004).

### **Potential Resources within Spirituality and Religious Life**

Based on previously cited studies and literature, the following potential resources within spirituality and religious life emerge:

- Spirituality can offer a sense of **hope** in the context of the hopelessness of trauma. Finding some sense of meaning, of belief in a power outside of one’s self can contribute to a sense of hopefulness (Perez, et al., 2007). The positive spiritual coping resources described previously draw upon the power of God to address this sense of hopelessness.
- Spirituality in the form of various religious traditions also offers a sense of **power** in partnership (“God on my side”) with the divine and growth in personal strength to counter the sense of helplessness, vulnerability, and powerlessness (Perez, et al, 2007; Hmum, et al, 2011; Hrostowski & Rehner, 2012).
- Spirituality provides a sense of **worth** and **being cared for** to counter being devalued and dehumanized and the crushing of one’s spirit (Van Hook, 2014; Siegel & Schrimshaw, 2002).
- Spirituality provides a path toward **personal purification** in a context of damage to worth of the self (religious purification) (Fallot & Heckman, 2005).
- Spirituality associated with a community can offer emotional and practical **support** in the context of feeling abandoned, exploited and devalued (Farley, 2007; Van Hook, 2008).
- Spirituality can offer leaders/counselors who offer **safe, comforting, and understanding relationships** to counter hurtful ones (M. Hrostowski & Rehner, 2012; MHum, et al, 2011).
- Spirituality as a source of **helping others, altruism, giving back** in the context of being made helpless can create a sense of **meaning and purpose** (Bryant-Davis, et al, 2012)
- Spirituality as accessed through **rituals** or practices that help access meaning and power (Hrostowski & Rehner, 2012).

- Spirituality and religion can offer a **hope for continuing life after death** in some form that provides comfort for other family members (Chappelle, Swift & Ziebland, 2011).

### **Helping Clients Identify and Access Their Resources in the Area of Spirituality and Religion**

#### **Opening the Door**

The first step in any effort to help clients identify and access their resources or struggles in the area of spirituality and religion is to open the door by inquiring if their spiritual life or religious life has any relevance for or gives meaning to what they are going through or have experienced. Such a genuine and concerned inquiry helps open the door to these concerns for people who might have thought that the counselor was not interested or did not think that these issues were relevant or of value. (This opening goes beyond a line on the intake form).

Opening the door also means that the social worker must be comfortable walking with the client on their pathway of pain, being willing to listen to issues of existential concern of the client, or is able to hear what traumatic stories the client wishes to share. As a young and inexperienced social worker, I discovered that I was unable to hear how my client had managed to survive despite being forced to dig her own grave and had inadvertently changed the subject.

Opening the door also means that the social worker is aware of his or her own sense of spirituality and is careful not to use this in an inappropriate way with a vulnerable client. It means assuming the role of facilitator, not a director (Smith, 2004).

Opening the door also means that one is willing to try to understand various spiritual traditions and ways in which they might be influencing how people are experiencing their world and their spirituality. Consulting with religious leaders or experts in relevant faith traditions, as well as study, can be useful here.

Opening the door for our clients also means that we take seriously the need to care for ourselves so that we do not risk the dangers of compassion fatigue or vicarious trauma that make us unable to be of help to our clients as well as invite harm to ourselves. Mary Jo Barrett, in her discussion of relational abuse (2008), discovered that she had lost her own sense of spirituality in spending her days listening to people who had been traumatized and needed to find ways to restore her own spirituality in order to be helpful to others.

### **Providing safety**

People who have been traumatized need to feel safe and secure as part of the healing process (Herman, 1997). A realistic assessment of the situation facing the individual is important—too many women are killed in the process of leaving their abuser. The young woman being trafficked needs to have a safe haven. Children who are being abused need to have a safe place to live. This represents a struggle in working with soldiers who are about to return to the world of combat.

People who have been traumatized need to have a safe haven in terms of relationships with others. The social worker needs to offer this safety in terms of a caring and accepting relationship. Helping the client find safe havens in terms of relationships and settings with others is important. In a real sense, caring relationships offer spiritual support to a hurting and traumatized person. The world of the spiritual is mirrored in that of real life relationships. Barrett's many clients who had been traumatized identified love as one of the two key elements in their recovery. They were able to experience being cared for and in the process also begin to love themselves again. Within this safe haven, they were able to begin to tell their story (Barrett, 2008).

### **Normalizing people's reactions**

People who are struggling with anger toward God, with doubts about their spiritual power, can experience further a strong sense of self blame for these thoughts and feelings. People can be troubled because their certainties have been shaken. Helping people recognize that this is an understandable and normal reaction can help lift this burden that in turn has been making it even more difficult to access any potential spiritual resources. A friend shared with others how he had to "have it out" with God after the accidental death of his son and the acceptance he experienced from God. His story gave healing to another friend who was angry with God for the death of his son-in-law. He, in turn, was able to relieve the burden of blame of a mother grieving the loss of her son and angry with God.

### **Asking Clients If They Wish to Include Spiritual Issues in the Helping Process**

Going beyond the principle of self-determination, this step of initiating the topic of spiritual issues but following the client's lead is especially important for traumatized individuals because they have been left feeling that someone has taken control over their lives and they do not have the power to make decisions. Acknowledging and respecting the client's critical decision making power represents an important step in creating a safe relationship.

### **Tailoring Interventions to be Responsive to the Client's Experience and View of the World**

If the client is interested in including spirituality, a joint functional assessment with the client in terms of identifying what aspects of their spirituality could be helpful. What are potential barriers to accessing them; what burdens might be represented in the spiritual life? This assessment process provides the guide for an individualized approach that incorporates individual life experiences as well as spiritual and cultural traditions. It also identifies ways in which spiritual issues are linked with other life issues—interpersonal relationships, self-image, and sources of support. The client might describe important rituals, beliefs that offer hope or contribute to self-blame, other relationships that offer support or condemnation, fears and doubts, new ways at looking at the world around them, and the nature of their spiritual tradition (for example, life after death may be understood very differently from Christian and Hindu perspectives). What is the role of suffering from the perspective of their spiritual tradition? What are the rituals that offer healing within the client's spiritual tradition?

### **Some Possible Intervention Strategies**

The following represent potential strategies only and must be tailored to the needs and wishes of the individual client—including culture and faith orientations).

#### ***Identify potential sources of emotional and practical support within the spiritual community of the person***

People within the spiritual community who are understanding and can appreciate the role of trauma can be an important potential resource. As a student, I had a client whose child was born without eyes. She had previously been divorced and remarried outside the Catholic Church (pre Vatican 2). She was always waiting for God to punish her. Understanding and sympathetic Catholic sisters who worked with children with disabilities were able to be a very healing and reassuring presence in her life.

People can be so burdened down with self-blame that they are reluctant to reach out to potential sources of support that might be valuable resources. Social workers can be aware of resources such as chaplains and faith groups with demonstrated efforts of concern that offer support (practical help, caring, support groups) that clients might find useful. These programs in turn offer people a sense of being valued and accepted.

### ***Obtain and use relevant knowledge***

Barrett's clients describe knowledge as the other important ingredient in healing from trauma—knowledge regarding their world, themselves, and ways to cope. This knowledge helps clients gain a better understanding of the nature of the world around them, the ways in which trauma has distorted their view of themselves, and ways to cope more effectively with the impact of trauma (2008).

### ***Identify the religious and spiritual coping strategies that are helping the individual cope with trauma***

It can be useful to explore with the client any thoughts and actions that have been helpful. What meaning do they have, how do they help, and how the client can continue to incorporate them in his or her life. For example, "You said, 'I feel God's presence as a guide.' When does this happen, what is its effect, and are there ways that you can draw upon this feeling when you are feeling caught up in a sense of fear created by what happened to you?"

### ***Identify ways to address the trauma inflicted by self-blame and self-hatred that destroys their spirituality***

While self-blame initially can be protective (I was in control), it is destructive if it continues. Cognitive behavior techniques can be useful here. Clients can be helped to reexamine their beliefs in terms of their religious or spiritual tradition. For example, "What does the Bible say about God's loving his children?" "What does the Quran say about who can offer judgment—only Allah?" (Bryant-Davis, et al, 2012). What does this mean regarding Hindu views of the divine within the person? If you include these statements in your response to "I must be a bad person that this happened to me, I must be a worthless person," how does this change your thoughts? Are there ways that one can explore more affirming spiritual ways of viewing self in terms of one's self talk? Helping clients identify sources of support within their spiritual tradition that are affirming and comforting can be drawn upon in these cognitive reframing efforts.

Asking clients what they would tell a friend or neighbor who had gone through this experience helps clients draw upon their spiritual traditions in more healing ways. "Would you tell a friend who had been raped or beaten up by her boyfriend that she was a bad person, that God was punishing her?" "What would you tell a fellow soldier who had been in an explosion and lost his leg?"

***Identify strengths of the client that can be used, especially those used to cope with violence and its impact, to establish safety, and to help counter negative cognitions***

This information can be used to counter shame and self-blame. Clients are able to recognize that they are not to blame and that they have self-worth and abilities (Bryant-Davis, 2005). A woman whose is effective in her job or as a parent can be helped to identify her problem-solving strategies and how these can be used in dealing with a potentially violent situation. It can also be used to help address her own sense of inadequacy resulting from a prior traumatic experience. Mrs. L was struggling with PTSD following years as a prisoner of war and her subsequent experience as a refugee. Helping her recognize how well her children were doing and how effective she was as a parent helped her address some of her sense of guilt and powerlessness.

***Explore earlier life experiences of trauma and their impact on the current event***

Learning about the client's life story, especially in response to earlier traumatic life events that have contributed to these beliefs can provide additional ways to help clients alter their interpretations. A client told of being sexually assaulted by an older man when she was a very young girl. When she told her mother what had happened, she was told not to tell her father and to pray to God for forgiveness. As a small child, she was unable to question her mother's interpretation of the event that in turn created an unquestioned basis for self-blame. When this memory was revisited after an adult trauma, she was able to recognize the mother's distorted view of the situation and to reevaluate these assumptions in ways that no longer made her feel unworthy and guilty.

People can also begin to evaluate their current situation and to separate it from the past. While a child who is abused is small and powerless, as an adult, the client now has new sources of strength and power and people who are willing to help. Identifying these people can also help begin to correct views that the entire world is dangerous and no one can be trusted.

***Use creative arts (music, art, stories, journaling) as a way of finding spiritual resources***

While valuable for everyone, art and stories can be especially useful for children in expressing and communicating their trauma and finding ways to express themselves. People can be encouraged to use journaling to cope and to think in terms of their personal and spiritual resources in this process.

***Involve parents or caretakers to help children who have been traumatized***

Caring adults can provide safety, can hear children's stories or help them draw pictures, and can reassure them of being loved and cared for. Psychoeducational approaches can be used with parents to help them recognize signs of trauma and ways they can respond that will give their child a sense of security and safety.

***Help clients find ways that they can contribute to others***

Many people who have been traumatized find further healing in helping others. This process helps give meaning to the life event and also helps people restore their sense of self-worth and power (Bryant-Davis, et al., 2012). The specific form of help varies depending on the person's resource and what is meaningful to them.

***Explore the possibilities of forgiveness***

For some people, forgiveness is part of the path to spiritual healing. Forgiveness can involve forgiving the person who hurt them or self-forgiveness. It is important that people not feel coerced or made to feel guilty if they do not follow this path. People also need to be past the first shock of the trauma. Individuals can be introduced to the concept of forgiveness so that they can make an informed choice in terms of their own lives and their readiness to consider such a step.

It is important to understand how forgiveness and harmful actions are viewed within their spiritual tradition. It is also important to identify if people are feeling coerced to forgive by spiritual leaders or others within their family or community. Such pressures to forgive only intensify the sense of powerlessness and trauma.

Forgiveness is not the same as reconciliation that implies that the offending party states that they are sorry for what they have done and seeks a restoration of the relationship. Forgiveness can occur even when the offending party is not aware of the forgiveness process. Forgiveness and its possible healing are not held hostage to the actions of the offending party. It allows the person to move on in terms of his or her life. Forgiveness is also not forgetting. While one can let go of the anger, it can still be important to recognize when someone or a situation is dangerous and to exercise self-protection. The forgiveness process involves a genuine acknowledgement and acceptance of the hurt and anger experienced by the person. Attempts to bypass this step can lead to problems in the future. Individuals need the opportunity to express their feelings and to have them validated (Frame, 2003).

### Conclusion

Trauma can have a profound impact on the cognitive, emotional, physical, interpersonal, and spiritual life of a person. Spirituality can potentially offer sources of healing, hope, and sense of worth for individuals who have experienced trauma. Trauma can also have a negative impact on one's spirituality. Incorporating spirituality into the social work process with traumatized individuals requires respect for their self-determination, conditions of safety, and help in strengthening positive cognitions, relationships, and coping strategies to address the impact of trauma. ❖

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# After Trauma: Family Relationships and the Road to Healing

*T. Laine Scales & April T. Scales*

*In this personal account of their adoption experience, the authors describe how childhood trauma has affected their mother-daughter interactions through the teen years and beyond. By sharing professional and personal knowledge about trauma and adoptive families, the authors hope to better equip Christians in social work to understand their clients and themselves. Literature on PTSD and attachment provides a theoretical foundation for their reflections.*

*My name is April; I'm 20 years old and all I have left of my childhood are two books filled with foster care notes and the memories I hold. For the first half of my life, people I loved and trusted abused and abandoned me. Up until the age of eleven, I moved from home to home where I was physically, sexually, and mentally abused by many different people. As I began healing, working through my trauma was not satisfying. I educated myself and saw how poorly many people are treated and the negative psychological and social problems that stem from this. My heart longs to make a difference in the lives of others. For so long, I have felt the weight of the world pressing down on my shoulders.*

**E**XPERIENCES LIKE APRIL'S ARE DEEPLY TRAUMATIC. CHILDREN WHO SUFFER violence and abuse in their families may continue to re-live that trauma many times over. How could one possibly ever heal from such horrific events? In our experience, positive family relationships, supportive community, friendships, therapy, helping others, sense-making, new knowledge, and faith have all worked together for healing. The story we will share in this article highlights only one of these factors: positive primary relationships, specifically the mother-daughter relationship. We are a mother (Laine) and daughter (April) who have forged a new primary relationship over the past eight years through the process of adoption. Our relationship continues to evolve and will continue to do so for the rest of our lives.

## A New Family

Our journey began in June 2005, when we first met through the help of Child Protective Services and a Christian adoption agency called Buckner International. Eleven-year-old April was still in foster care after years of moving from place to place with her two younger siblings. She had even been adopted into a “permanent” placement, only to find the adoption terminated after three years. April had suffered neglect, violence, and abuse most of her life and we will describe her circumstances in more detail later in this article. As Laine and April’s adoptive father prepared to welcome April into their home with a view toward adoption, they sent an introductory picture book for April’s therapist to share before their first meeting. Thus began the long journey to becoming family—a journey we are still traveling.

In addition to being a mother and daughter by adoption, we both study human behavior. Laine taught social work for 17 years, focusing on human behavior and April is a university student enjoying her major in psychology, particularly her courses in neuroscience. We both study and apply to our own lives our knowledge about trauma and various conditions such as Post Traumatic Stress Disorder (PTSD). We consider biological aspects of the brain’s development as well as psycho-social aspects such as family, community, and therapeutic interventions. In addition we are a Christian family, but with many struggles and uncertainties on our faith journeys. Our hope is that by sharing our professional and personal knowledge about trauma and adoptive families, our readers will be better equipped to understand their clients and themselves.

## Living with Trauma

To set a context for our story we will provide a brief overview of trauma and its effects; specifically, we will explore Post Traumatic Stress Disorder (PTSD), a disorder that April lives with daily. While many readers may associate PTSD with soldiers traumatized by war, it is also a common diagnosis for children and adults reared in violent families.

The American Psychiatric Association (APA) introduced PTSD as a possible diagnosis in 1980 when their diagnostic manual (DSM) defined a traumatic event as “occurring outside the range of usual human experience.” The revisions to the DSM in 2013 included more specificity in what constitutes a traumatic event. Sexual assault is specifically included in the DSM5 and four symptom clusters are featured:

- **Re-experiencing the event.** For example, spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress.

- **Heightened arousal.** For example, aggressive, reckless or self-destructive behavior, sleep disturbances, hyper-vigilance or related problems.
- **Avoidance.** For example, distressing memories, thoughts, feelings or external reminders of the event.
- **Negative thoughts and mood or feelings.** For example, feelings may vary from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.

*PTSD Dissociative Subtype* describes dissociative symptoms such as feeling detached from one's own mind or body, or experiences in which the world seems unreal, dreamlike, or distorted. (American Psychiatric Association, 2013).

April reports experiencing all of these symptoms at various times in her journey and was diagnosed in 2011 with PTSD. This diagnosis and the research we did after the diagnosis helped us make sense (separately and together) of April's behaviors. The diagnosis also gave us a place to begin working toward healing.

Children living with past traumas experience everyday events in dramatically different ways from the rest of us. Greenwald (2005) describes a "trauma wall" behind which a person surviving trauma holds all the fear, anxiety, anger, and helplessness, rather than being able to "digest" it or process it along with other memories. This is especially true for children and teens that were pre-verbal at the time of trauma. Since they have no language to express or remember words or stories about what happened to them, the processing and integration of their terrible memories becomes even more challenging. Greenwald relates an everyday experience of a traumatized teen bumped accidentally in the hallway at school. While most of us may be slightly irritated, but forget about it a few minutes later, the traumatized person has been hit in an emotional sore spot. "Behind the wall is piled-up fear of being attacked, a sense of helplessness, and rage. Naturally, being angry and not wanting to feel helpless anymore, he defends himself" (Greenwald, 2005, p. 13).

April reflects on ways her own trauma affected her sore spots:

Because of my experience of caring for myself at a young age, I always felt the need to have control over my life. When I was 15 years old, we were living in a university residence hall as part of my mom's job. I made friends with the college students, who were free to do as they pleased. Because I felt like I had earned the privilege to be an adult since I took care of myself most of my life, I could not understand why I needed a curfew on a school night. One night, when my

mom insisted that I come home at midnight, it really hit me hard. I felt so powerless and angry that I yelled, screamed and cursed. Now, that we look back, my mom and I both understand one another's reasoning.

### **The Confusion of Memory**

April deals daily with a variety of memory challenges related to her PTSD. We talk about her memory challenges in terms of four categories: difficulty with memorization, blocked traumatic memories, no recollection of neutral or pleasant memories, and sudden flashbacks.

First, it is difficult for April to memorize facts needed for her school-work. She excels in courses that require more application and synthesizing, but struggles to memorize facts and vocabulary. As she studies neuroscience, April is learning more about how her brain developed differently as a malnourished and traumatized child. She also has improved her ability to memorize facts by practicing various strategies for building study skills.

April has many gaps in her memory of events, particularly pre-adoption. On the one hand, she had no stable adults to tell and re-tell everyday stories about her childhood. In addition, it is common for traumatized persons to block unhappy or scary memories as a coping mechanism. Much of her past is recorded in CPS records and she often reads them with incredulity because she cannot remember the events that are recorded there.

While forgetting the bad times might make sense as a coping strategy, we have been surprised at how many of the *good* times April has forgotten, even those that occurred post-adoption. When Laine recalls stories of people or places they experienced together, April often does not remember. One explanation for these gaps relates to a third memory issue: dissociation. Traumatized persons can take themselves out of a situation emotionally and simply “not be there” (Rosenbloom, Williams, & Watkins,, 2010). April explains:

I didn't know what dissociation was when I was little, but I did it often. I could transport myself somewhere else and it came very easily to me. In the early years of adoption, even though I was not being hurt, I was still emotionally raw and scared. So I dissociated much of the time. When reading my foster care files, I find stories about things I supposedly did but don't remember such as “kicking another foster child in the head” or “rolling around on the floor for no apparent reason.” Although I still dissociate at times, it occurs less often.

When people dissociate they don't absorb and process what they experience; therefore there is no later memory of the event.

The fourth way in which April's memory has been affected involves flashbacks: a sudden and intense flood of memories that come at unexpected times and are often triggered by sights, smells, sounds, and other sensory stimuli (Rosenbloom et. al, 2010). For example the smell of horseradish, used as punishment food by one of the CPS-approved families she lived with, sickens her immediately. At age 20, she is still discovering and recovering childhood memories long forgotten, but surfacing from the unconscious with a trigger. Laine recalls:

One night, driving from a friend's house, April arrived home shaken and scared. All the traffic lights had been flashing due to an electrical problem, which set the scene for an eerie downtown. When April ran into my bedroom to explain that the traffic lights were flashing, I was confused by her facial expression of fright and the fear in her voice. Flashing lights are not uncommon in our downtown area and I knew April had experienced this before. While I could not understand the fear, I just tried to listen and acknowledge how scary it must have been and try to help her see she was safe at home.

Only later did April explain that while the lights were flashing, the siren of an emergency vehicle triggered a long forgotten memory of the night her grandmother had been taken away in an ambulance. A traumatized person experiences these memories with extreme fear and anxiety. Explaining the intensity of the fear to others is difficult, because the event that is so frightening to the traumatized person might seem commonplace to others.

### **Why Should I Trust You?**

Children and teens experiencing PTSD have great difficulty building trust. The heart of our story describes how we built (and continue to build) trust between us over a period of eight years. Like most families of adoption, we began with a "honeymoon phase" in which everyone was on their best behavior and everything was wonderful. Any anxieties on the part of parents are either pushed down, or still out of consciousness. In fear that they won't be adopted or loved, the child always tries to please the potential adopters and is careful not to show any negative behaviors during this time (Schooler, Smalley, & Callahan, 2009). Our trip to Disneyworld symbolizes the wonder of this magical time and our family photos serve as visual reminders. Pictures of Laine and April walking arm and arm through the Magic Kingdom remind us how we all enjoyed similar things, how affectionate April was, and how happy we were. We all believed that God brought us together as a perfectly fitting family. On the Sunday in Advent when we walked down the aisle of our church to light the candles and April

read the Scriptures in her clear and compelling voice, many friends in our congregation remarked how blessed we all were, and we felt it.

After the honeymoon phase, we had work to do: building attachments, establishing family norms and routines, and learning to trust each other. These tasks may happen naturally in most families, but for traumatized children and teens they are surrounded by anger, confusion, and grief. The wonderful pictures described above would soon shift dramatically after the honeymoon phase. Family photos from our difficult years (ages 15-18), few and forced, show unhappy and disconnected people. Laine explains:

As April entered adolescence she isolated herself from me and became rejecting and angry, particularly toward me. As a social worker, and careful reader of the attachment literature, I was quite prepared cognitively for this rejection. However, even that strong knowledge base could not prepare me for the human experience of being rejected by the child I so hoped would love me. Having faith that love would come was difficult, but occasionally, in a moment of transparency, April would give a clue that she wanted to love and be loved. These small moments would keep both of us trying.

April's therapist, a Christian social worker, explained to Laine: "the time you need most to get away from your child, perhaps when they are pushing away, will be the time they most need you to come near." But how does one move toward a child who is rejecting you daily? In order to understand how adopted children join families, we will briefly introduce the idea of attachment.

### **Bonding and Attachment**

Much of the literature on foster care and adoption deals with the very difficult process of attachment, defined here as "the deep and enduring biological, emotional, and social connection caregivers and children establish early in life" (Orlans & Levy, 2006). Laine learned early, through her reading, to distinguish between bonding and attachment. Bonding is a quicker, easier, but more superficial relationship often present in the early months of adoption. Attachment, on the other hand, is a much more complex human need which takes years to develop within adoptive families. Hurt children have disrupted and damaged attachments so they concentrate on survival and self-preservation rather than building relationships in more positive ways. Relationship struggles occur with peers and teachers, but the strongest intensity is expressed with family members. The traumatized person joining a new family feels the confusing dual feelings of fearing rejection by the family, and compelled to push them away at the same time (Scales, Straughan, & Scales, 2013; Hughes, 2006).

Understanding how attachment works can help adoptive parents tremendously, particularly when the child reaches an age and stage to be able to learn about and discuss the process with parents or therapists. Studies on the developing brain demonstrate that an infant's interaction with caregivers actually shapes the formation and operation of the brain, including the neocortex, limbic system, and brain stem. (Orlans & Levy, 2006). In fact, researchers are discovering that different types of abuse may affect different areas of the brain. (Heim, Mayberg, Mletzko, Nemeroff, & Pruessner, 2013). The parts of the brain most affected by neglect and/or abuse are the areas that regulate self-control, the release of stress hormones, and the way genetic material is expressed. Add to these negative effects the mental illness, alcoholism, drug use, and other factors common among parents giving birth to hurt children, and the obstacles to healthy living, beginning in infancy, seem insurmountable (Orlans & Levy, 2006).

When parents neglect or abuse their children, they fail to respond or they respond with violence to their children's needs. Orlans and Levy (2006) suggest that adoptive parents of hurt children engage in what they call "corrective attachment parenting" to build the attachments that should have been in place between parents and their infants. We began this process when April was 11 years old. According to Hughes (2006), a child with attachment difficulties often reacts most intensely and negatively to the mother figure in the home. Paradoxically, this is the person the child fears losing the most. Over time, we were able to "change the dance, change the outcome" as Orlans and Levy (2006) suggest to create new relationship experiences for April. What was not surprising, but still very disheartening, was that building attachment was not an overnight process; it has taken years and our trust is still developing and deepening (Miculincer & Shaver, 2007).

### **Testing the Strength of Self and Other**

As Keck and Kupecky (1995) point out, "One of the hardest things for many hurt children to let go of is the dynamic of anger they often experienced and participated in while in their birth family. They have an amazing ability to recreate this dynamic with their new parents, who once considered themselves patient and loving" (p. 124). This was certainly the case with us. What we understand now is that children who are fighting their hurt, desperately trying to trust, and generally still in survival mode, will battle for control using any means possible: lying, rejecting, defying, and fighting. This constant fight is exhausting, so children and teens behaving their worst are often desperate for someone else who is sturdy, strong, and consistent, to take over (Troutman & Thomas, 2005). They fight for control at the same time they desperately want to relinquish control.

There is wide consensus in the attachment literature that the adoptive mother is often the target of this anger and fear. In addition, mothers may

seem to be weaker than fathers because they lack many of the masculine symbols of strength in our culture: height, physical strength, a voice that is deep and strong. Mothers often must prove to scared kids that they are strong enough to protect their hurt children. However, let's not pretend that the child is the only one who is angry; Laine was hurt, angry, and lacking trust as well! Older, wiser, and less-wounded than the child, the mother has to offer proof of love, over and over again, whether she feels like it or not. This daily commitment was what Laine often described to her skeptical teenage daughter as “deciding to love.”

### **The Love Decision**

In our family, the phase of April's testing Laine's love coincided with adolescence, straining our relationship with the double task of adolescent separation, (pushing away) but complicated by the attachment process (drawing near). In other words, April was pushing away for the purposes of individuation, but at the same time, desiring to come closer to her relatively new mother in the task of attachment—a process that most other mother-daughter pairs started in infancy, or in fact, in the womb. Laine recalls:

Whenever we would argue, April would shout accusingly at me: “you **can't** love me, and you don't love me; people don't just love people they've never met before!” I would insist, “yes, I can, because I decided to: From the very first day I heard about you, I decided I would love you. And each morning when I wake up, no matter what is happening between us, I decide again: “today, I will love my child, to the best of my ability, no matter what; and that is a daily decision!” Hearing those words seemed to make April even MORE angry at something she did not understand and we would argue even more intensely about whether this kind of love was real. While a part of her wanted to believe this love was true and lasting, the wounded part of her was so afraid it might not be.

April continued to hear this idea that love is a decision: She also read it in a poem Laine wrote for their second anniversary together and published in a journal: a printed expression of love shared publically.

....Love decides in this moment  
to love forever;  
my heart aches as it opens deep and wide  
to receive the girl who receives me too.... (Scales, 2008).

Pulled apart from her birth mother, several foster mothers, and “thrown back” to CPS by an adoptive mother at age 10, April had no *rational* reason

to trust that a mother could or would stick to her decision to love. Trust between us would take a long time and is still growing.

However, when she was 19, after experiencing several unhappy dating relationships in high school and a longer term dating relationship in college, April tried on the idea that love is a decision rather than a feeling. Posting an inspirational word to her Facebook friends, April repeated the message in her own words that love is not a fleeting feeling, but a decision. It may have taken 8 years, but Laine recognized that the repeated message and the daily proofs finally were bearing fruit. And, April's more recent experiences with friendship, romantic love, and even the pets she cares for and nurtures, are giving her the chance to practice making the daily decision to love, even when she might not feel like it.

### **Consistent Relationships are a Source of Healing**

Now that we have described many of the challenges for children and teens living with trauma and the tasks we had taken on as a mother-daughter pair, we turn to our reflections on how relationships, most particularly the mother-daughter relationship, served as a resource for healing. Even when the relationship felt “bad” or conflicted, healing was occurring. However, since the process is long and requires so much patience, this is often difficult to recognize.

We readily admit that we were not being strategic every day. Most days we were just slogging through, trying to survive, especially in angry or difficult times. During these years, we were both dealing with the challenges of a divorce, reunification with April's brother, and stressful responsibilities at work and school. Family-making became very confusing with dad and brother both moving out of and into our sphere. The therapist helped tremendously by contextualizing what we were doing and providing a framework for what we could do to help one another and improve our relationship. Looking back, we can see that we used many strategies to work on those tasks, but three actions in particular were helpful. We took on service projects to help others, we told our stories publically to multiple audiences, and both of those actions added up to spending time together, even on days we didn't feel close.

### **Strategy One: Helping Others through Church and Community**

“April has a heart as big as the ocean” her dad often says. She will stop to help any person asking for money, will pick up an abandoned dog or cat and foster it for days or years, and help any school friend in crisis. Her kindness turned into social action as she grew old enough to help in tangible ways and we have participated in several social action projects together, through our church and community. When April was 14, we joined a group of women from

our church crocheting shawls for women who were hospitalized or in crisis. We went together to the monthly home gatherings where we enjoyed sitting around the fire, talking, eating, crocheting, and praying. After enjoying the women's group, we branched out to start our own crocheting group among college students. Calling ourselves *Kids Komfort*, and gathering support from our church, we made blankets for older kids in foster care, a group we knew was often ignored by charities focusing on babies. Our first blanket was given to April's brother when he experienced the same type of trauma she had: his family terminated his adoption after 7 years. His re-entrance into the CPS system gave April more chances to help, this time, with someone she knew and loved. As she has grown in her skills and commitments, we have taken on a much larger community project: starting a settlement house in our neighborhood to bring people together for learning, gardening, recreation, worship, and the arts (Good Neighbor Settlement House, 2014).

### **Strategy Two: Telling our Stories**

Sharing one's story has long been recognized as a powerful healing tool and this became a second strategy toward healing. One of the first things April's CPS workers told us, even before we met her, was that she was extraordinarily open and communicative about her story. She could identify and describe her feelings better than most wounded kids and was highly verbal. Ever cautious, April carefully selected what to reveal and what to keep private. However, from our first year together we had occasions to tell our story of becoming a family: A couple from our church who taught a college course called "Marriage and the Family" invited us to speak to their class about adoption. We worked together to write out our main points, and eleven-year-old April wrote her own script, which was funny and insightful. When April was 14, the two of us addressed our church on Sunday morning to ask for help with *Kids Komfort* blankets. April's own experiences provided the explanation:

Some kids don't like to be hugged by people, but they enjoy being cuddled by a blanket. I felt that way sometimes; I didn't want to hug or be close to a person because I knew I'd just have to leave them in a few weeks. But being hugged by a blanket is like being surrounded by God's love for you. You always have it (Scales & Scales, 2008).

April's words say so much about her quest to establish boundaries, her faith, and her reluctance to trust, all damaged by her trauma; yet it still has a hopeful and encouraging tone, a *resilience* that pervades her life, even in hard times (Muller, 1992).

Adolescence brought with it a new independence, but public speaking remained an important part of April's healing. She explains:

My therapist invited me to speak to a group of MSW social workers. This was the first time I had done it without my mom, but I wanted to tell them about both the ups and downs of adoption. I didn't sugar coat the story a bit and I think the graduate students were shocked by some of the things I told them. Then, when I took a public speaking class in college, I gave a speech about how the foster system should be improved. When I revealed toward the end of the speech that I came from the CPS system and that these were **my** experiences, you could have heard a pin drop in the class. No one expected that I would have that kind of background and still be a successful college student.

As writers and public speakers, we will continue to tell our stories; in fact, we found it fruitful and healing to write this article together. This occasion gives us a chance to recall, explain, and share openly with each other as we draft and revise it.

### **Strategy Three: Walking with Others on the Journey**

While speeches and publications allow us to tell our stories, and our community work provides an avenue for helping others generally, our special relationship with another adoptive family has given us an opportunity to practice a third strategy toward healing: walking beside people in similar situations. When April started college, a family we had known several years began the process of adopting an eight-year-old girl through CPS. Like April, this child had experienced many moves into new families as well as a terminated adoption. The adoptive father had been April's history teacher; the mother was her art and design teacher. Laine knew both parents well through work. "Will you come and share with us anything we need to know as we welcome this new child into our family?" they invited. April took the question very seriously and prepared for several days. She talked through her bulleted points with Laine and asked hopefully, "Do you think they might let me mentor her?" "We'll see," Laine responded.

April brought her most honest self to the meeting with the adoptive parents, including confessions of negative feelings and behaviors as well as suggestions on what the parents might expect. We were all quite moved, when the mother asked, "Would you be willing to mentor our girl?" The mentoring relationship is still evolving and has joys and challenges of its own. However, it is a clear example of what social workers call, "mutual aid." When April spends time with a hurt child who is both similar to and different from her, she continues to recall, heal, and grow at the same time she is giving help to another family. And Laine heals from her wounds too, when listening to the parents, re-living both the honeymoon days and the

most painful days. We try to represent for these dear friends, often discouraged by this long process, a hopeful future when love finally comes.

### **Unopened Messages**

Family love requires daily expression, but communicating love can be difficult when tension and anger have become the norm. During our hardest times, both of us sought different ways of expressing positive feelings, using our common interests in reading and writing. After April was finally diagnosed with PTSD, we bought a book called *The Post-Traumatic Stress Disorder Sourcebook: A Guide to Healing, Recovery and Growth*, written by Glenn R. Schiraldi (2009). In an earlier honeymoon phase, we might have read portions aloud together. But in the middle of our difficult days, when communication was hard, we agreed that April would read the book first and use a highlighter to mark all the relevant passages she wanted her mother to read carefully and write in the margins any messages she wanted to express. Then Laine would review the book, receive the messages, and try to understand, even if we were not able to talk about it just yet. Another way we communicated was by leaving each other notes and cards, usually with positive sentiments. One of us might write a note of apology or appreciation for the other to find in the kitchen.

This may not work for everyone; we are both readers and writers. But these small acts were bits of glue that held things together during the roughest times. When we began preparing to write this article we pulled out the old PTSD sourcebook for reference. Laine flipped through the pages and soon realized that she had reviewed some, but not all of the highlighted words and margin comments. Looking at these marginalia, years later, Laine experienced these “unopened messages” that provided insight into April’s feelings from a few years ago and the notes served as a benchmark for how much April had grown over the years.

Tucked into the book, we found an unopened card Laine wrote to April. Was it a note that a busy mom forgot to give her daughter? Or had she tucked it into the book, given the book to April and it was never found? Or, perhaps the hurting daughter received the card but was saving it to open when she was in a better, more cheerful mood. Neither of us could remember! But during the years that had passed, somehow April had still received the card’s message of “I love you” even without opening the sealed envelope. We had fun opening the card together, years later while writing this article, and it prompted a sweet hug. Due to the mystery of familial love, we understood and knew intuitively many of the things expressed in the unread marginalia and in the unopened card. Daily life together, as hard as it was, still held messages of love.

## Conclusion

Trauma disrupts everything: the process of attachment, the road toward building trust, and the daily business of family-making. However, healing relationships: friendships, romance, and especially parental love can be powerful contributors to healing and growth. We are still living into our future as mother and daughter and making sense of our past. Writing this article has been helpful to us, and we hope our story will be of benefit to hurt children and teens, their families, and the social workers serving them. ❖

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**Keywords:** Childhood Trauma, Adoption, Attachment, PTSD

**Dedication:** We dedicate this article to Elizabeth Timmons, LCSW; the Christian social worker who walked this journey faithfully alongside us for 8 years.

# The Role of Spirituality in Helping African American Women with Histories of Trauma and Substance Abuse Heal and Recover

Joan Marie Blakey

*There is increased interest in spirituality and the role it plays in helping individuals with histories of trauma and addiction heal and recover. Using the Case Study method, the purpose of this study was to highlight the ways 26 African American women with histories of trauma and substance abuse used spirituality during the recovery process. Data analysis revealed components of a spiritual process that were used to facilitate healing and recovery. The first component, reclaiming spirituality, involved helping women reclaim and reconnect to their spirituality or spiritual practices that brought them solace and comfort. Finding meaning, the second component, consisted of helping the women find meaning and purpose for their lives. Trusting the process, the third component entailed building the women's capacity to trust the process and to a lesser extent, surrender. Finally, active faith involved helping the women learn to rely on their faith in God rather than turning to drugs when obstacles and challenges arose. This study's findings revealed that spirituality can be an effective tool that promotes and facilitates recovery. Nonetheless, professionals need to recognize that not all women want to develop and nurture a spiritual life and that they must take their lead from them.*

**A**FRICAN AMERICAN WOMEN HAVE RELIED ON SPIRITUALITY (E.G. individual's belief, faith in, and personal relationship with God/higher power that transcends human limitations, restores them to well-being, and loves them unconditionally) to cope with unimaginable experiences such as slavery, racism, domestic violence, rape, as well as other forms of interpersonal trauma (i.e. childhood and adult victimization that causes significant psychological distress and functional impairment)

(Brome, Owens, Allen, & Vevaina, 2000; Bryant-Davis, 2005; Potter, 2007; Stevens-Watkins, Sharma, Knighton, Oser, & Leukefeld, 2014). Spirituality is a significant part of many African American women's daily lives. They derive a great deal of fulfillment and solace from their religious practices and faith in God (Ahrens, Abeling, Ahmad, & Hinman, 2009; Hooks, 2003; Stevens-Watkins et al., 2014; Yick, 2008).

Moreover, spirituality can counter the negative effects of oppression and trauma as well as contribute to positive mental health outcomes among African American women (Brome et al., 2000; Paranjape & Kaslow, 2010; Washington, Moxley, Garriot, & Weinberger, 2009; Watlington & Murphy, 2006). Studies have reported that spirituality is related to increased well-being, decreased levels of depression, anxiety, and post-traumatic stress disorder (PTSD) symptomology, longer periods of sobriety, and a more optimistic view of life (Ahrens et al., 2009; Avants, Warburton, & Margolin, 2001; Flynn, Joe, Broome, Simpson, & Brown, 2003; Gillum, Sullivan, & Bybee, 2006; Piedmont, 2004; Pardini, Plante, Sherman, & Stump, 2000; Paranjape & Kaslow, 2010; Piedmont, 2004; Watlington & Murphy, 2006).

Despite a growing body of literature documenting positive outcomes associated with spirituality, there is a need for more research that examines the ways trauma survivors in general use spirituality during the recovery process. Most studies have exclusively focused on intimate partner violence or sexual assault victims' use of spirituality (Ahrens et al., 2009; Ai & Park, 2005). There also is a need to extend research in this area beyond white women or women as a whole and explore the use of spirituality by African American women with histories of trauma and substance abuse (Bryant-Davis, Ullman, Tsong, & Gobin, 2011; Curtis-Boles & Jenkins-Monroe, 2000; Drescher & Foy, 1995; Fallot, 2007; Fontana & Rosenheck, 2004; Fowler & Hill, 2004; Gillium, 2009; Stevens-Watkins et al., 2014).

Using the Case Study method, the purpose of this study was to understand how 26 African American women with histories of trauma and substance abuse used spirituality during the treatment process. Given the high prevalence of trauma among African American women and the growing recognition that spirituality is an important dimension of healing and recovery, it is critically important to understand more about spirituality as it relates to African American women (Brome et al., 2000).

## **Literature Review**

### **Prevalence of Trauma among African American Women**

African American women experience disproportionately high rates of trauma as compared to their Caucasian counterparts (Hampton & Gillotta, 2006; Renison & Planty, 2003). Alim, Charney and Mellman (2006) reported that 65% of African Americans had exposure to trauma in their lifetime.

African Americans who live in urban areas are at significantly higher risk of exposure to traumatic events resulting from community violence, racism, segregation, oppression/discrimination, and poverty (Alim et al., 2006; Davis, Ressler, Schwartz, Stephens, & Bradley, 2008). Moreover, rates of interpersonal trauma among African American women are disproportionately high. Between 2001 and 2005, almost 50% of all victims of rape, sexual assaults, robberies and aggravated assaults were African American (Harrell, 2011). Nationally representative studies in the United States reported that African American women consistently reported higher rates of intimate partner violence than their white counterparts (West, 2004). Twenty five to 31% of African American women experience intimate partner violence (Gillum, 2009; Harrell, 2011). Among African American women ages 20–24, intimate partner violence was 29 per 1,000 victimizations for black women versus 20 per 1,000 victimizations for white women (Rennison, 2001). Finally, African American children have higher rates of child abuse and neglect as well as child fatalities than their white counterparts (United States Department of Health and Human Services, 2013). For example, Amodeo, Griffin, Fassler, Clay, & Ellis (2006) found that 34.1% of African American women versus 22.8% of white women had higher prevalence of childhood sexual abuse.

Commonly, African American women experience multiple forms of trauma (complex trauma) throughout their lives (Kubiak, 2005). Blakey and Hatcher (2013) reported that 73% of the African American women in their study experienced 5 to 12 traumatic events. Complex trauma refers to a combination of early and late-onset, multiple, and sometimes highly invasive traumatic events, usually of an ongoing, interpersonal nature (Lanktree & Briere, 2008). Complex trauma refers to the pervasive, severe, chronic, and hard-to-treat aspects of individuals who repeatedly have experienced multiple forms of prolonged trauma throughout their lives, usually starting in childhood (Cohen & Hien, 2006; Cottler, Nishith & Compton, 2001; Herman, 1992; Sacks, McKendrick & Banks, 2008).

### **Spirituality and Trauma Survivors**

There are myriad ways that individuals cope with and manage symptoms related to trauma (Fowler & Hill, 2004). Commonly, women turn to alcohol and illicit drugs to numb the pain associated with trauma and/or mental health symptoms such as PTSD, depression and anxiety (Sacks et al., 2008). Some women use self-harm or self-mutilation as a way to cope with trauma (Gladstone et al., 2004). Still other women cope with their traumatic histories by praying, meditating, worshipping God and other forms of spirituality (Bryant-Davis, 2005; Gillum, Sullivan, Bybee, 2006; Hooks, 2003; Stevens-Watkins et al., 2014; Potter, 2007; Yick, 2008).

The majority of studies focusing on spirituality and trauma have identified positive and negative ways in which spirituality has facilitated

or hindered survivors' healing and recovery (Ahrens et al, 2009; Bryant-Davis et al., 2011).

### ***Positive Ways***

Positive spiritual coping involves using spirituality and faith in a higher power to find meaning, solace, and support to manage and make sense of the things that have happened to them (Ahrens et al., 2009). Many studies have found that spirituality helps trauma survivors leave abusive relationships (Ahrens et al., 2009; Pargament, 1997; Potter, 2007). Spirituality offers an opportunity to open to the spiritual realm and in some cases caused them to have a spiritual awakening, offered them hope, and opened the possibility for growth (Adams, 1995; Ryan, 1998; Vis & Boynton, 2008). Spirituality has helped people transcend their pain by redefining the event as part of God's plan, finding something beneficial in their experiences as well as turning to the church or God for guidance and support (Fallot, 2007; Frankl, 1962; Marcus & Rosenberg, 1995; Pargament, Koenig, & Perez, 2000; Potter, 2007). Moreover, spirituality has replaced trauma survivors' emptiness and despair with hope, meaning, comfort, and direction (Frankl, 1962; Garbarino & Bedard, 1996; Lightsey, 2006; Marcus & Rosenberg, 1995; Pargament, 1997; Ryan, 1998). Finally, spirituality allowed many trauma survivors to put their lives into perspective, and catalyzed the process of post-traumatic growth (Potter, 2007; Ryan, 1998; Vis & Boynton, 2008).

### ***Negative Ways***

Negative spiritual coping involves individuals struggling with their faith in a God who allowed negative, hurtful, things to happen to them. These negative feelings towards God or spirituality have led them to denounce the existence of God and distance themselves from spiritual beliefs that once provided comfort (Ahrens et al., 2009; Pargament, Tarakeshwar, Ellison & Wulff, 2001). Trauma survivors who had negative feelings about spirituality felt distrustful, fearful, abandoned, and unprotected by God because they believe He allowed the abuse to occur by not preventing or stopping the traumatic event despite having the power to do so (Garbarino & Bedard, 1996; Herman, 1992; Lemoncelli & Carey, 1996; McCann & Pearlman, 1990; Ryan, 1998; Wilson & Moran, 1998). Some trauma survivors believed that God was punishing them and consequently had forsaken them in their time of need (Harris, Erbes, Engdahl, Olson, Winskowski, McMahill, 2008). Still other trauma survivors felt silenced by their religion or certain spiritual practices and/or blamed for the abuse instead of holding the perpetrator accountable (Taylor & Fontes, 1995; Wulff, 1991). These feelings were exacerbated in situations that included a religious/spiritual component or when religious figures perpetrated the trauma (Ryan, 1998).

## **Gaps in the Literature**

Spirituality is one of the few positive coping strategies used by trauma survivors that has been found to facilitate healing, so there is a need for more research examining the ways trauma survivors use spirituality during the recovery process. There also is a need to explore trauma and spirituality as it relates to African American women (Bryant-Davis et al., 2011; Curtis-Boles & Jenkins-Monroe, 2000; Drescher & Foy, 1995; Fallot, 2007; Fontana & Rosenheck, 2004; Fowler & Hill, 2004; Gillum, 2009; Stevens-Watkins et al, 2014). This study begins to address these important gaps in the literature.

## **Method**

This study uses the case study method that allows for an in-depth understanding of a contemporary phenomenon (e.g., African American women's view of spirituality) within its real-life context (Creswell, 2013; Fisher & Ziviani, 2004; Padgett, 2008; Scholz & Tietje, 2002; Stake, 1995, 2006; Yin, 2009). Case studies enable the researcher to better understand a specific issue, problem or concern, and allow multiple facets of problem to be revealed and understood (Baxter & Jack, 2008; Creswell, 2013; Yin, 2009).

## **Sample**

A maximum variation sample of 26 African American women with histories of substance-abuse women was recruited from a large, urban Midwestern city to participate in the study (Padgett, 2008). The goal of maximum variation sampling is to deliberately take full advantage of variations that might be present in a sample population so that when patterns emerge, they are believed to highlight core experiences and shared aspects of the sample population (Patton, 2002).

The women's ages ranged from 19 to 43 years ( $M=36$  years old). The women had used alcohol and illicit drugs (e.g., marijuana, heroin, or crack cocaine) from 3 to 37 years. On average, the women had been using drugs and alcohol for 22 years. The youngest woman started using alcohol or illicit drugs at the age of 5 and the oldest started at 20. On average, the women started using drugs when they were 14. Women remained in treatment from 14–661 days ( $M=99$  days). Finally, 19 of the 26 women (73%) had some kind of mental health diagnosis with depression, bi-polar disorder, and anxiety being the most common.

## **Data Collection**

Data collection methods employed in this study were interviews and document reviews. In-depth, semi-structured, open-ended interviews were

conducted at the treatment center and lasted one to two hours. Interviews were digitally recorded and transcribed verbatim by a professional transcription service. Pseudonyms were used throughout the interviews to protect the anonymity of the substance abuse treatment agency and clients. The interview protocol explored general questions regarding each woman's history and experiences with substance abuse treatment and child protection, ways women coped with traumatic experiences, and the types of services that lead to recovery and healing. None of the interview questions asked specifically about the role of spirituality in these women's lives. Nonetheless, spirituality was identified as an important part of all 26 women's recovery.

In addition, I took notes on all of the pertinent information contained in each woman's file, which included case notes written by substance abuse treatment professionals, biopsychosocial assessments, documents and reports involving the child welfare agency, psychological evaluations, and homework assignments completed by the women. The interviews, typed notes, and documents were uploaded into NVIVO 10, a qualitative software program that allows researchers to code and categorize narrative text, make connections between codes, and develop themes (Gibbs, 2002).

Participants received \$25 for their participation in the study. All study protocols were approved by the university institutional review board that oversees research with human subjects. These protocols included a complete explanation of the study, consent forms, recruitment materials, and interview guides.

### **Data Analysis**

The first step in the analysis process is open-coding (allowing the codes to emerge from the data) the transcripts from in-depth interviews and information from the women's files (Miles & Huberman, 1994; Padgett, 2008). This primarily involved reading the data multiple times and generating a list of *in vivo* codes (codes that used the study participants' words) and descriptive codes (Miles & Huberman, 1994). The case study analytic technique of looking within and between cases entails continuously returning to the interviews and repeatedly checking for disconfirming and corroborating evidence, as well as alternative explanations.

Multiple reviews of the codes generated themes. Thematic analyses involve searching for patterns that emerge from the data (Fereday & Muir-Cochrane, 2006). Yin (2009) refers to this process as *pattern matching*, a way of dissecting the data to understand "the patterns, the recurrences, the plausible whys" of individual instances, as well as the aggregation of instances (Miles & Huberman, 1994, p. 69). Pattern matching is the most desirable technique for case study analysis (Yin, 2009).

To enhance the rigor and credibility of the findings (Lincoln & Guba, 1985; Padgett, 2008), an audit trail through memos and field notes was

created. Member checks (confirming the findings with the participants) during the data collection and analysis phases were also used as a cross-case analysis tool to confirm, challenge, and add complexity to the study findings (Lincoln & Guba, 1985; Padgett, 2008; Yin, 2009). Prolonged engagement (e.g. spending significant time in the field in order to understand the culture, setting or phenomenon) was another strategy I used to increase rigor (Padgett, 2008). I spent 14 months at the treatment center collecting data of the project. Finally, negative case analysis (e.g. giving equitable attention to divergent viewpoints) also was used as a strategy to increase rigor (Padgett, 2008).

### Findings

Based on self-reports, clinician reports, and documents in the women's files, all 26 women in this study (100%) experienced two or more traumatic or potentially traumatic events. Seven women (27%) experienced two to four traumatic or potentially traumatic events. Ten women (38%) experienced five to seven traumatic or potentially traumatic events. Nine women (35%) experienced eight to 12 traumatic or potentially traumatic events.

Of the traumatic events reported, 14 women (54%) reported being sexually abused as a child. Eight women (31%) indicated they were physically abused as children. Ten women (38%) reported being raped as adults. Twenty-one women (81%) indicated that they had been or currently were involved in domestically violent relationships. Five women (19%) were forced to prostitute against their will. Finally, 13 women (50%) reported witnessing or experiencing some kind of violence (e.g., being kidnapped, tied up and severely beaten, witnessing close family members or friends being shot and killed) often associated with the drug trade.

With respect to potentially traumatic experiences, four women (15%) witnessed, as children, their mothers being beaten. Eleven women (42%) reported extreme emotional abuse as children. Seventeen women (65%) admitted to engaging in prostitution to obtain drugs or get money to pay their bills. Violence often was a part of these experiences. Eighteen women (69%) reported being neglected and abandoned, often because of parental substance abuse. Seventeen women (65%) had a biological parent or parents who abused drugs. Thirteen women (50%) indicated that loss of children through their involvement with child protection was traumatic. Finally, four women reported being involved with the foster care system as children, and indicated that their involvement was traumatic. All four of them reported being abused in some way (e.g., sexual abuse, physical abuse, extreme neglect, and emotional abuse) while in foster care.

In terms of spirituality, data analysis revealed a spiritual process that 26 African American women with histories of trauma and substance abuse used four primary spiritually related strategies to facilitate healing and

recovery: reclaiming spirituality, finding meaning, trusting the process, and active faith. A detailed explanation of each factor is described below.

### **Reclaiming Spirituality: “If it’s not alive, I am not alive”**

Reclaiming spirituality involved restoring their relationship with God by returning to prayer/talking to God, meditation, reading their Bible, and for some, church attendance. In most cases, the women in this study restored their relationship with God/higher power upon entering treatment. Many of the women described how the traumatic experiences and substance abuse made them feel dead inside and corrupted them to the point that they stopped praying, going to church, reading their Bible, and meditating on God’s word. Reclaiming spirituality brought the women back to life. Kai is a 40-year-old woman who was physically abused and neglected as a child. As an adult, she was a victim of domestic violence, raped multiple times and witnessed many of her friends and family members killed. She stated:

When I was out there, my spirituality was corrupted... I got to get that relationship with Him you know that bond and you know to have that faith in Him to do for me what I can’t do for myself because I believe but somehow or another my faith is you know – my inner spirit... you know died when I was using. If it’s not alive, I’m not alive, you know?

Traumatic experiences often diminish or destroy any faith trauma survivors have in themselves, people, and relationships (Courtois & Ford, 2013). However, many of the women in this study trusted God and believed that God loved them unconditionally and would never leave them. Vickie is a 26-year-old woman who was sexually abused by her father for many years until she was placed in foster care where she was neglected and abused. As an adult, she was a victim of domestic violence and often forced to prostitute to make money for her “boyfriend.” She described how reclaiming her spirituality renewed her faith and restored her sense of self:

Love is a powerful, powerful thing and it will pull you up from drowning. God loves us so much. God will be in your life even when you... walk away from him... I was like disconnected from God spiritually and I had disconnected my soul not even knowing it. I was like dead, just rotten... But you know now the connection is hooked back up and I’m trying – I’m going to Him like and developing a relationship with Him and my relationship with Him is growing... I feel like I’m alive, resurrected. You know like being raised from the dead for real like I can see. I can breathe. I can grow. That’s all the things that a living thing does. You can’t do none of that when you on drugs, you’re dead.

Many of women believed that they could not heal and recover without restoring their relationship with God. Lashaun is a 41-year-old woman who was a victim of domestic violence, witnessed several people killed, was kidnapped, tied to a bed, and forced to prostitute. She indicated that God was an important part of her recovery:

Since I been here, the main part of me staying sober is having a relationship with God. I know now that I cannot do it on my own. Prior to coming to treatment this time, I thought I could do it my own. I didn't need no sponsor. I didn't have to make meetings. But today I know I must make meetings. I must have a relationship with God.

Bailey, a 32-year-old woman with an extensive history of intimate partner violence confirmed Lashaun's sentiments. She said:

Being in treatment opened my eyes to help me realize that I need to put God first and forget material things as well as let go of my relationship with Tony. I also realize that until I start putting God first nothing will go right in my life. I have to start working a spiritual program. I need to get into the word [my Bible] as well as the big book [Narcotics Anonymous] if I am going to have any chance of getting better.

Reclaiming spirituality for women with histories of trauma and substance abuse was the first step towards healing and recovery as it brought them back to life, helped restore their relationship with and faith in God, and move towards healing and recovery.

### **Finding Meaning: "God has something for me to do"**

The second way women used spirituality to heal and recover was finding meaning in the traumatic experiences they had been through in their lives. Experiences of trauma often challenge individuals' core beliefs and raise questions about meaning and purpose of life (Ai & Park, 2005; Weaver, Flannelly, Garbarino, Figley, & Flannelly, 2003). The women believed that God saved them for a reason, part of which was to share their story so they could help other young women. Darla is a 43-year-old woman who was sexually and physically abused as a child. She had been raped multiple times. During the last rape, she was sodomized and left for dead. She also has an extensive history of being physically, verbally, and emotionally abused by romantic partners. She states:

I was always abused you know and I look at it in a spiritual aspect that God has always shown me and He has always brought me through...because my greatest fear was a fear

of being alone. He always showed me...He was always there to let me know that a relationship with God is the best relationship that you could ever have. He will never leave you. He would never hurt you...A lot of times I almost died by the hands of a man. But God showed me that it wasn't time for me to go you know...I know that God has something for me to do. I saw my vision and I look at it as being me sharing my experiences with young women.

Kai also believed that despite being raped several times and witnessing people being killed, her life was spared for a reason. She states:

I was—man, on the road to a nervous breakdown or to flip out. God just kept me sane. He's holding me for some reason. He got me. He has me. I know I'm in his hands. He's carried me a long way. Through a whole lot of terrible situations, he done got me out of. I don't know what I am supposed to do with it yet, but I know He has a purpose for all of this...I know to how to reach others and get on they level. I don't know if that's my calling from God but I be feeling that it is sometimes.

Finding meaning also involved women believing these traumatic experiences brought them closer to God and that God's purpose for their lives was greater than their current situation. Edith is a 42-year-old woman who was sexually, physically, and emotionally abused and neglected as a child because her mom struggled with addiction all of her life. She was raped and involved in physically, verbally, and emotionally abusive relationships as an adult. She states:

All of these things that have happened to me help me to get closer to God. Cause I always say God I done did this and I don't know what you got me here for but I know it ain't using. I know He don't got me on earth to use. I got too many talents and all that but I can't get with it in the state of mind I'm in... I'm gonna try as hard as I can to stay motivated to do what I think God want me to do.

Finding meaning was the way many women made sense of the traumatic things that happened to them. They believed that their lives had been spared so they could prevent others from experiencing the same things.

### **Trusting the Process: "His will and not mine"**

The third way women used spirituality to heal and recover was accepting that God knows best and while they did not always understand God's

ways, they believed there was a reason and trusted that God was going to work everything out. Tonia is a 34-year-old woman who was sexually abused and neglected as a child. She was raped while engaging in prostitution as an adult. She states:

I prayed constantly. Maybe she [my child protection worker] did have my best interests at heart but I didn't feel that way. I truly have to depend on God and know that this is His will and not mine, and to trust...that God put these people in my life to help me.

Trusting the process also included the belief that God had blessings in store for them if they did their part. Vanessa, a 40-year-old woman who has been in a domestically violent relationship for years said:

I just need to ask God to reveal to me. Maybe it's best for me to get my treatment without my kids this time...When I had them kids I wouldn't take care of them kids. My focus really wasn't on them kids. So maybe I just gotta look at that's why God placed me back here to try to get it without my kids...I want to live the life that God intended for me... He keeps showing me. Everything I try to do prospers—everything. That's just God saying see look what I got for you. Why won't you stop playing, come here, come back you know...I want that. I want what God has for me.

Finally, trusting the process entailed believing that regardless of the outcome, they must do their best and have faith that God will do the rest. Edith said:

You know I'm like wondering why God did this. I can't make out why I can't be the one raising my kids. But I ain't gonna question God about it. Believe that, I'm not gonna question Him not one time. I know that God has forgiven me, and He has a plan...I am just gonna have to wait to see how this unfolds and trust that God knows best... I'm still gonna do the best I can...I am gonna see what miracle is for me this time.

Trusting the process was the women's attempt to surrender to a higher power. They accepted God knows best, that God has a plan even though they did not always know the plan, and if they did their part, everything would work in their favor.

### **Active Faith: "I ask him to show me the way"**

The final way women used spirituality to heal and recover was active faith, which involved having confidence in God's leading by pressing forward, persevering and persisting in spite of obstacle and challenges

that arose. Kai, a 40-year-old woman with an extensive history of abuse shared her struggle:

God might not keep giving me chances to change my life... Everyone's faith gets shaky sometime...But I turn to drugs instead of turning to God...I just tell myself God loves me and I ask Him to show me the way. Show me how to love me because I don't even know... how to love me...And eventually I will ...learn it.

Many of the women had an active desire to remain abstinent, were learning to rely on their faith in God rather than turning to drugs to manage flashbacks and other effects of trauma, accepted God's love and guidance, and actively strove to get better. Harriet, a 39-year-old woman with a history of childhood sexual and physical abuse and a victim of domestic violence and rape stated:

Using drugs made me numb and dull. When I stop using drugs, all these memories and flashbacks keep coming back. I don't know what to do. I know God and I am working on trusting my higher power to help me.

Active faith did not mean that the women never had doubts about whether God was present in their lives. Rather, their previous experiences taught them to depend on God. Lisa is a 37-year-old woman who was physically, emotionally, and sexually abused as a child and adult. She witnessed the murder of two of her brothers by her "boyfriend" and captor. She also has been raped repeatedly and left for dead on at least two separate occasions. She said:

Sometimes it doesn't seem like God hears me. But I still keep praying. Because I have learned that even though it doesn't seem like it, He is working things out.... I am grateful that God gave me another chance to live without the drugs and alcohol. Because I know God is not finished with me. I am a child of God and was created in His image. I am blessed to be loved and shown favor by God's grace.

Active faith also involved the women's strong convictions about God and a declaration that God served as their most powerful motivation to be drug free. Vickie, a 26-year-old victim of childhood sexual abuse said:

God done set it up, He done laid the ground work for me to have a good life and I want that you know. If I keep using drugs...I'm gonna die and He don't want me to die...God made you. He been with you all your life. So He gonna fix it to where you ain't gonna be able to take it, you gonna come

back to Him. . . It's all out of love so God will be like the most powerful influence in your life. He's been the most powerful influence in my decision to want to be clean for real.

There were four primary ways African American women with histories of trauma and substance abuse used spirituality to heal and recover. Once they were sober, they reclaimed or restored their spirituality. They also found meaning in the pain they experienced by hoping to help others from going through the same things. They believed that while God does not always reveal the plan, He has one and that they trusted it would be revealed in time. Finally, active faith represented the women's commitment to spirituality and the ways in which they sought to nurture their spirituality and make it a major part of their lives.

### **Discussion**

Substance abuse treatment is designed to open wounds, initiate the resolution of issues that have kept participants stuck in a cycle of addiction, and help them resolve and move beyond these issues (Beveridge & Cheung, 2004). While many substance abuse treatment modalities such as Alcoholics Anonymous are rooted in spiritual principles, clients' use of spirituality is still a choice. Spirituality emerged among these African American women as a powerful force in their lives, even though none of the interview questions specifically asked about spirituality. During the course of an interview focused on women's history and experiences with substance abuse treatment and child protection, each of the 26 women mentioned the powerful role that their relationship with God played in moving their recovery forward. Despite the abuse, neglect, and mistreatment these women experienced, they perceived that their faith and belief in God remained a critical factor in their healing and recovery. They believed God was a benevolent being that saved their lives, kept them sane, made them feel alive, loved them unconditionally, and forgave them for any wrongdoing. Their connection to God gave their life purpose and meaning. Their spirituality enabled them to adapt, transform, and transcend various traumatic experiences while maintaining their faith in God.

In this study, the African American women only had positive views of spirituality. There are a couple of reasons that might explain this. First, 24 out of the 26 women indicated that they had been raised with spirituality, a belief in God, and religion. They grew up praying, reading their Bible, and going to church. Many of them indicated that their mothers and other family members had been consistently praying for their healing and recovery. According to Curtis-Boles and Jenkins-Monroe (2000), "African Americans speak of 'being raised' in the church, which reflects not only church involvement from early childhood but also an important aspect of socialization that includes values transmission; positive modeling...and important lessons in managing life" (p.464). These women turned to their

spirituality to help them cope with life's difficulties because that is how they were raised. Second, the treatment center staff tended to have positive views of spirituality and believed that spirituality was a fundamental part of the recovery process. The staff reinforced the women's spiritual beliefs as well as helped those women who had no spiritual foundation establish one.

While this paper identified some new themes such as reclaiming spirituality and active faith, finding a sense of meaning and trusting the process has been confirmed by other studies (Mattis, 2002; Vis & Boynton, 2008). Alim, Feder, Graves, Wang, Weaver, Westphal et al., (2008) found that women's sense of purpose promoted resilient outcomes and significantly aided the recovery process. Yick (2008) reported that spirituality helped trauma survivors find meaning and establish their life purpose. Principles such as trusting the process, surrendering to a Higher Power, accepting limitations, overcoming seemingly impossible obstacles, practicing gratitude, changing thought patterns, and grieving losses are the cornerstone of any 12-step (i.e. Alcoholics Anonymous) program (Alcoholics Anonymous World Services, 1976; Galanter, Dermatis, Bunt, Williams, Trujillo, & Steinke, 2007; Stoltzfus, 2007).

This study's findings are important because they revealed components of a spiritual process that could help women with histories of trauma and substance abuse heal and recover. The first component involved the women reclaiming and reconnecting to their spirituality or spiritual practices that brought them solace and comfort. The second component consisted of helping the women find meaning and purpose for their lives. The third component entailed building the women's capacity to trust the process and to a lesser extent surrender, which may be challenging as past experiences have reinforced trauma survivors distrustfulness (Courtois & Ford, 2013). The final component was active faith, which involved helping the women understand that spirituality, faith, and trusting in God are not always constant and that sometimes believers have periods of doubt and question whether God is still active in their lives. But it is important that they continue to rely on their faith in God.

### **Limitations of the Study**

This study offers insight about spirituality among African American women with histories of trauma and substance abuse and the importance of acknowledging the significance of spirituality in the recovery process. However, several limitations should be considered. The first is that this study involved only one substance abuse treatment agency. The treatment center is located in a large, urban city in the Midwest. Moreover, it represents the "gold standard" of treatment facilities (i.e., gender-specific, comprehensive services that allows women to bring their children) in that it is the only publicly funded treatment center of its kind in the state. Therefore the

findings may not be representative of women in another part of the state or country because the treatment context and approaches are often different. This particular agency did not have any policies regarding including religion/spirituality in treatment planning. Treatment professionals had complete discretion to include spiritual components they felt were most appropriate. This may not be true for other agencies, particularly those that are faith-based. Further, the study findings only included African American women. Women from other racial groups and ethnicities may have different experiences or see spirituality differently than the African American women in this study. Moreover, all participants were Christian. The findings are presented from this vantage point. Individuals from other faiths would likely have a different experience. Finally, I did not ask in-depth questions about the women's spirituality. While this can be seen as a strength in that many women discussed their faith and spirituality as part of the recovery process, asking in-depth questions specifically about the women's use of spirituality may have yielded different results.

### **Implications for Practice**

Inclusion of spirituality in trauma and substance abuse treatment programs may serve to greatly benefit women as spirituality plays a vital role in post-traumatic processing (Gillum et al., 2006; Vis & Boynton, 2008). For African American women specifically, it may serve to increase their social support network and connection to other people and God which may give them added emotional and practical support they need to cope with the abuse they have experienced or provide them with courage to end an abusive, unhealthy relationship (Bryant-Davis et al., 2011; Curtis-Boles & Jenkins-Monroe, 2000; DiLorenzo, Johnson, & Bussey, 2001; Gillum et al., 2006; Lewis, Hankin, Reynolds, & Ogedegbe, 2007; Mattis, 2000, 2002). Spirituality also is an important source of strength, which aids many African American people in times of distress and is often seen as an important part of their identity (Curtis-Boles & Jenkins-Monroe, 2000; Mattis, 2000, 2002).

In terms of treatment, it is beneficial for helping professionals to understand that clients may have spiritual beliefs and that these views may influence their recovery in positive and negative ways (Beveridge and Cheung, 2004). Although, none of the women had negative views of spirituality, other studies have found that negative views are not uncommon and can affect women's recovery from trauma and substance abuse (Ahrens et al., 2009; Garbarino & Bedard, 1996; Harris et al., 2008; Herman, 1992; Lemoncelli & Carey, 1996; McCann & Pearlman, 1990; Pargament et al., 2001; Ryan, 1998; Taylor & Fontes, 1995; Wilson & Moran, 1998; Wulff, 1991). Professionals also need to recognize that not all women want to develop and nurture a spiritual life. Professionals have to be careful to avoid proselytizing or promoting any particular belief systems. Instead

they must leave this decision completely up to the individual and take their lead from the women.

Helping professionals who work with severely traumatized clients need to be comfortable working with and talking with individuals who raise existential and spiritual issues (Shaw, Joseph, & Linley, 2005). It is important that substance abuse treatment programs include spirituality as part of the programming offered to women. This can include daily prayer and meditation, making available a quiet room for prayer or reflection, holding church service onsite, allowing the women to attend church services offsite, and providing the women access to clergy or religious figures of their choice (Gillum et al., 2006). Again, individuals should not be penalized if they choose not to participate in these kinds of activities.

Spirituality can be an effective tool that aids women in recovering from trauma and substance abuse (Brome et al., 2000). Incorporating spirituality in the treatment process can restore women's faith and trust (things that are often eroded by trauma) in a higher power (Miller & Guidry, 2001) as well as promote and sustain healing and recovery. ❖

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# Trauma, Religion, and Social Support among African American Women

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*African American women have disparate rates of trauma exposure and subsequent PTSD that is often considered in relation to their religion, spirituality, and the availability of social support. The present study adds to the existing literature by examining various religious behaviors and social support among 101 African American women who were distinguished based on the problem-generating nature of their traumatic event. Almost all of the women experienced an event (91%), of which a majority of the events qualified as traumatic (61%), and a quarter of the women who experienced an event (27%) experienced the additive influence of PTSD. A majority of the women reported frequent religious behaviors such as daily prayer (80%) and taking religious advice or teaching into consideration (67%). Most also reported the availability of social support. There was a higher probability of being in the additive PTSD group if women had ever married and reported poorer health. Women with PTSD were also more likely to receive comfort and security from religion and report regular Bible reading when compared to women who did not have a qualifying event. Implications of the results for the promotion of healing from trauma exposure among African American women are discussed.*

**A**FRICAN AMERICAN WOMEN ARE AT-RISK FOR EXPOSURE TO TRAUMATIC events and subsequent Post-Traumatic Stress Disorder (PTSD) based on the disparate rate of events such as personal violence and subsequent disorder among African Americans and women in general. While African Americans report lower rates of exposure to any traumatic event, they are at greater risk for PTSD once exposed (Roberts, Gilman, Breslau, Breslau, & Koenen, 2011). Additionally, African Americans report more frequent exposure to specific events such as combat, personal violence, and witnessing violence than their White counterparts, and they have slightly higher odds of lifetime PTSD (Alegria et al., 2013). In national studies of trauma exposure, the subsequent rates of PTSD among African

Americans range from 7.8% to 8.7% compared to 6.9% to 7.4% among non-Latino Whites (Alegria et al., 2013; Roberts, et al., 2011). Women have more clinical severity of PTSD than men, which could be attributed to the higher rates of violence and assault (Cottler, Nishith & Compton, 2001; Falck, Wang, Siegal, & Carlson, 2004; Najavits et al., 2003), since the violent nature of trauma increases the likelihood that the event will qualify as traumatic (Rasmussen, Rosenfeld, Reeves, & Keller, 2007). Violent events lead to more PTSD-related symptoms (Kimerling, Alvarez, Pavao, Kaminski, & Baumrind, 2007; Vranceanu, Hobfoll, & Johnson, 2007; Scott, Chant & Andrews, 2007) and increase rates of PTSD (Vinck, Pham, Stover, & Weinstein, 2007).

### **Trauma and Religion**

Spirituality and religion have received considerable attention as they relate to trauma exposure and, specifically, trauma exposure among African American women. The results of the research indicate discrepancy in the importance of these concepts in their use as a coping mechanism (e.g. prayer, reading religious writings, attendance at religious services, etc.) for event exposure. Watlington and Murphy (2006) examined the role of religion and spirituality as coping mechanisms within a small sample of African American women who were victims of domestic violence and found that religious involvement was negatively associated with posttraumatic stress symptoms. Likewise, Bradley, Schwartz, and Kaslow (2005) found that negative religious coping was associated with more PTSD symptoms in a sample of African American women.

Religious/spiritual coping is the dealing with stressful life events through beliefs and practices that are based around religion or are spiritual in nature. For example, they could include such things as prayer, meditation, the belief that God will not give you more than you can handle, and social support (Canda & Furman, 2010; Nelson-Becker, 2005; Pickard & Nelson-Becker, 2011). However, religious/spiritual coping can have negative effects as well, such as when individuals feel that they are being punished by their God or when they feel that they have not lived up to the expectations of their fellow parishioners (Krause & Wulff, 2005; Pickard & Nelson-Becker, 2011).

While Bryant-Davis, Ullman, Tsong, and Gobin (2011) found that religious coping was associated with more PTSD symptoms among African American female assault victims, in a sample of female methamphetamine users, being African American was associated with strength of religious faith, but strength of religious faith was not associated with trauma-based symptoms (Lutnick, Lorvick, Cheng, Wenger, & Kral, 2012). Similarly, in a study by Ahrens, Abeling, Ahmad, and Hinman (2010), African American sexual assault survivors reported more spiritual-based coping than their

White counterparts, but such coping was not related to PTSD symptoms. It is possible that instead of religion shaping trauma response, the effects of trauma exposure influences one's religious faith and behavior as people turn to religion to cope with traumatic events. When religion is important to individuals experiencing an event, PTSD has more impact on changes in religious beliefs than the experience of the event alone (Falsetti, Resick, & Davis, 2003).

Religion is often considered a coping mechanism among African American women exposed to trauma; however, the literature indicates that any positive association of religion to trauma outcomes may be due in part to religion's association with social support. Among African Americans who are religious, there are indirect effects of religion on distress because of social support and sense of control (Jang & Johnson, 2004). In African American victims of sexual assault, those who had stronger support networks experienced less PTSD compared to those who reported more religious-based coping (Bryant-Davis, et al., 2011). The availability of tangible support was found to moderate the relationship that event exposure has on the development of PTSD following a traumatic event among low-income, urban women who were majority African American (Glass, Perrin, Campbell, & Soeken, 2007).

### **Trauma and Religious-Based Interventions**

Numerous studies have examined the role of religion on outcomes consequent to trauma exposure and there appears to be limited support for religion as a coping mechanism (e.g., Murray-Swank & Pargament, 2005). Sloan and Bagiella (2002) conducted a review of the literature and concluded that only a small percentage of research exists to support the beneficial nature of religion on positive health outcomes. For instance, African American women with more social support from fellow church members are more likely to seek help when confronted with an emotional problem (Pickard, Inoue, Chadiha, & Johnson, 2011). Notwithstanding the divergent research evidence, interventions with African American women who experience trauma often incorporate religious and spiritual components. Arnette, Mascaro, Santana, Davis, and Kaslow (2007) proposed that spiritual well-being is important to abused African American women and should be explored as a part of treatment efforts and there is some support for the effectiveness of such an approach. Bowland, Edmond and Fallot (2012) found that a spiritual intervention that focused on spiritual histories, spiritual gifts, and development of a spiritual recovery action plan had some success in reducing trauma symptoms in a sample of older and highly traumatized women. Incorporating aspects of spirituality into treatment may be effective; however, mental health service providers tend to lack frameworks through which to integrate spirituality and religion into

their practices (Pickard & Nelson-Becker, 2011).

It is clear from the existing literature that African American women who are exposed to traumatic events develop PTSD at disparate rates. Given the importance of religiosity and spirituality in the lives of African American women, research has focused on the role that these concepts have on coping with the trauma response. While the research does not overwhelmingly support the value of religion for reducing the effects of PTSD, efforts to incorporate religion and spirituality into therapeutic interventions with African American women continue. A significant proportion of the research on this topic is often limited to clinical samples of African American women exposed to violent events such as domestic violence or rape. Considering the disparate rate of exposure and negative outcomes for African American women, ongoing research involving different subgroups of this targeted population is needed.

### **Study Purpose**

This study adds to the growing body of research examining religion and trauma exposure in two distinct ways. First, the study provides a comprehensive examination of trauma exposure by distinguishing qualifying event exposure based on its problem-generating nature. That is, we distinguish event exposures based on subsequent symptoms that were problematic even if the symptoms did not lead to diagnosable PTSD. Second, the study examines different religious behaviors and feelings as well as the availability of various forms of social support as independent factors, rather than collectively as one conceptualization of religion or social support. Specifically, we examine among African American women, what factors, including religious/spiritual coping, are associated with qualifying traumatic event exposure that does not lead to PTSD compared to qualifying traumatic event exposure that does lead to PTSD.

### **Method**

#### **Design**

Data for these analyses were collected in a quantitative research study examining developmental psychopathology and maternal substance use among African Americans. The research sought to determine the feasibility of recruiting mother/adolescent dyads of substance-using mothers and demographically matched comparisons to examine the nature, extent, and onset of maternal substance use on adolescent development. Mothers were asked about their substance use and other psychopathology as well as trauma exposure and PTSD through structured interviews using standardized assessments during this cross-sectional effort that took place from

2006 to 2009. Approval was obtained from the Institutional Review Board of the University of Missouri-St. Louis. Women were recruited through street outreach and fliers at local social service agencies and schools. The appropriate screening mechanism was implemented when contact was made with the project office. Informed consent was obtained for participation in the research. Interviews were conducted in a private office on the university's campus, a location within the home, or in a private room at a public library for subject convenience. Small incentives were provided to all of the participants.

### **Sample**

Contact was made with 190 urban, African American women to determine their eligibility for the study. A follow-up attempt with the women was unsuccessful for 17% due to inaccurate contact information. Eighty-three percent ( $n=158$ ) of the contacted women were subsequently screened. Of the women screened, 92% ( $n=146$ ) were deemed eligible if they were African American and had a biological adolescent child that resided with them and for whom they still maintained legal custody. Of the eligible women, 101 provided completed data on their exposure to traumatic events, religion, and social support.

### **Measures**

Demographic variables were assessed with items from the Computerized Diagnostic Interview Schedule Version IV (CDISIV; Robins et al., 2000). Age and number of children were open-ended questions. Marital status, education, and health status were each coded as dichotomous variables: never married = 1 and ever married = 0; GED or high school diploma = 1 and no GED or high school diploma = 0; good to excellent health = 1 and fair to poor health = 0.

PTSD was also measured with the CDIS IV. The presence of traumatic event exposure and subsequent PTSD were determined by asking the respondents about terrible, frightening, or horrible experiences they may have had at any time in their life. The events included being: shot or stabbed, mugged, raped, held captive, diagnosed with a life threatening illness, exposed to a disaster or radiation, experiencing the untimely death of a close friend or relative, being in a serious accident, witnessing a serious injury or killing, discovering a dead body, and combat-related events. Those who answered yes to a qualifying traumatic event were then asked questions that assessed DSM-IV PTSD criteria for each event. For these analyses, we dichotomized traumatic event exposure into those who had a qualifying traumatic event = 1 and those who had no event or whose event was not a qualifying event = 0.

Religious behaviors, commitment, and connection were measured with 7 items from the Religiosity Scale (Rohrbaugh & Jessor, 1975). Because each item varied in its scaled response, we considered each as an independent measure that was dichotomized for these analyses. The items included past year frequency of attending church, worship services, or other religious activities for something other than a funeral or memorial service (regular attendance = 1; non-regular = 0); practice of prayer or religious meditation (daily prayer = 1; non-daily = 0); reading/studying a holy book such as the Bible (usually or almost always = 1; sometimes, rarely or never = 0); frequency of taking religious advice or teaching when having a serious personal problem (usually and almost always = 1; sometimes to never = 0); influence of religion on the way you choose to act and spend your time each day (large influence = 1; fair to no influence = 0); feelings of religious commitment and devotion in the past year (frequently to daily = 1; sometimes to rarely = 0); agreement with religion providing a great amount of comfort and security in life (agree to strongly agree = 1; uncertain to strongly disagree = 0).

In addition, the Religiosity Scale asked women to choose statements that came closest to their belief about God and their belief about life after death. Five statements were presented for each belief. For their belief about God, the responses included "I am sure that God really exists and that He is active in my life" and "I don't believe in a personal God or in a higher power." For their belief about life after death the responses included "I believe in a personal life after death, a soul existing as a specific individual" and "I don't believe in any kind of life after death."

Social support was assessed with three items from the Missouri Assessment of Genetics Interview for Children-Parent Version (Todd, Joyner, Heath, Neuman & Reich, 2003) that assessed past year availability of friends that women saw from time to time; belonging to any groups, clubs, church or religious group; and activities enjoyed with friends. Each item was a dichotomous measure (yes = 1; no = 0).

## **Analyses**

Descriptive frequencies were computed to stratify the sample into three groups based on exposure to a qualifying event: those with no qualifying traumatic event; those with a qualifying event and no PTSD; and those with a qualifying event and PTSD. Chi-square analyses were conducted to examine differences in religion and social support across the three groups. Multinomial logistic regression analyses were used to examine the comparative strength of associated factors when qualifying event presence and qualifying event and PTSD combined were compared to no qualifying event presence. In the regression models for the dependent variable, the absence of a qualifying traumatic event was the referent category. Independent

factors were coded so that the referent group for each religion factor was the absence of the factor, and never married and good health were referent categories for their respective variables for ease of interpretation.

## Results

All of the women were African American and ranged in age from 28 to 53 ( $M = 39.50$ ;  $SD = 5.47$ ). Over half of the women had never married (55%), and they had a mean of 4 children ( $SD = 2$ ). The majority had at least a GED or high school diploma (68%) and reported being in good to excellent health (57%).

Almost all of the women (91%) reported at least one targeted event and reported an average of 4.47 ( $SD = 2.92$ ) events that they considered terrible, frightening, or horrible experiences that had occurred in their lifetime. The most frequently reported event was experiencing the unexpected, sudden death of a close friend or relative (76%) and experiencing a rape (58%). A majority of the women's events (61%) qualified as traumatic based on the event's problematic nature as measured by their report of problems such as not being able to get the event out of their minds and the event causing them to lose interest in other people or activities. More than a quarter (27%) of the overall sample and 44% of women with a qualifying event met criteria for PTSD.

Over half of the women (54%) reported regular attendance at religious services and a significant majority (80%) reported praying on a daily basis. Slightly more than a third (35%) of the women regularly read a holy book like a Bible. In the presence of a personal problem, 67% of the women indicated that they take religious advice or teaching into consideration. Half of the women (50%) felt that religion had a large influence on how they chose to act and the way they chose to spend their time each day. A majority (62%) of the women felt a frequent or daily religious commitment or devotion in the past year and nearly three-quarters (73%) agreed that religion provides a great amount of comfort and security.

The overwhelming majority (84%) of the women felt certain that God really exists and that He is active in their lives and even more (87%) believed in life after death. Most of the women also had good social support including friends that they saw from time to time (82%), belonged to groups, clubs, church or religious groups (62%), and had activities they enjoyed with friends (77%).

The women were stratified into three groups: those with no qualifying traumatic event (no QTE;  $N = 39$ ); those with a QTE and no PTSD (QTE only;  $n = 35$ ); and those with a QTE and PTSD (QTE/PTSD;  $n = 27$ ). As shown in Table 1, the groups differed on only one demographic factor. Women with no QTE (74%) were overwhelming more likely to have never married compared to QTE only women (49%) and QTE/PTSD

women (37%). The difference in the reported health status of the women approached significance ( $p=.10$ ). No QTE women (67%) and QTE only women (60%) reported higher percentages of good to excellent health than did QTE/PTSD women (41%).

**Table 1: Comparison of Demographics, Psychopathology, Religion, and Social Support across Event Classification**

	No Qualifying Trauma (N=39)	Qualifying Trauma Only (N=35)	Qualifying Trauma & PTSD (N=27)	X <sup>2</sup> (p-value)
<b>Demographics</b>	%	%	%	
Good to excellent health	67	60	41	4.53 (.10)
GED or HS diploma	72	63	70	.75 (.69)
Never married	74	49	37	10.02 (.01)
<b>Religious Factors</b>				
Regular religious attendance	54	57	48	.50 (.78)
Pray daily	77	77	89	1.75 (.42)
Regular Bible reading	28	29	52	4.82 (.09)
Take religious advice/teaching	62	66	78	1.98 (.37)
Large influence of religion	41	49	63	3.09 (.21)
Felt frequent commitment/devotion	51	77	59	5.41 (.07)
Religion provides comfort/security	62	74	89	6.12 (.05)
<b>Social Support Factors</b>				
Availability of friends	82	91	78	2.23 (.33)
Belong to groups	64	60	63	.14 (.93)
Activities enjoyed with friends	68	83	82	2.56 (.28)

The women did not differ on measures of social support. However there was significant difference in the religion factors. Women with QTE/PTSD (89%) were more likely to agree that religion provides them with a great amount of comfort and security in their lives than were women with no QTE (62%) and women with QTE only (74%). While this was the only religion factor significant at the .05 level, it should be noted that women with a QTE only (77%) had higher rates of past year feeling of religious commitment or devotion than women with no QTE (51%) or women with QTE/PTSD (59%), with this difference approaching significance ( $p = .07$ ).

Also, QTE/PTSD women (52%) reported more regular Bible reading than no QTE women (28%) and QTE only women (29%), and this difference was approaching significance ( $p = .09$ ).

All factors that significantly varied or were approaching significance across the groups were entered into multinomial logistic regression models with the first model comparing QTE women with no QTE women and the second model comparing QTE/PTSD women with no QTE women (See Table 2). When women with a QTE were compared to women with no QTE, having ever married and religious commitment or devotion increased the odds for being in the QTE group. Women who had married at some point were almost three times ( $OR = 2.81$ ) more likely to be in the QTE group, and women who reported frequently feeling religious commitment or devotion in the past year were over three times ( $OR = 3.23$ ) more likely to be in the QTE group.

**Table 2: Multinomial Logistic Regression Analysis of Factors Associated with Event Exposure Classification**

	Qualifying Trauma Only N=35		Qualifying Trauma & PTSD N=27	
	Exp (B)	95% CI	Exp (B)	95% C.I.
Poor health	1.51	.54- 4.23	4.83	1.44-16.22
Ever married	2.81	1.02-7.78	7.35	2.12-25.43
Regular Bible reading	.70	.23-2.19	3.94	1.03-15.08
Religious commitment/ devotion	3.23	1.07-9.74	.58	.15-2.18
Religion provides comfort/ security	1.76	.61-5.09	6.99	1.47-33.31

No qualifying event (N=39) is the reference category

Poorer health, having ever married, religious comfort/security, and regular Bible reading increased the odds of QTE/PTSD group association. Women who reported fair to poor health were almost five times ( $OR = 4.83$ ) more likely and women who had married at some point were seven times ( $OR = 7.35$ ) more likely to be in the QTE/PTSD group. Women reporting that religion gave them a great amount of comfort and security in life were almost seven times ( $OR = 6.99$ ) more likely and women who regularly read their Bibles were almost four times ( $OR = 3.94$ ) more likely to be in the QTE/PTSD group.

## Discussion

The research examining the relationship between trauma exposure and religion is complex and often relies on clinical samples of women, particularly those exposed to domestic violence or assault. This study adds to the existing body of knowledge by examining the presence of a qualifying traumatic event that was characterized as problematic for the women regardless of the nature of the event or whether or not the event was personally or vicariously experienced.

Our prevalence rate of exposure to any traumatic event was 91%, with the most frequently reported events being rape and the unexpected death of a friend or loved one. These rates are higher than national rates of 84% that also indicate the most prevalent events are loss of a loved one and witnessing violence (Alegria et al., 2013). This is not surprising, however, considering that other samples of African American women have reported increased rates of traumatic events. For instance, Glass and associates (2007) found that a sample of urban, low-income majority African American women had an average of nine lifetime traumatic stressors. This is higher than the current sample's average of four events. After stratification, 61% of the women had experienced what is considered a qualifying event because of subsequent symptoms that were problematic, even if the symptoms did not lead to diagnosable PTSD. The additive influence of PTSD was present for almost half of those with a qualifying event.

The women reported the availability of social support that did not vary based on the increased level of risk associated with their trauma exposure. While our specific measures of social support did not capture a potential association, we did find that marital status was significantly associated with qualifying event exposure and subsequent PTSD. It appears that the presence of a spouse at some point in the women's lives increased the likelihood of potential risk associated with event exposure. The protective influence of having never married has been found in other research of African American women's violence exposure (Johnson, Cunningham-Williams, & Cottler, 2003). It is possible that instead of providing social support, these marriages were problematic or resulted in additional opportunities for risk exposure.

The results of the multinomial logistic regression reveal that experiencing a qualifying event when compared to no qualifying event exposure was most associated with commitment and devotion to religion in the past year. Because the measure of event exposure was based on lifetime experiences and commitment and devotion asked about feelings in the past year, women may have increased their commitment and devotion in response to the traumatic event. Additive PTSD was associated with perceptions of poorer health among the women. The symptomatology present with PTSD likely contributes to physical health status as well. Aspects of religion were

more highly associated with additive PTSD than to the other types of event experiences. Women in this group reported more regular Bible reading and reported receiving more comfort and security from religion.

It is not surprising that participants in this study who had a QTE were more likely to report more religious commitment and devotion, as religious/spiritual coping is known to be common among African Americans (Taylor, Chatters, & Levin, 2004). Practitioners recognize the importance of religion and spirituality in women who are exposed to trauma as this is evidenced by the attention these factors receive in treatment efforts when women, and especially African American women, have been exposed to traumatic events. While we cannot make causal inference from this cross-sectional research, it is evident that women with trauma and PTSD have a strong religious connection regardless of whether it was present before or developed after the event. It is likely that the women in this study are turning to their faith in times of need as a place where they can find comfort and support. Their faith organizations are becoming, for them, a place of refuge where they can heal in safety. Indeed, the proposal by Arnette and associates (2007) that spiritual well-being is important to abused African American women and should be explored as a part of treatment efforts is supported by this study. This study indicates that matters of faith and religion are important coping tools for African American women who have experienced trauma and/or PTSD, and these things should be incorporated into a strengths-based, client-centered model of treatment.

### **Limitations and Future Directions**

The results of the research must be considered in light of the limitations inherent within this sample and the design of the research study. While this is a community-recruited sample, the project targeted women who had histories of substance use for inclusion along with a demographically similar group of women who did not have a history of problematic substance use. Women in the sample also represent those who had an adolescent between the ages of 12 and 17 at the time of the interview, thus, restricting the age range and parenting status of the women interviewed. Some of our variables are limited because the focus of the research project was to examine the outcomes for youth in the presence of maternal psychopathology. Our study utilized a measure of religion that might not have fully captured spirituality and does not encapsulate a full range of religious based practices, though it is primarily based on religious behaviors. In general, there are issues in many studies with the various ways that religion and spirituality are measured or conceptualized. In addition, our measures of social support do not represent the full range of support that a woman can receive from those around her, and the measures were not specific to support that was available to them following or prior to a traumatic event.

This study's findings suggest several general conclusions. Additional research is needed to explore whether experiencing specific qualifying traumatic events impact African American women's use of religion and/or social support. It is possible that experiencing a rape or the unexpected loss of a loved one is more likely to increase one's dependence on religious involvement compared to being in a serious accident. Equally important, is determining the relationship between the event and religious involvement with regards to time. For example, women in the QTE/PTSD group were nearly seven times more likely to report that religion gave them a great amount of comfort. However, it is unclear if they felt this way prior to the traumatic event or if the traumatic experience heightened their need for additional religious support.

Since segments of this population may seek assistance and support from religious institutions, particularly after experiencing a traumatic event, it is important to ensure that religious practitioners are knowledgeable about PTSD and are prepared to address possible concerns. Religious leaders would benefit from trainings on identifying symptoms of PTSD and can become a more influential resource in promoting appropriate mental health service utilization among this population. Incorporating supportive religious components with a more specialized mental health care may generate a more holistic help-seeking experience, thereby better equipping African American women to address experiences of trauma and more readily promote healing. ❖

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# Reflections on Collective Trauma, Faith, and Service Delivery to Victims of Terrorism and Natural Disaster: Insights from Six National Studies

*Leola Dyrud Furman, Perry W. Benson, Bernard Moss, Torill Danbolt, Einar Vetvik, & Edward Canda*

*This article presents insights on spiritual assessment and helping activities in work with victims of natural disasters and terrorism. The article draws upon international survey research and the authors' own experiences as victims of natural disaster and terrorism to explore raising the topics of religion and spirituality in the helping relationship. The article also considers the appropriateness of twenty-one generic, spiritually based, helping strategies for potential use in the helping relationship following a disaster.*

**D**ISASTERS AND TERRORIST ACTS ADVERSELY AFFECT INDIVIDUALS AND communities around the world. On any given day, traumatic events such as natural disasters, terrorist acts, community violence, and technological disasters, engender widespread loss and suffering. Natural and human-made disasters will likely increase as the 21<sup>st</sup> century progresses (Rogge, 2004). For some, disasters are recurrent—individuals and communities may be in an on-going state of recovery from past and current disasters (Ferris, Petz, & Stark, 2013). Disasters, natural and human-made, impact economic well-being and migration patterns, induce traumatic responses in victims, such as Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder (PTSD), and generally affect the mental and physical health of diverse service populations, including the poor, children, and other disenfranchised and vulnerable populations (Rosenfeld, Caye, Ayalon & Lahad, 2005).

Christian social workers and faith-based organizations (FBOs) often form part of the vanguard of disaster management. Christian workers and FBOs may inform communal, governmental, and organizational pre-and post-disaster management planning, training, policy-making, and document the concerns of vulnerable populations, and advocate for their needs. (Coisman, 2002; Dahlberg, 2002; Joshi, 2010). Social workers, as members of their respective communities, also may play a dual role in disaster settings, that of worker and victim (Meldrim, 2002).

In this article, we consider spirituality and religion to be related but distinct concepts. *Religion* is defined as “an organized structured set of beliefs and practices shared by a community related to spirituality.” *Spirituality*, on the other hand, is defined as the “search for meaning, purpose, and morally fulfilling relations with self, other people, the encompassing universe, and ultimate reality however a person understands it. Spirituality may be expressed through religious forms, but is not limited to them” (Canda & Furman, 2010, p. 385).

The religious and spiritual orientations of individuals and communities can serve as a source of resilience and strength during a disaster and in its aftermath. Involvement with religion and spirituality, furthermore, may be a predictor of positive emotional, physical, and mental health (Tarakeshwar, Stanton, & Pargament, 2003). Conversely, belief systems can be challenged, prompting a crisis in faith as victims face existential issues that transcend the physical dimensions of disasters. At the core of a crisis of faith in theistic religions is the fundamental question: Why did God allow this to happen? The meaning of life, the status of personal and communal relationships, the sources and structures that define a victim’s sense of safety and security, and long-standing religious beliefs, might be brought into question. Victims, alternatively, may find solace by returning to previously abandoned religious values and practices (Coisman, 2002; Tan, 2006).

Faith also can play a positive role in Christian social workers’ practices and provide a compatible interpretive framework that enhances core social work values, which can, in turn, open avenues of resilience, reconciliation and forgiveness (Harris, 2012). The supportive and ethical use (Sherwood 2012) of faith-based assessment and helping interventions can serve as vehicles that express and model God’s love, which is important since victims may enter the helping relationship with feelings of helplessness, diminished personal control, and doubt about their relationships, environment, and cultural and belief systems (Rosenfeld, et al., 2005). Social workers, however, may be reticent to broach the subjects of spirituality and religion in the helping relationship, if they fear that clients will interpret such a gesture as proselytizing (Sherwood, 2012). From this vantage point, it is important that Christian social workers consider not only how, but also what kinds of, spiritually-based helping activities can be ethically integrated

in the post-disaster helping relationship to maximize victims' strengths, resiliency, and abilities to cope, over the course of recovery.

This article focuses on three aspects of spiritually-sensitive service provision for clients experiencing the effects of a catastrophe. First, we examine the importance of assessing clients' and social workers' physical proximity to a catastrophe at the time that it occurred, and the subsequent degrees of vulnerability that may surface in the catastrophe's aftermath for clients and social workers alike. Second, we explore the primary helping strategy of raising the topics of religion and spirituality in the helping relationship with clients experiencing the effects of natural disasters and terrorism. Third, we suggest ways in which a set of generic, spiritually-sensitive, helping activities can be adapted by social workers who may be engaged in long term post-disaster spiritual care, given client interest and self-determination.

We draw from extant literature on disaster and trauma response, autobiographical accounts provided by the authors who have experienced disasters personally and professionally, and Christian social workers' attitudes on religious and spiritual helping strategies based on six surveys in four countries (i.e., Norway (2002, 2011), New Zealand (2006), United Kingdom (2000), and United States (1997,2008)), with the aim of producing practical suggestions for integrating spiritually-based helping strategies in the care of disaster victims.

### **Circles of Physical and Psycho-Social Vulnerability**

Social workers, religious leaders, healthcare workers, and others in public service, who provide services in a post-disaster environment, often occupy a unique position in that they may be called to help victims and/or find themselves to be victims. The vignettes given below describe the authors' personal experiences with human-made and natural disasters. Torill and Einar, although outside of the immediate disaster area, shared a nation's collective shock and horror in the aftermath of a terrorist attack and the massacre of seventy-seven people in 2011, most of them children, at the labour party's youth camp near Oslo, Norway. Leola and Perry were victims of a major flood in 1997 that devastated the Red River Valley in North Dakota and Minnesota. Bernard witnessed, in close proximity, a terrorist bombing in London.

#### ***Vignette 1: A Mass Shooting, July 22<sup>nd</sup>, 2011 (Oslo, Norway)***

*Friday July 22, 2011, was an ordinary summer day in Oslo. A white van parked close to the main government building, and a man wearing a 'police uniform' was observed on closed circuit TV cameras, walking away. At 3.15 pm, a car bomb exploded, killing eight people and injuring at least 200, some very severely.*

Meanwhile the ‘policeman’ started his trip to Utøya, about 25 minutes away. The labour party youth camp at Utøya was under way. The island is accessible only by boat. There were 564 persons on the island. The boat with the terrorist (Anders Behring Breivik) disguised as a ‘policeman’ arrived a quarter past five, and he started to shoot at 5:21. The island is small, and the young people ran all over, trying to find hiding places. Many of them jumped in the water, and were rescued by volunteers from a camping site on the mainland. He shot at those in the water, and the rescuers were also at risk. He managed to kill 69, and with the eight persons who lost their lives in the bombing, the total number of deaths was 77. Breivik was captured by the police at 6:34 pm, after more than an hour of random shooting.

I (Torill) was not directly affected by all this. I was in Denmark on holiday, desperately trying all evening to get news on my iPhone from the online newspapers and following the Danish television. I was extremely thankful that my son—a government employee—was far away on holiday. While I did not have any friends or family in the bombed area, I knew people who knew someone directly involved. The terrorist being ethnic Norwegian—how could we understand that at all?

I (Einar) was on the west coast 600 kilometers away from Oslo with my family on holiday. Just before midnight I turned on the radio and heard something that I understood as a dramatic play, but then the news came and I realized that it was about a terrible reality—not a play. If we had not been on holiday, my son and daughter-in-law, both government employees, would have been at work 200 yards from the targeted building. My thoughts went back to the time (1962) when I was a participant at the youth camp.

**Vignette 2: A Century Flood, April 1997 (Red River Valley, North Dakota/Minnesota, USA)**

In 1997, the Red River inundated the town of Grand Forks, North Dakota, with a ‘once-in-two hundred years’ flood. The floodwaters forced the evacuation of all 50,000 residents from their homes and businesses. Until that time, no other city in the United States had been forced by a natural disaster to evacuate its entire population. Everybody experienced homelessness. The city’s residents relocated to the fifty states and two foreign countries in the immediate aftermath. Churches and religious organizations across the country came to the region’s aid, providing economic support, labor, and emotional and spiritual care.

In hindsight, we (Leola and Perry) both acquired a sense of the power of denial. Why hadn’t we known this would happen? All of the blizzards we had that winter, bringing over a hundred inches of snow, and then the deadly ice storm a week and a half before were warning signs. But the Army Core of Engineers told us not to worry: the dikes would hold; the water would not get any higher than it had in the past; everything was under control. A memorable moment was the evacuation. I (Leola) was able to drive to safety into Minnesota

just before the only bridge that was still passable closed. My home was severely damaged. Where does one turn when there is a need for calm and comfort? In a state of panic, unable to think, I found solace in a childhood prayer: Jesus, tender shepherd, hear me; Bless thy little lamb tonight; Through the darkness, be thou near me; Keep me safe till morning light.

I (Perry) was rescued first by a stranger whose identity remains unknown to this day and then evacuated by the National Guard. In the attempt to evacuate by automobile, the car became partially submerged under water at an intersection. As the car began filling with water, a man showed up and, with the car in neutral gear and with the force of the current, was able to push the car, and the animals that I was attempting to rescue, to higher ground. The memory of the press of wet clothing and the bone-chilling cold override any memories of the trip to the nearest shelter.

Natural disasters leave their mark, however, long after the event has passed. Over a decade later, although spared, I (Perry) witnessed the direct effects of a tornado, or a microburst, that destroyed property and killed one person. The microburst tossed cars around and flattened buildings.

### **Vignette 3: A Terrorist Bombing, July 7, 2007 (London, England)**

It was a day just like any other day. A trip to London to attend a leadership seminar. Uneventful, but with a touch of national pride—we had just won the 2012 Olympics for the city of London (how we cheered!). London itself—busy commuters everywhere spilling urgently into their well-rehearsed rabbit-runs to the office. No one was noticing anyone else very much, myself included.

When the bomb exploded just round the corner from where I was standing, I guess I was too numb to undertake any reflection at all, let alone a theological one. When the full picture began to emerge of the carnage, the bloodstained anguish, and the unfathomable motives of the perpetrators, I wish I had been able to echo the psalmist's cry: "Put your hope in God." But in truth a more immediate cry of selfish self-preservation was deep within me: "Do not drag me away with the wicked, with those who do evil ( Psalm 28:3)."

Where is God in all of this? An easy maybe even glib question to ask.... Perhaps answerable without too much delay in the self-sacrificing outreaching love and compassion and sheer determination of people coming to the rescue, without thought of their own safety and wellbeing. Perhaps answerable in a steely determination of ordinary people not to allow evil to triumph, but to carry on regardless, refusing—sometimes with superhuman, even divine, grace—to let evil have the final say. Perhaps, too, God is there in the anguish we feel for those cut down and in our yearning for a more just and tolerant world—maybe at a deep level these reactions are hints of what it means to be created in the image of God?

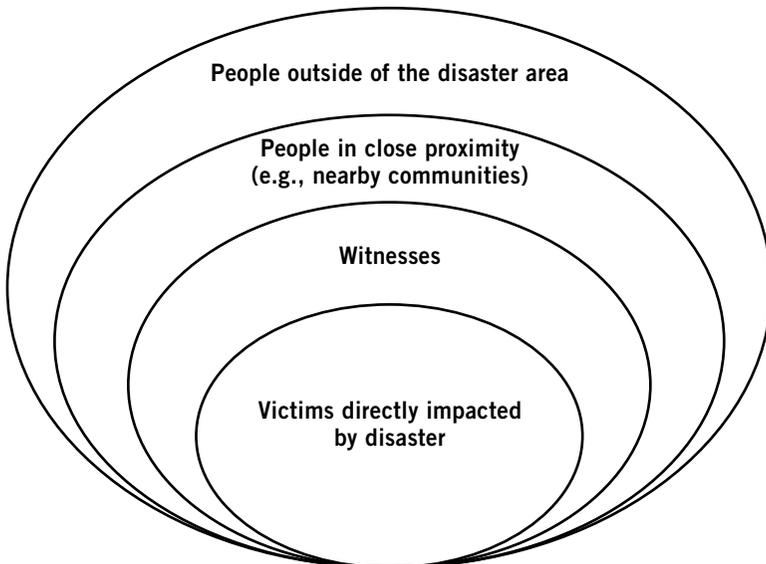
All of this touches a Christian soul at the deepest possible level—until yet another layer is uncovered. A stone is rolled away and undergirding the pain

*and anger, anguish and turmoil, a glimpse of resurrection shines through. It is as if a theological Google earth moment has happened when we are allowed to see things from a wider perspective, and through the rainbow of our tears we glimpse a love and a vision, a justice and a possibility of life as it just might be if we allow ourselves to trust in who God is and what He has done for us all in Christ. Perhaps the deepest theological reflection of all, therefore, is to be able to say without a hint of glibness or even pretending fully to understand:*

*Thanks be to God who gives us the victory through our Lord Jesus Christ (1 Corinthians 15:57).*

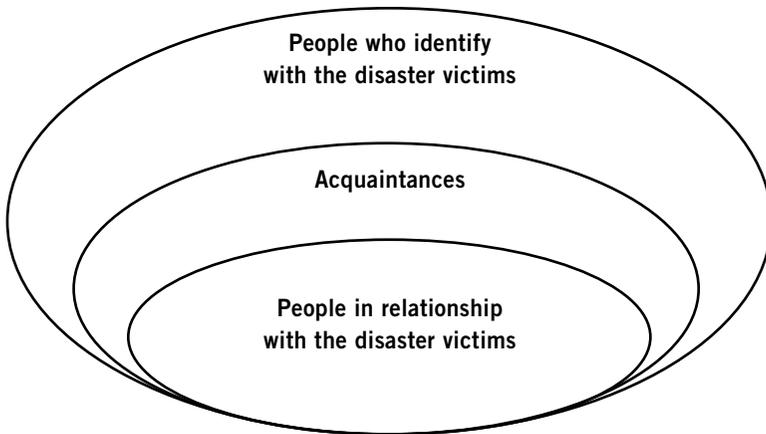
Victims' descriptions and stories can reveal a great deal in terms of how they position themselves in relation to a traumatic event. Empathic listening skills may help social workers home in on clients' fears and concerns, providing some comfort by reassuring clients that their responses to the event are normal and understandable, and exploring options for living in a world that has changed irreparably. Rosenfeld and associates (2005) identify three domains of vulnerability based on risk that relate to a victim's physical and psycho-social well-being and potential re-traumatization due to past events. These domains of vulnerability can be helpful in assessing clients' proximity to an event, and in contextualizing clients' experiences. Proximity, however, does not measure the severity or impact that an event may have on an individual client's emotional and mental well-being.

**Figure 1: Circles of Physical Vulnerability**  
(adapted from Rosenfeld et al, 2005)



The circles of *physical* vulnerability (Figure 1) include people who experience direct exposure to the disaster in the innermost circle. People in the second circle are witnesses who have a near-miss experience (less vulnerable than those in the inner circle). People in the third circle are those who are close enough to hear, feel, smell, and so on, aspects of a disaster but do not witness it. People in the fourth circle are outside the disaster area, in distant places (like non-New Yorkers during 9/11), although it is difficult to assess the concept of ‘distance’ given the 24/7 media cycle (Rosenfeld, et al, 2005). According to this schema, Torill and Einar (Vignette 1), for example, would be situated in circle four because they were in Denmark and the west coast of Norway, respectively, at the time of the terrorist attack, and their exposure was mediated by telecommunications and the news media. Bernard (Vignette 3), given his ‘near miss’, would be situated in circle two, and Leola and Perry (Vignette 2), circle one, given their direct exposure to the floodwaters, subsequent displacement, and destruction of property.

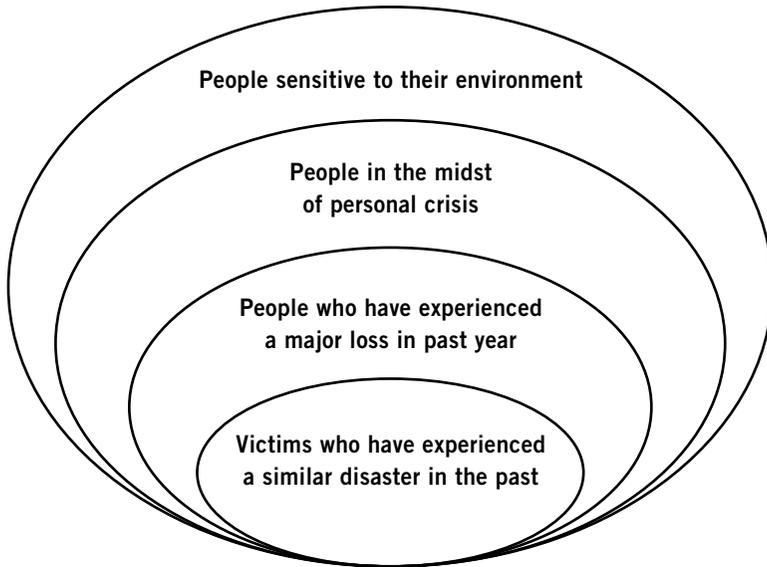
**Figure 2: Circles of Psycho-Social Vulnerability**  
(adapted from Rosenfeld et al, 2005)



The circles of *psycho-social* vulnerability (Figure 2) include people in the innermost circle who are socially close to victims who experienced the disaster. People in the second circle are those who know the victims as acquaintances. People in the third circle are those who identify with the victims, or see themselves as similar to the victims (e.g., identifications based on age, ethnicity, occupation, fellow citizens) (Rosenfeld, et al., 2005). Although this model clearly situates victims and others in terms of relational proximity, in practice, people may describe their feelings and experiences with victims to whom they are related, more relationally distant victims in their social networks, and victims in the community at large. Based on

Torill's and Einar's accounts (Vignette 1), they would be situated in circle three according to this model. Bernard's account (Vignette 3) suggests a concern for an individual friend as well as fellow citizens. In Vignette 2, Leola and Perry describe an event shared not only by them, but also by neighbors and the community in general; thus, in speaking of the event and other victims, they may occupy any of the circles of psycho-social vulnerability depending on about whom they are speaking.

**Figure 3: Circles of Vulnerability Related to Re-Traumatization**  
(adapted from Rosenfeld et al, 2005)



The circles of vulnerability related to potential *re-traumatization* (Figure 3) include in the innermost circle individuals who have had similar traumatic experiences in the past. The second circle of vulnerability includes individuals who have suffered a major loss in the year prior to the disaster. Typically, people in the third circle are in the midst of a personal life crisis when a disaster happens, which may trigger existential crises and the collapse of faith in God, community, and institutions and figures of authority. People in the outermost circle include those who have an acute awareness of their environment, such as children, and thus may be affected by fears concerning personal safety, and the safety of family and friends (Rosenfeld, et al., 2005). In the accounts given by Torill and Einar (Vignette 1) and Bernard (Vignette 3), one can infer that, among others, venturing into public may be approached with some degree of trepidation given the possibility that a similar event could occur, and that questions about good and evil, and the motivations of terrorists, might surface. In

Vignette 2, Perry describes the impact that similar, but chronologically distant, events can have on survivors' awareness and emotional health long after an original traumatic experience.

The dangers of re-traumatization underline the importance of establishing safe and supportive environments in a post-catastrophe setting, and helping victims to develop adequate coping skills and resiliency. Although survivors' testimonies can be quite meaningful in the helping relationship, social workers themselves are vulnerable, given that they share the same post-catastrophe environment and may be susceptible to event countertransference, which could inhibit social workers' ability to address, diagnose, and treat the potential effects of a traumatic event. Thus, it is important that organizations provide training and services for workers in the field, and that social workers have a plan for self-care in place (Meldrim, 2002; Pulido, 2012).

Disaster management includes providing stability and essential care for victims and communities immediately impacted by a traumatic event, ameliorating the symptoms of traumatic stress, helping victims with resiliency and coping skills, and assisting individuals and communities in their efforts to adapt to and function in the post-disaster environment. Spiritual care is another aspect of this endeavor.

Victims' testimonies, in addition to contextualizing victims' proximity to a traumatic event, may play an important role in terms of spiritual assessment. For example, victims may speak of their congregational involvement, of a punishing God, spiritual or religious orientations and affiliations, their pastors or spiritual leaders, inspirational texts, spiritual crises and challenges to faith, existential crises, anger against or gratitude for God, miraculous interventions, dreams, concerns about death and the afterlife, specific practices such as prayer, or of spiritual assets that help with coping and resiliency, among others. Some may explicitly request spiritual care. The incorporation of victims' testimonies in social workers' initial spiritual assessment efforts may establish the relevance of spiritual care in the helping relationship in a non-intrusive, open-ended manner.

### **Raising the Topics of Religion and Spirituality with Victims Suffering from the Effects of Natural Disaster and Terrorism**

Although there have been major strides forward in the professional integration of religion and spirituality, it is often difficult to ascertain what kinds of religious and spiritual helping activities and assessments Christian social workers employ in their practices, and to what extent they approve of such activities. In response to these concerns, Christian social workers (n=3,207; see Table 1) were selected from six independent national samples surveyed at various time points over the past two decades in the U.S. (1997, 2008), United Kingdom (2000), Norway (2002, 2011), and New Zealand

(2006) (for detailed discussions of the studies' sampling methodologies see Canda & Furman, 1999; Canda & Furman, 2010; Furman, Benson, Grimwood, & Canda, 2004; Furman, Zahl, Benson & Canda, 2007; Stirling, Furman, Benson, Canda & Grimwood, 2010; Vetvik, Danbolt, Furman, Benson, & Canda, n.d.).

**Table 1: Respondents Self-Identifying as Exclusively Christian by Country**

Country	Total Sample (N=5,559)	Percentage Christians	Number of Christians
U.S. 1997	2,069	57.5	1189
United Kingdom 2000	789	56.3	444
Norway 2002	601	65.4	393
New Zealand 2006	162	53.1	86
U.S. 2008	1,804	56.8	1024
Norway 2011	134	53.0	71
	<b>Total Christians</b>		<b>3,207</b>

In the aftermath of natural and human-made catastrophes, early intervention is critical in the mediation of potentially harmful physical, psychological, and emotional effects that may impact survivors, including vulnerability to PTSD due to past traumatic experiences. Survivors may be preoccupied by concerns related to basic survival, finances, health, relocation, isolation, and loss of loved ones, pets, and possessions. Fear and anxiety related to the safety of self and others may exacerbate these concerns. In the aftermath of a catastrophic event, survivors may have difficulties related to disaster assistance (e.g., language barriers, complex forms, and accessibility issues), nutritional and medicinal needs, financial exploitation, and physical and mental abuse due to the erosion of familial and non-familial support systems. Thus, social workers may be called upon to assess the client's safety and well-being, the physical and material impact of the event upon a client, and the client's cognitive abilities and post-event environment. Optimally, the social worker will have the opportunity to build rapport with the client, secure the client's safety and well-being, help the client process the catastrophe and the client's subsequent emotional and behavioral responses in the aftermath, discuss and prepare the client for the future, and facilitate referrals should they be needed.

The overview of post-catastrophe interventions given above focuses on the biological, psychological, and sociological needs of clients in the aftermath of a disaster. Social workers also may encounter victims for whom a catastrophic event is contributing to a newly discovered spiritual awareness, victims who turn to their religious and spiritual beliefs, values, practices, and support systems as sources of strength and resilience in re-

sponse to catastrophic circumstances, and victims who may be questioning their faith and belief in a benevolent God. Raising the topics of religion and spirituality with victims of terrorism and natural disasters as a primary intervention in the post-catastrophe environment, may play an important role in defining the helping relationship.

**Table 2: Norwegian Christian Respondents' Endorsement of Raising the Topics of Religion and Spirituality with Clients Experiencing the Effects of Terrorism**

	<b>Strongly Agree (%) n</b>	<b>Agree (%) n</b>	<b>Neutral (%) n</b>	<b>Disagree (%) n</b>	<b>Strongly Disagree (%) n</b>
Religion	(2.9) 2	(15.7) 11	(38.6) 27	(31.4) 22	(11.4) 8
Spirituality	(5.6) 4	(33.8) 24	(39.4) 28	(16.9) 12	(4.2) 3

Note: Missing values have been excluded from the analysis. Percentages have been rounded to one (1) decimal place.

Table 2 shows Norwegian (2011) social workers' endorsement of raising the topics of religion and spirituality with clients experiencing the effects of terrorism. The 2011 Norwegian study is the only study that asked social workers to express their views on raising the topic of religion with victims of terrorism. Over 18% (n=13) of Norwegian Christian respondents agreed or strongly agreed that it is appropriate to raise the topic of religion with victims of terrorism, compared with over 39% (n=28) who approved of raising the topic of spirituality. A large minority, however, was neutral on raising the topics of religion (38.6%, n=27) and spirituality (39.4%, n=28). One possible interpretation of the 'neutral' endorsement is the stance that the client should always initiate such discussions. Also, most social workers practice in the public sector, and thus may be constrained by agency policies, or the fact that social workers likely would not meet clients with presenting issues related to religion and spirituality. Such issues would generally fall under the domain of health personnel and psychologists.

Tables 3A and 3B report social workers' endorsement of raising the topics of religion and nonsectarian spirituality with clients experiencing the effects of natural disaster. A higher percentage in each country were more likely to support raising the topic of nonsectarian spirituality rather than religion.

**Table 3A: Christian Respondents' Endorsement of Raising the Topic of Religion with Clients Experiencing the Effects of Natural Disaster by Country**

Country	Strongly Agree (%) n	Agree (%) n	Neutral (%) n	Disagree (%) n	Strongly Disagree (%) n
U.S. 1997	(21.0) 247	(38.2) 450	(21.0) 247	(15.0) 176	(4.8) 57
UK 2000	(11.0) 48	(38.1) 167	(28.8) 126	(16.4) 72	(5.7) 25
Norway 2002	(3.3) 13	(17.0) 66	(35.2) 137	(26.0) 101	(18.5) 72
NZ 2006	(7.2) 6	(32.5) 27	(34.9) 29	(13.3) 11	(12.0) 10
U.S. 2008	(15.2) 154	(46.8) 474	(22.4) 227	(11.9) 121	(3.7) 37
Norway 2011	(4.3) 3	(12.9) 9	(42.9) 30	(28.6) 20	(11.4) 8
<b>All Countries</b>	<b>(14.9) 471</b>	<b>(37.6) 1,193</b>	<b>(25.1) 796</b>	<b>(15.8) 501</b>	<b>(6.6) 209</b>

Note: Missing values have been excluded from the analysis. Percentages have been rounded to one (1) decimal place. A total of 3,170 participants responded to the question (U.S. 1997, n=1,177; UK, n=438; Norway 2002, n=389; NZ, n=83; U.S. 2008, n=1,013; Norway 2011, n=70).

**Table 3B: Christian Respondents' Endorsement of Raising the Topic of *Spirituality* with Clients Experiencing the Effects of Natural Disaster by Country**

Country	Strongly Agree (%) n	Agree (%) n	Neutral (%) n	Disagree (%) n	Strongly Disagree (%) n
U.S. 1997	(31.1) 366	(44.6) 525	(14.8) 174	(7.9) 93	(1.7) 20
UK 2000	(16.4) 71	(41.5) 180	(26.7) 116	(11.3) 49	(4.1) 18
Norway 2002	(5.4) 21	(36.6) 142	(33.0) 128	(15.7) 61	(9.3) 36
NZ 2006	(17.9) 15	(50.0) 42	(17.9) 15	(4.8) 4	(9.5) 8
U.S. 2008	(24.9) 252	(50.5) 512	(15.3) 155	(6.9) 70	(2.5) 25
Norway 2011	(7.0) 5	(28.2) 20	(33.8) 24	(26.8) 19	(4.2) 3
<b>All Countries</b>	<b>(23.0) 730</b>	<b>(44.8) 1,421</b>	<b>(19.3) 612</b>	<b>(9.3) 296</b>	<b>(3.5) 110</b>

Note: Missing values have been excluded from the analysis. Percentages have been rounded to one (1) decimal place. A total of 3,169 participants responded to the question (U.S. 1997, n=1,178; UK, n=434; Norway 2002, n=388; NZ, n=84; U.S. 2008, n=1,014; Norway 2011, n=71).

In Table 3A, when asked if it is appropriate to raise the topic of religion with victims of natural disaster, respondents in the U.S. (1997) and U.S. (2008) indicated the highest levels of agreement, 59.2% (n=697) and 62.0% (n=628) respectively, followed by respondents in the United Kingdom (49.1%, n=215). In Table 3B, a larger majority (67.8%, n=2,251) of Christian respondents from *all* countries agreed that it is appropriate to raise the topic of nonsectarian spirituality with victims of a natural disaster. This included majorities of social workers in the U.S. 1997 (75.7%, n=891), UK 2000 (57.9%, n=251), New Zealand 2006 (67.9%, n= 57), and the U.S. 2008 (75.4%, n=762) surveys.

As part of the assessment process in the aftermath of a catastrophic event, social workers may want to pose some basic questions to determine if religion or spirituality is important to the client. For example, (1) Are faith, spirituality, and/or religion important to you? (2) Do you belong to any religious or spiritual groups that are supportive and meaningful to you? (3) Do you have any beliefs, religious or spiritual practices such as prayer, meditation, or rituals, or any values that are meaningful to you at this time? (4) Are there any clergy or spiritual advisors whom you would like me to contact? (5) Is there anything related to your spiritual or religious life that might be relevant to our work together (Canda & Furman 2010)?

### **Adapting Generic, Spiritually Oriented Helping Activities for Disaster Spiritual Care**

Christian social workers also were presented a series of generic, spiritually oriented helping activities, and asked to indicate the ethical appropriateness of each activity for clients (see Table 4). There are activities designed for social workers preparing for practice (e.g., praying for a client), for social worker interactions with clergy and clients' spiritual support systems (e.g., collaborating with clergy), for clients engaged in reflective practices outside of the helping relationship (e.g., journaling), and for practice settings (e.g., pray or meditate with a client). Although these generic helping activities were not specifically linked to particular presenting issues such as terrorism and natural disasters, social workers may find them to be useful strategies when addressing victims' spiritual concerns in the post-catastrophe helping relationship.

**Table 4: Christian Social Workers' Views on Spiritually Oriented Helping Activities by Country<sup>a</sup>**

Helping Strategy	U.S. 1997 (N=1,189)		UK 2000 (N=444)		NOR 2002 (N=393)		NZ 2006 (N=86)		U.S. 2008 (N=1,024)		NOR 2011 (N=71)	
	%	N	%	N	%	N	%	N	%	N	%	N
1. Use or recommend religious or spiritual books or writings	83.2	940	47.1	198	44.3	170	63.6	49	79.8	777	63.2	43
2. Pray privately for a client	79.6	882	64.0	265	39.1	150	65.8	50	76.5	753	41.8	28
3. Pray with a client	55.0	608	35.2	142	22.7	87	64.1	50	52.8	504	22.1	15
4. Meditate privately to prepare for seeing a client	--	--	70.5	284	43.6	167	--	--	89.0	876	59.4	41
5. Meditate with a client	--	--	--	--	--	--	31.5	23	61.3	589	14.5	10
6. Use religious language or concepts	80.8	909	52.5	221	41.1	156	63.5	47	77.9	765	--	--
7. Use nonsectarian spiritual language or concepts	93.2	1,049	73.3	305	86.9	333	76.0	57	90.6	899	--	--
8. Recommend participation in a religious or spiritual support system or activity	88.7	1,017	58.5	244	52.1	199	70.9	56	86.7	864	47.9	34
9. Touch clients for 'healing' purposes	23.8	266	10.1	43	4.4	17	17.9	14	22.4	218	2.9	2
10. Help clients develop religious and spiritual rituals as clinical intervention	81.5	919	62.6	266	30.3	116	72.5	58	77.4	763	42.9	30
11. Participate in a client's religious or spiritual rituals as practice intervention	39.1	429	37.7	158	20.4	78	51.9	40	34.0	333	28.2	20
12. Encourage the client to do regular religious or spiritual self-reflective diary keeping or journal keeping	82.5	935	49.3	209	91.5	354	61.5	48	80.2	799	--	--
13. Discuss the role of religious or spiritual beliefs in relation to significant others	91.8	1,049	75.8	320	70.5	270	72.4	55	89.4	893	76.8	53
14. Assist clients to reflect critically on religious or spiritual beliefs or practices	78.2	884	58.7	249	59.3	229	61.5	48	72.4	710	--	--

Helping Strategy	U.S. 1997 (N=1,189)		UK 2000 (N=444)		NOR 2002 (N=393)		NZ 2006 (N=86)		U.S. 2008 (N=1,024)		NOR 2011 (N=71)	
	%	N	%	N	%	N	%	N	%	N	%	N
15. Help clients assess the meaning of spiritual experiences that occur in dreams	65.5	733	26.3	111	32.6	125	23.8	19	63.9	620	--	--
16. Help clients consider the spiritual meaning and purpose of their current life situations	82.7	938	62.7	262	68.8	263	61.3	49	81.4	803	--	--
17. Help clients reflect on their belief about what happens after death	87.4	1,003	76.5	319	58.5	226	71.4	55	88.6	873	55.1	38
18. Help clients consider the ways their religious and spiritual support systems are helpful	97.6	1,127	89.3	376	71.5	276	88.5	69	96.8	953	79.4	54
19. Help clients consider the ways their religious and spiritual support systems are harmful	87.6	996	70.2	294	68.4	255	71.1	54	82.3	807	73.5	50
20. Refer clients to a clergy person, or other religious or spiritual helpers or leaders	--	--	--	--	--	--	--	--	91.0	901	81.2	56
21. Collaborate with a clergy person or other religious or spiritual leaders	--	--	--	--	--	--	--	--	87.6	859	--	--

Notes: <sup>a</sup>Percentages and frequencies are based on valid responses. The notation ‘--’ signifies that the question was not asked.

## Preparing for Practice

Social workers engaged in disaster relief are often exposed to devastating circumstances and to human suffering. Some, in addition to helping clients meet basic needs and safety, also may be moved to express their concern for clients’ well-being through prayer or meditation throughout the recovery process. A majority of Christians in the U.S. 1997 (79.6%, n=882), UK 2000 (64%, n=265), New Zealand 2006 (65.8%, n=50), and U.S. 2008 (76.5%, n=753) surveys indicated that praying privately for a client is an appropriate helping intervention (see Table 4, item 2). A majority of respondents in the UK 2000 (70.5%, n=284), U.S. 2008 (89%, n=876), and Norway 2011 (59.4%, n=41) surveys endorsed private meditation as preparation for seeing a client as an appropriate helping intervention (see

Table 4, item 4). Dombo and Gray (2013) discuss the importance of rest, spiritual activities with others, professional help, spiritual cleansing, meditation, and consistent maintenance of a spiritual practice for social workers, in order to offset the effects of secondary, or vicarious, traumatic stress.

### **Interacting with Religious Helpers and Spiritual Support Systems**

A large majority of social workers in the 2008 U.S. survey (91%, n=901) and the 2011 Norway survey (81.2%, n=56) indicated that referral to clergy is an appropriate helping intervention (see Table 4, item 20). Over 87% (see Table 4, item 21) in the U.S. 2008 survey also believed that collaboration with clergy or other religious or spiritual leaders is appropriate. Furthermore, a majority in each survey, with the exception of Norway 2011 (47.9%, n=34), endorsed recommending participation in a religious or spiritual support system or activity as an appropriate intervention (see Table 4, item 8). Involvement in a religious or spiritual support system, if available, could help to offset some of the dangers and challenges related to isolation and/or distressed familial and communal support systems throughout the recovery process. Such involvement could be very helpful in later stages of recovery as clients gain some distance from the catastrophic event and seek to become more community-oriented.

### **Encouraging Clients' Self-reflective Practices**

Encouraging clients to do regular religious or spiritual self-reflective diary keeping or journal keeping (see Table 4, item 12) can be very meaningful, not only in discerning the event and effects of a traumatic event, but also as an instrument or channel for constructing one's life narrative. A majority of Christians in each country, with the exception of UK 2000 (49.3%, n= 209) and Norway 2011 (not surveyed), approved of this activity. Should the client share this narrative with family and others, it can promote a shared sense of understanding and serve as an articulation of trauma and grief that other family and community members may not be in a position to voice. Such documents can also serve as historical documents for a family and a community. Spiritual autobiography is, after all, a time-honored form of discourse. A majority of Christians in the U.S. 1997 (83.2%, n=940), New Zealand 2006 (63.6%, n=49), U.S. 2008 (79.8%, n=777), and Norway 2011 (63.2%, n=43), endorsed as an appropriate helping intervention the use or recommendation of religious or spiritual books or writings (see Table 4, item 1). Such texts may serve as a source of inspiration and as models for clients who are interested in exploring their experiences and current life situations through the consumption and production of spiritually-oriented texts.

### **Engaging Clients' Spiritual Concerns in the Practice Setting**

Respondents were more reserved in terms of praying with a client (Table 4, item 3). This intervention was endorsed by a majority of Christians in the U.S. 1997 (55%, n=608), New Zealand 2006 (64.1%, n=50), and U.S. 2008 (52.8%, n=504) surveys only. Over 60% (n=589) in the U.S. 2008 survey also approved of meditation with a client (Table 4, item 5). Prayer or meditation with clients as a helping intervention, of course, should be used with caution, and take into consideration ethical and organizational guidelines, the potential for proselytizing, as well as clients' self-determination. If a client frames the catastrophic experience in religious or spiritual terms, it may be appropriate to use religious or nonsectarian spiritual language and concepts within the context of the helping relationship (see Table 4, items 6 and 7). A majority of Christian social workers, with the exception of Norway 2002 (41.1%, n=156) and Norway 2011 (not surveyed), approved of using religious language and concepts. A large majority in five of the six studies approved of using nonsectarian spiritual language and concepts (Norway 2011 did not ask this question).

Personal and public rituals and commemorative events can be an important way to structure the experiences of loss and grief. A majority of respondents in the U.S. 1997 (81.5%, n=919), UK 2000 (62.6%, n=266), New Zealand 2006 (72.5%, n=58), and U.S. 2008 (77.4%, n=763) surveys endorsed helping clients develop religious and spiritual rituals as a clinical intervention (see Table 4, item 10). A minority in each country, however, endorsed social worker participation in clients' rituals (Table 4, item 11). There may be times, however, when collective grief may warrant participation by the social worker, especially in the case of public events of commemoration and mourning after a catastrophic event.

A catastrophic event can undermine the personal and collective identities of survivors. Belief systems that shape how a nation perceives itself and feelings related to security and safety can be decimated by a single event, prompting existential and spiritual crises. A majority in each country except Norway 2011 (not surveyed) felt that assisting clients to reflect critically on religious or spiritual beliefs or practices is an appropriate helping activity (see Table 4, item 14). As clients move beyond the direct effects of a catastrophe, belief systems and identities may be called into question, underlining the importance of a social worker's role as a guide and anchor when clients confront these difficult crises.

Some catastrophic events are comprehensive in terms of the damage they inflict. Natural disasters, for example, may result in loss of life, loss of personal possessions and memorabilia, and displacement individually and collectively. The world, once perceived as safe and predictable, is now a hostile and forbidding place. A majority in each country (note, not surveyed in Norway 2011) endorsed helping clients consider the spiritual meaning

and purpose of their current life situations (see Table 4, item 16). This may be critical in working with disaster victims as existential and spiritual crises emerge in the aftermath of the event. One aspect of traumatic stress can be sleep disturbance and disturbing dreamscapes. Helping clients assess the meaning of spiritual experiences that occur in dreams (see Table 4, item 15) may also be useful should clients ask for assistance.

At times, a traumatic event may produce uncanny moments where clients may ask “what if” questions: What if I had arrived 5 minutes earlier? Underlying such questions, of course, is an unspoken question: what if I had died? A majority in each country endorsed helping clients reflect on their belief about what happens after death (see Table 4, item 17). Existential and spiritual questions related to mortality may also be linked to other transformations in clients’ recovery. A change in a clients’ worldview may have an impact on relations with family members, friends, and co-workers. At times, such changes can result in estrangement from others (i.e., I no longer feel that I know my spouse or loved one). A majority in each country endorsed discussing the role of religious or spiritual beliefs in relation to significant others (see Table 4, item 13). Clients may not be aware of the impact that their personal transformations may be having on those around them, and social workers can play an important role in shaping the client’s awareness.

Catastrophic events have the potential to tax clients’ material, social, emotional, and mental capacities, and to challenge clients’ emotional and mental limits. Spiritual challenges also may arise in the form of spiritual crises and dysfunctional group dynamics. There is great wisdom in social workers’ broad support of helping clients consider the ways their religious and spiritual support systems are either helpful or harmful (see Table 4, items 18 and 19).

The least endorsed helping activity, touching clients for healing purposes (see Table 2, item 9), should be used with even more discretion in traumatic circumstances. There may be times, however, when an encouraging pat on a client’s back or shoulder can bring comfort or reinforce the social worker’s words of support in challenging circumstances.

### **Concluding Remarks**

Traumatic events place overwhelming demands on victims and the social workers who help them. Traumatic events have the capacity to shatter all that we take for granted, leaving in their wake distrust, uncertainty, insecurity, and instability for individuals, families, and communities. Part of this destruction may include damaged identities and firmly held belief systems. Alternatively, traumatic events may engender spiritual growth as clients search for meaning and purpose in a post-catastrophe environment.

Social workers, however, often do not have the luxury of working with victims in the mannered setting of a private office or the time and opportu-

nity for formalized approaches to spiritual assessment. Assessing proximity and spiritual concerns, if present, based on victims' testimonies may help social workers garner insights on victims' needs for spiritual care. General, non-intrusive questions may be used, furthermore, as a means of raising the topics of religion and spirituality with victims, to assess the efficacy of addressing spiritual and religious concerns in the helping relationship. If there is need, a number of practical strategies exist that can be adapted to the post-catastrophe helping relationship. Social workers, of course, should examine these helping strategies carefully, and consider how these might be used and under what circumstances. Social workers' attitudes about and approval of these helping activities, based on survey data from the United States, New Zealand, Norway, and the United Kingdom, also may provide insights in this process. Areas of peer consensus, or the lack of it, may also guide relief workers as they compile a set of helping activities and treatment options for use in the post-catastrophe helping relationship. ❖

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# Religious Coping Strategies Among Traumatized African Refugees in the United States: A Systematic Review

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*This study examined extant scholarship focused on the use of religious coping resources by traumatized African refugees resettled in the United States of America (USA). Most African refugees are from war-torn, natural-disaster-affected, ethnic, religious, and political conflicts ridden countries. Moreover, resettling in the USA equally precipitates traumatic experiences for African refugees. It is therefore not uncommon that African refugees are usually symptomatic of traumatic experiences such as posttraumatic stress disorder (PTSD), anxiety, and depression. We systematically searched seven databases using keywords to identify evidence-based religious coping strategies often utilized by traumatized African refugees. The study found that religious activities and membership of religious congregations show marked improvements in overcoming traumatic experiences among African refugees. In addition personalized religious undertakings empowered African refugees to effectively address traumatic reminiscences, and acculturation stressors in the USA. Implications for social work practice, education, and policy as it relates to African refugees are delineated.*

**I**N THE LAST THREE DECADES THE UNITED STATES OF AMERICA (USA) HAS become the haven of refuge and beacon of hope for many African refugees displaced by natural or human-made disasters. The majority of African refugees were resettled after witnessing extreme traumatic incidents including civil war battles, murder, rape, and other unimaginable violence. It is not uncommon for an average African refugee to spend a considerable length of time spent at a refugee camp which can last from weeks to years, depending upon the social services and resources available to the refugees

(Ramsden & Taket, 2013). To put the status of refugee in proper perspective, the UN refugee agency (UNCHR) defines a refugee as:

[S]omeone owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country. (UNCHR, n.d., para. 4)

Moreover, to underscore the large numbers of African refugees received annually in the USA, Filippi, Faseru, Baird, Ndikum-Moffor, Greiner, & Daley (2014) reported that within 1995-2005, over 280,000 Somali refugees were resettled in the USA. Most recently, it has been estimated that African refugees comprised 33% of new refugees and asylees admitted into the USA in 2007 (Akinsulture-Smith, 2014; Terrazas, 2009).

Unsurprisingly, the consequence of all the traumatic experiences faced by African refugees from their home country, through the refugee camps, and finally in a new destination and culture as America, significantly predisposes African refugees to be symptomatic of posttraumatic stress disorder (PTSD) and other mental illnesses (Akinsulture-Smith, 2012; Matteson, Jordan & Anisman, 2008). Studies indicate that African refugees have suffered more traumatic experiences compared to other refugees from other parts of the world (Hooberman, Rosenfeld, Lhewa, Rasmussen, & Keller, 2007; Rousseau, Mekki-Berrada, & Moreau, 2001). More specifically, in a study Jaranson et al., (2004) reported that African refugees are four times likely to have an incidence of PTSD than other refugee groups.

### **Challenges of the African Refugee Population**

Government refugee resettlement programs and policies are oriented and designed for refugees from European nations where a much larger percentage of immigrants originate. United States resettlement programs often attempt to create a community of refugees from the same nation. However, such cultural assumption fails to take into account the arbitrary nature of African nation states created by colonizing European powers. An example of this is when the USA created a "Sudanese Community" of 300 refugees, but failed to consider that within that "community" there were 13 distinct ethnic groups, each with their own culture and language (Fox, & Willis, 2009). This is indicative of the tendency the resettlement programs have in assuming that one nation means one culture; thus, all African refugees can be processed as though they come from the same culture (Fox & Willis, 2009).

According to Fox & Willis (2009) the USA government does not perform culturally sensitive health screenings to African refugees when transitioning to Western medicine. Moreover, very brief and incompre-

hensive routine mental health screenings or services are administered to those who have survived refugee camps and undergone significant physical and emotional trauma (Adams, Gardiner, & Assefi, 2004; Fox & Willis, 2009; Simmelink, Lightfoot, Dube, Blevins, & Lum, 2013). Resettlement programs and policies do not abate stressors and triggers of mental health issues (Simmelink, Lightfoot, Dube, Blevins, & Lum, 2013; Smith & Akinsulure-Smith, 2011). Refugees may only receive eight months of monetary support and insufficient employment training after arriving in the USA. This contributes to the mental health issues and intense stress that African refugees experience (Fox & Willis, 2009).

The African refugee population resettled in the United States is classified as an under-studied and underserved population (Akinsulure-Smith, 2012; Filippi et al 2014; Guenther, Pendaz, Makene, (2012). Incontrovertibly there is a research gap in current literature about the use of religious coping strategies utilized by African refugees to overcome the traumatic experiences of relocation from their countries of origin and resettlement stressors in the USA (Leaman & Gee, 2012; Lothe & Heggen, 2003; Mulatu, 1999). Subsequently, the current systematic review of extant literature is intended to understand how African refugees resettled in the USA utilize religious coping mechanism to overcome PTSD. Since religiosity has always been part of the African culture and continental identity (Bentley, Ahmad, & Thoburn, 2014) this systematic review will also explore the impact of religious activities in the resettlement process (such as employment issues, parenting challenges, language barriers, culture shock, and access to social services to mention but a few) of African refugees in the USA.

For this study we subscribe to the conceptual definition of religious practices as having two major facets (Leaman & Gee, 2012). First, private religious practices (PRAs), including personal prayers, meditations, and scripture readings, and second, public (or organized) religious practices (ORAs) involve membership, regular attendance, and participation in an organized and formalized religious organization services (Idler et al., 2003; Leaman & Gee, 2012).

### **Study Purpose**

An extensive literature review revealed the paucity of studies discussing how religiosity functions as an effective coping mechanism for African refugees living in the United States (Leaman & Gee, 2012). There was also little research regarding the importance of integrating Western medicine and traditional African beliefs in order to cater to traumatized African refugees in medical and mental health settings (Rasmussen, Katoni, Keller, & Wilkinson, 2011; Smith & Akinsulure-Smith, 2011). Given the growing number of African refugees in the USA, it is necessary to conduct research and understand the specific needs of African refugees in the USA.

The purpose of this study was to identify and understand the role religion plays as a coping mechanism in the mental health (PTSD in particular) of African refugees resettled in the USA by means of a systematic review of the literature. We reviewed seven databases for peer-reviewed articles in the past 20 years to understand the specific traumatic challenges faced by African refugees in the USA, and how their religious activities play a role in improving challenges posed by PTSD and other mental health issues.

## **Methodology**

### **Research Design**

A systematic review of literature is defined by Cooper, Hedges, & Valentine (2009) as a methodological, step-by-step, and replicable method to discover, assess, and synthesize relevant studies to answer research questions. We conducted a systematic review of both quantitative and qualitative studies focused on the importance of religion and spirituality in coping with traumatic and mental issues among African refugees resettled in the USA.

### **Databases Searched**

We searched seven academic databases for relevant articles that investigated the traumatic experiences, and mental health challenges faced by African refugees in the USA, and the role that religion played in coping with the traumatic experiences in their lives. The seven electronic databases searched were: CINAHL, PubMed, PsycINFO, Social Work Abstracts, SocINDEX, Medline, and Applied Social Sciences Index and Abstracts (ASSIA). The review encompassed twenty years, 1994-2014.

### **Inclusion and Exclusion Criteria**

In accordance with the protocol of conducting a systematic review, we decided *a priori* the inclusion and exclusion criteria (Cooper, Hedges, & Valentine, 2009; Petticrew and Roberts, 2006) to guide the identification and selection process of articles for the current study. The following inclusion criteria were used: 1) Peer-reviewed articles published between 1994 and 2014; 2) Studies whose population of comprised of African refugees resettled in the USA; 3) Studies focused on PTSD, a traumatic episode, or mental health challenges of African refugees; 4) Studies in which religious activities were used as an intervention to address the traumatic challenge; and 5) Studies published in English language.

On the other hand studies were excluded if: 1) The population of interest were refugees from other continents apart from sub-Saharan Africa; 2) The percentage of African refugees as study participants was less than 50 percent, especially in studies that had other African descent refugees

from the Caribbean islands, such as Haiti and Jamaica; 3) Articles were not published in the English language; 4) Studies did not use religious activities as intervention; and 5) Studies were conducted outside of the USA

### **Search Terms**

To identify eligible articles relevant to African refugees and their diagnosis with PTSD or mental health issues, as well as the intersection of religiosity and spirituality, the following search terms were used: African refugees AND religion, OR spirituality AND PTSD; African refugees AND mental health disorders; African refugees AND PTSD; African refugees AND religion OR spirituality AND United States; African refugees AND trauma; African refugees AND psychological disorders; African refugees AND spirituality; and African refugees AND mental health.

## **Results**

### **Study Population and Sample**

Our initial database search revealed 195 potential studies that were conducted based on the search terms and the inclusion-exclusion criteria. Thereafter, two authors (CB, and MG) screened the potential studies by utilizing a three-step iterative process as recommended for screening eligible studies in a systematic review (Littell, Corcoran, & Pillai, 2008; Moher, Liberati, Tetzlaff, & Altman, 2009). The iterative process adopted the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) and it is delineated with a Flow Diagram (See Figure 1).

First, after an initial review of the abstracts and titles of the 195 potential studies, three duplicate studies were found and dropped.

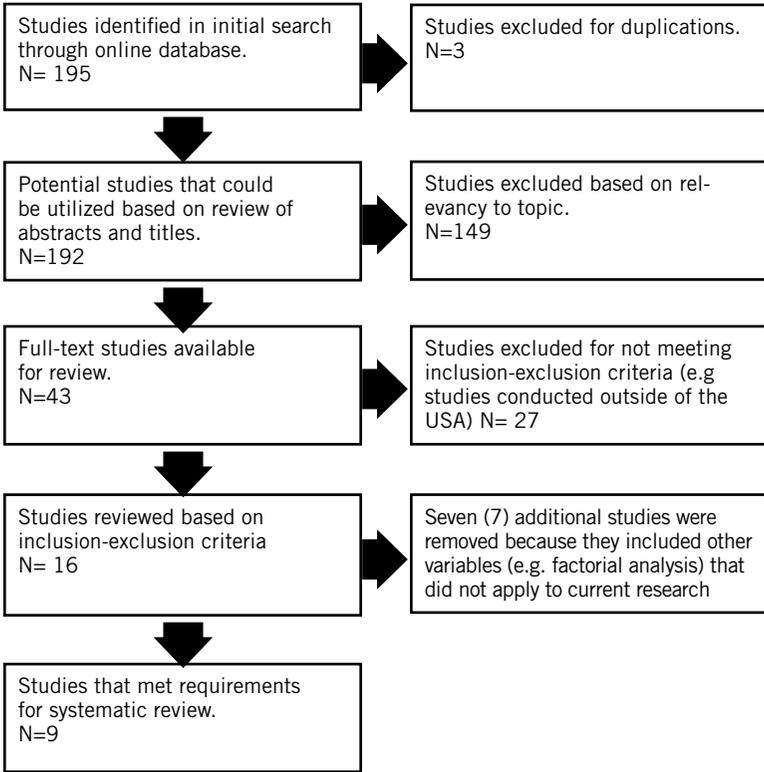
Second, 149 of the studies were removed after elaborate reviews, and reexamined by two independent authors (AM and CN) based on their irrelevancy to the topic and focus of the current study. A fifth author (ACA) independently verified the iterative process the previous authors followed and potential conflicts were resolved.

Third, of the remaining 43 potential studies that met the inclusion-exclusion criteria, a full-text review was consequently conducted. Out of the 43 potentially eligible studies we removed 34 studies for the following reasons:

1. 16 studies were excluded because they did not fully meet the inclusion-exclusion criteria for current research on African refugees.
2. Eleven (11) studies were removed because they were conducted outside the United States of America.
3. Seven (7) studies were excluded because they indicated other variables that did not apply to the interest of the research.

Therefore, nine (9) studies out of the 195 (or 21.6%) qualified as the study sample based on the inclusion-exclusion criteria. The PRISMA Flow Diagram below outlines the iterative process.

**Figure 1: PRISMA Flow Diagram for Studies Screening and Inclusion-Exclusion Process**



**Data Extraction and Article Coding**

To answer the major research question for this systematic review, the nine (9) studies that met the inclusion-exclusion criteria were coded, and synthesized according to two major domains of interests. The two domains are: descriptive information (authorship details, and refugees’ country of origin); and specific activities related to religious coping skills utilized by African refugees suffering from PTSD and other mental health challenges.

**Typology of Religious Practices as a Coping Mechanism for African Refugees**

We utilized a summary of findings table to display our findings on the specific typology of religious activities that African refugees adopted to cope with PTSD and other mental health challenges in the USA (see Table 1). In the summary of findings, four articles (Clarke and Borders, 2014; Ellis et al., 2010; Clarkson Freeman, Penney, Bettmann, and Lecy, 2013; and Isakson and Jurkovic, 2013) indicated the role that organized religious activities (ORAs) played in addressing traumatic challenges among African refugees. Five articles (Bentley, Ahmad and Thoburn, 2014; Jaranson et al., 2004; Leaman and Gee, 2012; Simmerlink, Lightfoot, Dube, Blevins, and Lum, 2013; and Weine et al., 2011) identified private religious activities (PRAs) as a strategy to overcome traumatic experiences. However, the overall evidence indicates that religiosity plays vital roles as the coping mechanism of choice that African refugees utilize to overcome psychological disorders associated with trauma.

Moreover, a summary of findings demonstrated that the two major religious beliefs that are practiced by African refugees resettled in the USA, and in coping with traumatic experiences are Christianity and Islam (see Table 1). The substantial number of African refugees who self-identify Islam as their religion is not surprising. For instance, between 1996 and 2004, of the 325,000 Somali refugees resettled in the United States, over 90 % of them self-identified as adherents of the Islamic religion (Clarkson Freeman, Penney, Bettman, & Lecy, 2013).

The Islamic religious practices and belief system have a huge impact on its adherents' daily lives. Therefore, Islamic religious practices, and especially the recitation of the "Quran" (the holy book of Islam), are seen as the indispensable for coping with difficult situations, and living a righteous life (Clarkson Freeman et al., 2013).

**Table 1: Summary of Findings on the Role of Religion Plays as a Coping Skill among African Refugees**

Author (Year)	Refugee Population	Findings
Bentley, Ahmad and Thoburn (2014)	East African Refugees (Somali and Ethiopian)	Organized religious activity (ORA) among Muslims was found to be a significant moderator, buffer, and protective regarding traumatic life events and PTSD
Clarke and Borders (2014)	Liberian Refugees	Gratitude to God and American people, hopefulness, and positive optimism about the future were forms of cognitive spiritual /religious coping mechanisms used to overcome past traumatic, and post migration experiences

Author (Year)	Refugee Population	Findings
Ellis, MacDonald, Klunck-Gillis, Lincoln, Strunin, and Carbral (2010)	Somali Refugee Adolescents	Religious dressing was one of the strategies used to amplify cultural and social identity, and thus overcome stressors as an African refugee
Clarkson Freeman, Penney, Betmann, and Lecy (2013)	Somali Refugees	Recitation and meditation of the Quran was identified as a coping mechanism to address mental illness
Isakson & Jurkovic (2013)	African and Asian Torture Survivors and Refugees (The African Refugees from Somalia, Eritrea, Ethiopia, Liberia and the Democratic Republic of Congo made up 63% of the respondents)-	The African refugees reported the use of spiritual practices such as prayers fasting, meditation, belief and faith in Higher power to move on in life, reframe their cognitive experiences of torture, and empower themselves.
Jaranson et al. (2004)	Somali and Ethiopian Refugees	Continuing religious activities was associated with coping with resettlement and traumatic experiences
Leaman and Gee (2012)	African refugees (from Cameroon, Ethiopia, Kenya, Sierra Leone, Togo, Burundi, and Mali)	Public religious coping mechanism (e.g. religious attendance) and private religious coping (e.g. prayers, meditation, and scripture reading) were used to ameliorate traumatic experiences
Simmerlink, Lightfoot, Dube, Blevins and Lum (2013)	East African Refugees (Eritreans, Ethiopians, and Somalis)	Attendance of religious services (i.e. prayer meetings), consultations with spiritual leaders (e.g. imams, and pastors), reading scriptures and dependence on God was used to overcome stress and mental health challenges
Weine, et al., (2011)	Burundi and Liberian Refugees	Church-based support used as a coping mechanism for initial settlement in the USA

## Discussion

This systematic review summarizes the current knowledge base on religious coping interventions used as a coping mechanism for African refugees suffering from PTSD that were precipitated by torture, man-made, or natural negative experiences before migrating to the USA. It is interesting to note that traditional African religious beliefs and practices were not mentioned by African refugees as a form of religious coping mechanism. It is therefore unsurprising to find that traditional African religious practices

are not as popular as Christianity and Islam among African refugees who utilize religious practices to assuage traumatic experiences. Religiosity is the dominant sub-type of culture in most African culture, and it is not surprising that African refugees resort to religious activities during adversities. Religiosity is central to the value systems of most Africans, and a key ingredient in how Africans interact with people and their environment. Religiosity is also the way Africans maintain their overall well-being. Our study found that African refugees use spirituality to heal both the physical body and the mind from post-traumatic experiences.

The importance of religiosity and the unwavering faith associated with their beliefs provides African immigrants with initial physical and mental health benefits. Overall, religiosity has been shown to be one of the highest coping mechanisms used by African immigrants while overcoming the countless struggles they face being merged into American culture (Gladden, 2013; Kanya, 1997). As previous studies have suggested, religiosity is a necessary coping skill that can help African refugees to endure and overcome mental and physical illness, racism, unemployment, isolation, vitiation, and acculturation (Gladden, 2013; Leaman & Gee, 2012; Nwadiora, 1996).

### **Study Limitations and Implications**

There were several limitation indicated in this systematic review. First, the study was limited to African refugees who used religion as a coping mechanism when migrating to the United States. Other geographical jurisdictions, for example, European countries, might have provided additional findings in terms of available religious activities used for intervention. Second, the study focused secondary sources (published articles). Therefore, the pre-and post-migration, and the severity of the impact of trauma on African refugees resettled in the USA is not fully represented in the current study. Third, we only searched seven databases and published articles, which may be a gross under-representation of available religious intervention, knowledge-base, best-practices, and strategies that African refugees adopt to overcome traumatic experiences.

Despite these limitations, this study has a number of implications. First, the study undergirds the importance of religion as a coping method for African refugees. In addition, this study suggests that those who experience trauma while migrating to the United States are in great need of therapeutic support, which Christian (or Muslim) social workers may be best suited to provide. The study may also contribute to improved understanding of these religious traditions by social workers generally. Results also suggest the urgent need for further research, and a deliberate development of culturally-competent helping professionals and a religiously-sensitive knowledge base for working with the African refugee population.

In another vein, African immigrant religious places of worship (especially churches and mosques) should be in collaborative and partnership relationships with social work and other healthcare agencies to better serve African refugee population. The proposed collaboration may help to tear down every imaginary wall of suspicion, fear, and differences that may otherwise impede professional and therapeutic interventions. Partnership between social service providers and African immigrant clergy also bridges the cultural and language divide and fosters trust, and cooperation.

Such partnerships may improve social workers' understanding of the importance of religion for African refugees and facilitate education that integrates culturally competent and spiritually sensitive therapeutic interventions.

### Conclusion

The number of African refugees in the United States will continue to grow with time. This will require having multi-faceted social service programs, culturally competent government assistance, and healthcare practices, and professionals who are knowledgeable to meet their unique needs. Since religiosity is so important to African immigrants, it is recommended that the USA healthcare educators, and providers should integrate religiously sensitive, and culturally-competent content in the educational and professional training of future healthcare professionals who may become involved in professional intervention or contact with African refugees. ❖

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**Keywords:** Refugees, African immigrants, PTSD, trauma, mental health, religiosity, religious coping, resiliency, resettlement

# Lessons Learned from Disaster: Behavioral Health for Social Workers and Congregations

James W. Ellor & Sara Dolan

*When a disaster hits a community, it always seems like a surprise, despite planning, preparation, and knowledge of the history of such events. From the perspective of the individual and the community, disaster recovery, from immediately following the event to the end of the long-term recovery effort, is a journey. While every disaster situation is unique, common threads of disaster reaction and process, or recovery, can be picked up and employed to enhance emotional/spiritual health efforts by the community. In this article, the authors combine their experience working with several different disasters into one fictitious community, called Home Town. This article walks through the journey from preparation to final recovery with this community discussing common challenges for social workers and clergy and offering suggestions at each step along the way.*

**D**ISASTERS OFTEN SEEM TO DESCEND UPON COMMUNITIES LIKE A THIEF in the night. Even when some warning is possible, the experience of the average person is that it came from out of nowhere. Social workers, mental health providers, and pastors are generally a part of the impacted community, but are also part of the response teams. Emotional/spiritual care plays an important role in the recovery from the event, throughout all phases of the recovery. In this article, we will examine what the individual and community experiences when a disaster comes to town. This article results from the experience of two disaster behavioral health workers who have responded to multiple disasters. These experiences have been aggregated into a single fictitious disaster community called Home Town in order to illustrate the discussion.

Home Town is a community in a rural area in a Southwestern state that has sustained a major tornado. In this town of 3000 persons, 550 homes were impacted with 40% of the homes damaged or demolished. This town has a historically Polish identity whose people are hardworking, mostly farm-

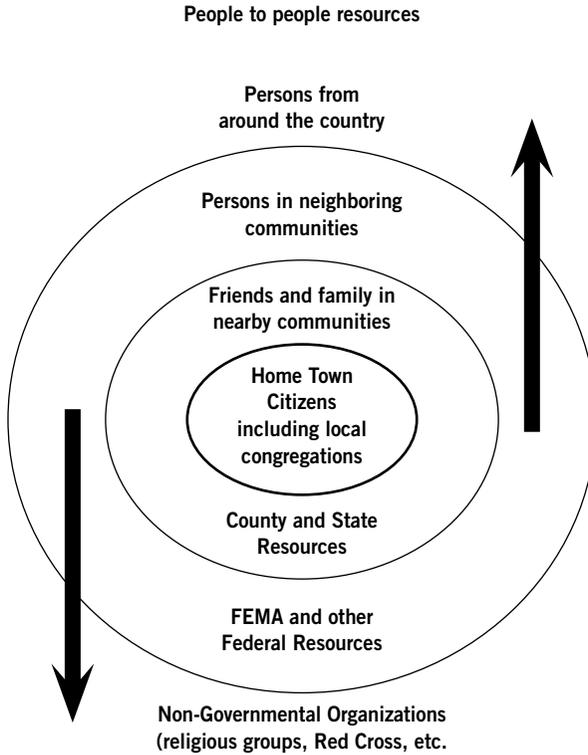
related families who through the generations have taken pride in their identity of pulling themselves up by their own means. The largest church in town is Roman Catholic, however, there are several protestant Christian churches who generally reflect smaller congregations (40-100 members) most with a higher than normal average age. The community is close in proximity to Capital City, which has many resources; however, Home Town citizens do not feel comfortable leaving their community to go to the “big city.”

Like individuals, crises strike unexpectedly for the average community. While extensive planning for disasters has been mandated and orchestrated by the Federal Emergency Management Agency (FEMA) and local county and municipal governments, few believe that a disaster will ever happen to them. At 10:00 p.m. last spring, the unthinkable happened in Home Town. A major tornado touched down, causing massive destruction. From the time of the touch down to the present, Home Town has demonstrated a need for a wide variety of services ranging from municipal, governmental, construction, practical (e.g., food and water), and, of course, emotional/spiritual resources. In an effort to support Home Town toward achieving their “new normal” which will come at the end of a long-term recovery period, social workers, pastors, and lay leaders of the community are needed to be there to support the community. The process from meeting immediate needs to completion of long-term recovery can take several years. Emotional and spiritual caregivers are needed to help progress through the various phases of a disaster as well as walking alongside individuals, churches and community leaders facing the new reality that will become Home Town.

### **The Nature of a Disaster: All Disasters are Local**

It is said among disaster responders that every disaster is local (DeWolfe, D., 2000; Weisaeth, L., 1994). While the entire country hurt after 9/11, after Hurricane Sandy, and all of the school shootings, the persons who experienced the greatest impact are those who were present and physically impacted by the various disasters. In this case, a devastating tornado in Home Town makes Home Town the location of the disaster, the center of the response paradigm. Radiating out of Home Town are two types of resource groups who will both be impacted and also stand ready to help. Immediately after the disaster, survivors make contact with friends and families and then work outward through the circles for resources and support from outside friends and family. (The order of the circles in resource chart, Figure 1, will vary depending on the type of disaster and the nature of the response.) They will also immediately be supported by certain community assets: first responders to any disaster will be local police, fire, and other Emergency Management officials. While these groups will be the first on the scene as they live closest to Home Town, local, county, state and federal responders will all be there, depending on the size and scale of the disaster.

**Figure 1: Disaster Resources**



(Graphic sources: Moghaddam & Breckenridge (2011); Ursano, R., Fullerton, C., Weisaeth, L, Raphael, R, (2007); Jones, R.A. (2012))

In Home Town, after the tornado and all the noise and commotion created by this major event happened, people began to dig themselves out of their damaged properties. They started by checking themselves for injury and then looked at those around them, possibly persons who sheltered elsewhere in the home, or neighbors. Immediately after the disaster most survivors are on their own to determine what has happened and the extent of the damage. Home Town is a small town, but it had extensive damage. First responders attempted to go to the places where there was the greatest damage. While the Emergency Medical Technicians, Police, and Fire Department moved in to help, they were also setting up Incident Command. The Incident Command System is an organizational structure that was developed first by the military and then adapted by FEMA. Their role is to coordinate the community resources needed to respond effectively to a disaster, first from the local community, then outward from the county, and

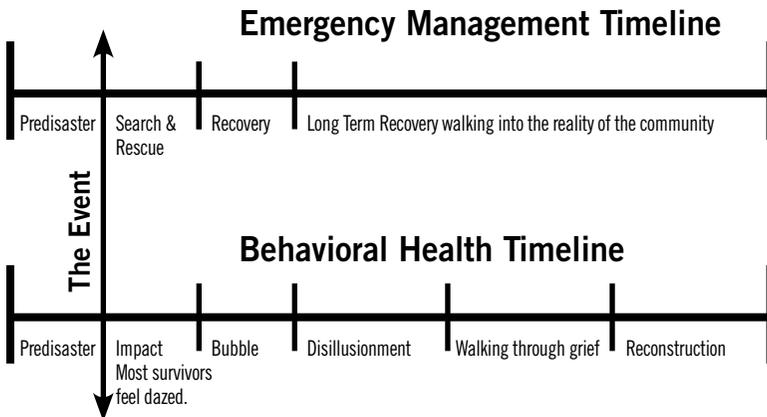
in the case of Home Town, state and federal resources were also called in.

In Figure 1, each circle calls in persons and materials that can help from further away from the local community. In a case like Home Town, their local resources were designed to help if one house or even if 2-3 homes were destroyed. The challenge for any small town is the overwhelming volume of need that is presented. The Incident Command structure is designed to expand to correspond with the size of the need, thus calling in resources from further and further away. For example if one house is on fire, the local fire department can usually handle it; however, in rural areas if a supply of water is a problem, the first fire department may call on a second fire department, at least for their water tanker as a specialized piece of equipment in order to put out the fire. If multiple houses are on fire, then the call is expanded even further for more firemen and equipment. The Incident Command structure is set up to accommodate this expansion and call on the resources needed, always starting from the most local and then reaching out as needed. This could include both interpersonal and local human resources as well as agencies and other public or non-governmental groups as needed.

### Stages of the Response

A disaster timeline starts with a single incident, but then progresses through several incident based stages. From the perspective of Emergency Management, there are four basic phases. From the perspective of behavioral health, there are six (see Figure 2).

Figure 2: Stages of Response\*



(Graphic sources: Moghaddam & Breckenridge (2011); Ursano, R., Fullerton, C., Weisaeth, L, Raphael, R, (2007); Jones, R.A. (2012))

### **Predisaster Phase**

The Predisaster phase for both Emergency Management and behavioral health is the time before events have happened when efforts to both prevent and prepare are under way. The activities of this phase vary from community to community but should involve a team of persons that include local Emergency Management as well as the various community resources to support each phase of the event. It should also involve the development of behavioral health resources through such groups as Citizen Corps whose sub-groups are The Medical Reserve Corp (MRC), Fire Corp, Critical Emergency Response team (CERT), through Non-Government groups (NGO) like the Red Cross, or Voluntary Organizations Active in Disaster (VOAD) and faith-based groups such as the Salvation Army, Presbyterian Disaster Assistance, Lutheran Disaster Assistance, St. Vincent DePaul, Baptist Men, Islamic Relief, and local clergy and appropriate local social service agencies. Depending on the size of the community and the resources available, the community alone cannot staff an entire disaster. People from the outside may need to assist.

One option in communities where colleges or universities are present is to develop a Medical Reserve Corp unit made up at least in part of faculty and students from the Psychology, Social Work and Counselor Education/Family Therapy departments. Local seminaries can serve in a similar capacity. This option can serve two complementary purposes: higher education programs often have willing volunteers who are well-trained with no avenue for putting their skills to practice, and local communities could greatly benefit from local citizens with such training and desire. By offering local mental health professionals training in advance and creating a recognized Medical Reserve Corp unit, the liability is not on the college, but rests with all emergency responders in the FEMA and Good Samaritan legislations.

It is often difficult to get social service agencies to plan ahead for a disaster, but ideally, planning should not stop with the determination that there are enough fire trucks or ambulances available. Social services should be meeting with local chaplains and clergy to talk about the types of disaster contexts common in the area and how to coordinate an appropriate response. Particularly in rural areas like Home Town, there often are few or no social workers with offices in the community; however, there generally are churches and thus clergy. If there is a local clergy association in the area, this could be an appropriate agenda item for this group to then invite social workers in to discuss coordinated needs.

Along with coordination of services in the pre-disaster time frame, persons willing to volunteer need to be trained. Crisis training from graduate programs in mental health service delivery is important, but specific training in search and rescue or fire fighter support are also critical and can be obtained through the various Citizen Corp or community programs.

### **Immediately after the Disaster**

While the role of behavioral health/mental health care providers immediately after the disaster may vary by the disaster, there seem to be some consistent needs that should be addressed immediately after the disaster. In these first hours, two human forces are struggling to consume the people involved. The first one is stress with its concurrent adrenalin rush. Stress and adrenalin will walk with even the most experienced first responders to any disaster as well as those who have survived the event in Home Town. The second is the need for control. Disasters leave most people feeling very out of control of their lives.

During these first hours first responders will be putting out the fires and attending to the people involved for medical and other primary needs. Often emotional/spiritual providers use this time to try to determine the needs and organize behavioral health responders. Each aspect of the immediate response can benefit from having a social worker or clergy person involved, but these persons must be trained to work with whatever team is involved. It is possible at some disaster sites to find “just-in-time” training which is an on the spot shorter version of the longer training tailored to the incident that can be given just prior to starting to work in the disaster location.

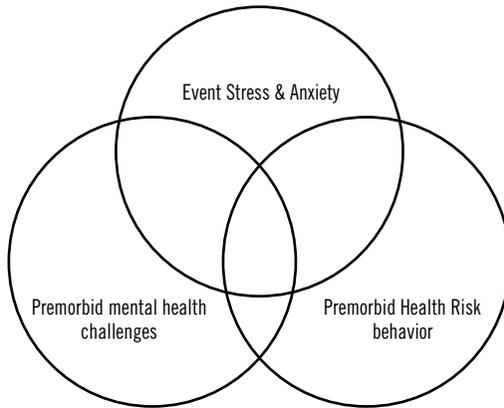
### **Impact: Search and Rescue**

During the search and rescue phase social workers and clergy need to pay attention to two important groups, the survivors and the first responders. For survivors, the issues focus primarily around basic issues of reuniting with the people they love and obtaining shelter, food, water, and other basic necessities. Secondly, as they are able, they will need to understand the full story of the disaster event. This can help them start to regain a sense of control. Responders are trained to open a family assistance center, (or in some places it will be called a family service center) a safe distance from the disaster site to minimize interference with the work of first responders. This is the place where family members can be reunited if they have been separated and where other family members who were not present can find their loved ones. This is also an important place for local clergy to be present to offer members of their congregation and others spiritual support. If the disaster involves mass fatalities, the family assistance center may be designed to help loved ones of the deceased where the family service center will be for those whose families have been separated or who have lost pets or material goods.

The task for social workers and clergy is to respond in family assistance centers in two ways. First, there is a case management style function that works with the Incident Command structure of the Emergency Management team to develop communication, both to find loved ones who have

not arrived at the family assistance center and to connect those that have with factual information about the event. It is important to note that only factual information be given to family members. As a behavioral health responder in a disaster, it is crucial to be honest and to report only information that has been communicated directly by the Emergency Management command structure. Social workers and clergy may have the desire to help a survivor to feel better by telling them something about the disaster event, or the location of a missing loved one, that has not been confirmed but is later proven false. Instead, it better to tell a family member that *you don't know*, but that you will get them the information as soon as possible. Life has suddenly become quite unreliable and unsafe as the survivor experiences the disaster. They don't need for the behavioral health responder to contribute to this sense of uncontrollability. It is equally critical for the behavioral health team to maintain a positive working relationship with the Emergency Management command structure, specifically the Public Information Officer, in order to obtain factual information. Behavioral health leadership will also want to stay in communication with the command structure in order to be able to direct the behavioral health team to respond where, when, and how they are needed.

**Figure 3: Survivor Mental Health Groups**



Adapted from: Ursano, R.J., Fullerton, C.S., Weisaeth, L., & Raphael, B. (2007). Individual and Community Responses to Disasters. In R.J. Ursano, C.S. Fullerton, L. Weisaeth & B. Raphael (Eds.), *Textbook of Disaster Psychiatry*. New York: Cambridge University Press. P. 9

During this time, there is also a critical need for social work and clergy responders who can work in the community directly with individual survivors themselves. As noted above, stress is the key emotional factor at the time of a crisis. Since a crisis comes suddenly, it is as if it has cut a slice into the life of the survivor. In that slice, the behavioral health responder

may see a person who is chronically under stress, or a person with previous mental illness, as easily as they can find a person with only normal human stress and resilience factors.

Although resilience is the norm, in general there are three groups of people to be concerned about, (See Figure 3) 1) Those who are responding to the stress and anxiety of the actual event, but were highly emotionally functional prior to the event; 2) Persons who, prior to the event, were already emotionally challenged with some type of mental health issues; and 3) Persons with health risk behaviors, particularly addictions or persons who have been under significant life stress prior to the event (Ursano, et. al., 2007).

For the first group, the level of perceived threat or stress will conform to the formula of past traumas + current anxieties + the long term perceived impact of the trauma = the intensity of stress response. For the average person, sudden trauma will have a significant impact, but over time he or she will be able to absorb this and function well going into the future. There are specific vulnerability factors that reflect groups two and three. Females with preexisting mental health issues, low academic abilities, poor social support, and intense levels of exposure to the disaster are at the highest risk for the poorest stress response (Natha & Daiches, 2014).

Frequently, some of the first persons who are willing to come in to formal mental health services voluntarily are those with previous emotional challenges, who have had previous experience with the mental health system and understand how and when to access it. The most common premorbid diagnosis in survivors of a disaster is depression (Natha & Daiches, 2014), but depending on the community, the entire spectrum of mental health diagnoses generally can be found. In these cases, the stress of the disaster comes on top of the challenges they already face. Particularly if as a result of the disaster they are unable or unwilling to take their medication and/or engage in ongoing counseling, they will need the support of behavioral health responders. The third group is those who, prior to the tornado, were already challenged in coping with anxiety and were participating in unhealthy or dysfunctional coping behaviors, such as those who abuse alcohol or other substances or those who prior to the event were under significant stress. These people typically were not engaged with mental health services prior to the disaster. Such persons may not be willing to engage in formal mental health treatment on their own, but often are brought to counseling after a time by family members.

Frequently, during the first phase of a crisis the best response is to simply be an empathetic listener to the survivor, keeping in mind that the responder often cannot change what has happened or "fix it." The roles of behavioral health are simply to listen, to connect a person with available resources, and perhaps to help the person sort priorities. It may also be important to encourage the survivor not to make any sort of critical life decisions, but rather to wait to allow for time to recover from the impact of the disaster.

One of the significant considerations in times of trauma is that some Christians feel they should convert survivors to Christ. Proselytization is a concept well known to first responders from public service departments. It is also the greatest point of friction between faith-based groups and state and local authorities when involving emotional/spiritual health responders. Public responders feel very strongly against proselytization and often evict persons who are perceived to be attempting to evangelize. In our experience, it is important to listen and focus on the faith or even lack of faith of the survivor, to let the survivor bring up the subject of faith on his/her own. The time of the crisis when the person is under significant distress is not the time to be attempting to introduce a new theological or philosophical system without invitation. It is also potentially exploitive. During crisis, responders become the hands of Christ through which His love can shine. We are *listeners* to the faith, not *preachers* of the faith.

First responders also are generally running on high levels of adrenalin. Fire department, police, Emergency Medical Technicians (EMTs), as well as trained volunteers from CERT or Fire Corp may be involved in the search and rescue process. A number of factors need to be considered. For example for fire service, one significant stressor may be all of their equipment. Referred to as bunker gear, it includes the very heavy boots, pants, coats, and helmets that firefighters wear. Particularly during the summer, all that protective equipment is both heavy and hot. This can increase the core body temperature of the individual and lead to heat exhaustion.

The stresses of search and recovery will be greater if the first responders are in their own community and the potential for recovering a friend or family member is a reality. CERT and Fire Corp teams will often provide the capacity to physically cool the responder down, lower his or her blood pressure, and aid in recovery. However, emotional and spiritual concerns also need to be attended to. Occasionally the disaster event will bring back past events, thus elevating the level of stress of the current event. Behavioral/spiritual health generally takes the form of both listening and offering stress reduction techniques. It is important to note, however, that these first responders often have their own separate social worker and chaplain care providers. We can work alongside the services' chaplains and other emotional/spiritual care providers.

Immediately after the event, behavioral health concerns become somewhat intertwined with the search and rescue/recovery challenges, but at the same time somewhat independent. Behavioral health units as well as local clergy are called upon for emotional comfort for those who will describe themselves as "walking in a daze." Down the road, some of the most impacted persons will not even remember this time; others will remember it very clearly. Meyer and Wee (2005) suggest that there are four critical factors as to the nature of the impact for each person.

First, it will depend on the physical and mental health of the individual. This includes any preexisting stressors and how well these were processed previously, as well as other health and mental health concerns. Second are the interpersonal factors. Social resources and networks are critical as a resilience factor for persons experiencing a disaster. Conversely, the lack of social resources can become a stress factor where the person feels alone and isolated. The third factor reflects the community where the event took place. The sense of community, the experience of solidarity, the size of the community and the amount of predisaster preparation will all make an impact on individual recovery. Finally, the various factors specifically related to the disaster will also provide some impact (Myers & Wee, 2005, p. 14). The more directly one is impacted, the greater the impact. DeWolfe (2000) refers to this as the “dose-response” factor (Myers & Wee, 2005, p. 17). Persons whose home is demolished by the tornado will have a much higher trauma impact than those whose neighbor’s house was destroyed, but theirs was not. Everyone in a community like Home Town will be impacted in some ways, but those closer to the actual losses likely will have the highest stress responses.

### **Recovery**

Critical factors involved in emotional/spiritual recovery from a disaster are also referred to as resilience factors. Recent research suggests that there are two broad groups of “person centered factors associated with resilience: *pragmatic coping* and *flexible adaption*” (Mancini, A. D., & Bonanno, G. A., 2008, p. 584). Persons who demonstrate a *pragmatic coping* style are generally those with a very focused, often self-centered and goal directed, and often self-serving personality structures seem to cope well with trauma, albeit potentially at the expense of others.

The second and often more healthy group are those who demonstrate *flexible adaption*. For this group the emphasis is on *going with the flow*. The key for this group is that their “capacity for adaptive flexibility helps bolster resilience to aversive events” (Mancini & Bonanno, 2008, p. 585). This group often demonstrates more transcendent traits that reflect their emphasis on relationships. Some of the strongest resilience factors include strength of family and friendship bonds, community bonds and perceived support, and whether or not the person has experienced other significant traumas. Frequently, religion offers one of the stronger resilience or positive coping mechanisms (Pargament, 1997). The simplest use of religion as a coping mechanism is to reframe the human impact of a disaster, “my house has just been destroyed,” into “it was God’s will.” This sort of conversion allows people to see the impact of the disaster in a larger picture and even understand that God is walking with them, rather than just allowing the tragedy to happen to them.

For local clergy, this early time in the disaster cycle is also very important. Most parish clergy are not trained in disaster response or even crisis intervention. Chaplains and some local clergy have obtained some skill in this area, but most clergy don't see training for emotional/spiritual care during times of a disaster as a priority in their busy lives. Thus, when the unthinkable does happen within the parish, though the pastor may not be the best trained to respond, his or her role continues to be critical for parishioners. Clergy are an ongoing source of support and comfort at times of crisis. They were members of the community before the disaster and will continue to be long after. As such, they need to have an important place in the behavioral health response team. While some teams may want to pair local clergy with a trained behavioral health responder, local clergy have the ongoing relationship with the members of their church and thus should be considered a critical resource as behavioral health teams are developed in a community.

### **The Bubble Phase**

The "bubble" will roughly coincide with Emergency Management's recovery phase. It is a concept that was first articulated by Moghaddam and Breckenridge (2011). They suggest that there is a time right after a disaster, as people are emerging from the rubble, when suddenly neighbors who previously did not know each other well suddenly become friendly and supportive of one another. This phase offers a time when community good will is at its peak and the community could most benefit by organizing and coming together to begin the recovery process amiably. Unfortunately, while this time of community support after a disaster is consistently observed, it often does not last long, and comes before most communities can organize to take advantage of it (Moghaddam & Breckenridge 2011).

From a behavioral health perspective this bubble is much like a rainbow after the storm—when it disappears, it summons a period of disillusionment. Frequently, those who are recovering and relatives of those directly impacted by the event seem to need an object to focus their anger upon. This is understandable in human-caused disasters, since there is an identifiable culprit. Unfortunately this also seems to be true of natural disasters and other disasters where the perpetrator is less clear. One argument reflects the thought that all that energy consumed by anger could be better channeled into recovery, becoming a resilience factor. On the other hand, there seem to be people who need this anger to function. It does not seem to matter whether the person recovering is a person of faith or not; this time of focused anger seems to take place.

### **Long Term Recovery: Disillusionment, Grief, and Reconciliation**

The Long Term Recovery phase for the community can be understood in three parts for the behavioral and spiritual health workers. Spiritual and emotional response tends to closely reflect what is done during crisis counseling. During the actual crisis phase, responders are walking with survivors, listening and offering encouragement, and it is decidedly *not* counseling as one would normally understand it. However, as the community turns to long-term recovery, this changes and there will need to be a significant counseling-type response.

The primary challenge of long-term behavioral/spiritual health recovery can be summed up as a struggle with human denial. The textbooks do not talk extensively about this, but in Home Town, denial was a significant factor in reaching persons who clearly demonstrated negative symptoms of stress after the disaster. A community like Home Town is proud of its ability to take care of itself. An informal survey in Home Town suggested that survivors who reported symptoms like inability to sleep or flash backs took these concerns to their physician first. A few went to talk with their pastor, but most started with their family physician. Physicians and families sometimes referred community members to see mental health providers, and these individuals reported symptoms all along the stress continuum.

The first to access formal mental health services in Home Town were those with a known history of emotional challenges. (See Figure 3) Veterans who knew they had Post Traumatic Stress Disorder (PTSD), recovering substance abusers, and persons with known depression seemed to be among the first to come in for professional counseling. All felt destabilized by the tornado experience. In most states the local mental health authority is designated to be in charge of emotional support and often the local churches are understood to support their parishioners spiritually.

Persons for whom the disaster is their first major trauma and persons with premorbid health risks tend to come in for assistance more slowly (See Figure 3). In Home Town, it seemed that staying busy was the first coping response to the heightened anxiety brought on by the disaster. One often hears people talking about the need to keep busy. This is easily accomplished immediately after a disaster, since there is a lot to be done. Those with property damage will be working to secure shelter and rebuild their homes. A special group of these persons may be the community leaders and elected officials. Often these are dedicated persons who end up juggling the needs of their own families and doing the significant work of rebuilding the community.

The Behavioral Health timeline has three sub periods during what is considered long-term recovery for emergency management of the rest of the community. It is important to understand that the physical recovery of the community and the emotional recovery are bi-directional in their influence

since having one's house restored will help a frustrated and even depressed person feel better and frustrated and depressed people often don't respond as quickly to those who can help them repair or rebuild.

***Disillusionment:***

Disillusionment is a phase in which individuals and even groups in the community become discouraged with the progress or lack of progress to bring their community back. Sometimes this results from the focus on all of the red tape involved in government assistance; sometimes it comes from the evidence of fraud that generally comes with the predatory groups such as contractors and clean up groups who offer to help, then either fail to provide a service or greatly inflate the cost of service. As hard as many communities work to keep these groups out, they seem to be present, taking people's money along with their faith in their own recovery. During this time survivors often turn to local officials or local recovery groups with their anger at all of the losses that they have suffered.

For persons working in a Long Term Recovery Center this can be devastating. Volunteers and paid responders work very hard to facilitate recovery. With today's fast social media the rumors can be a real challenge to keep straight. Communication is the strongest tool to try to be sure that the community has the correct information rather than only social media observations.

For social workers and clergy the challenge is to not become a target of this disillusionment. As noted earlier, one way to do this is to always share facts and to address survivors and family with all the information that is possible to be shared as fact. In a time when the recovering person's world has just come crashing down, we do not want to be one more unreliable element in their world. This is also a time for listening. Share anything that is useful with Long Term Recovery staff to try to repair the system, but the focus should be on the recovering person's feelings and experience. By focusing on the person, that person can begin to be empowered to regain control over his or her own world.

***Grief:***

In a disaster there is considerable loss experienced by survivors. Part of the challenge for clergy and social workers is the various elements of the survivor's grief. One loss may involve property. Insurance companies run ads about how wonderful they are to work with for a claim, but that is not everyone's experience. Once all of the insurance issues are addressed, then come all of the hassles with the repair or rebuilding process. This same survivor just a couple of months ago was perfectly happy with his or her property; now they have to go through so much to try to just get back

to where they were. A second part of the challenge is the loss of memories that generally accompany the loss of property. Human beings often empower objects with a memory. Even something simple as a stone, or a toy or a picture can be much more than a stone, toy or picture, because it may be one that a child played with for many years and now the memory of this object is enmeshed with the person. Especially if the person has died, part of surviving is giving up a lot of objects that have been empowered as reminders of someone or something important in their lives.

Loss of a pet or loss of a person is the hardest kind of loss. Pets can often be overlooked, but particularly for children or older adults, pets are their companions and loved ones and clearly reflect major losses. The phases of grief have never been linear, moving from shock to some sort of resolution. Given all of the disruptions to the emotional process, like rebuilding a house or business, there will be many stops and starts in this process.

Finally, the greatest challenges may come from persons with multiple losses. For example, an older woman may have lost her husband the week before the tornado hit Home Town and then lost her home in the tornado. The two are unrelated as physical acts and yet very related for this person. Such losses need to be addressed separately, but it is important to recognize that the second loss compounds the distress from the first loss. This may be a challenge since the home will contain many symbols of the new deceased spouse. Such persons will need someone to walk with their grief at first and then to facilitate the one going grief caused by the traumatic loss of her home watching for a potential depression.

### ***Reconciliation:***

At the end of the grief and loss period individuals in Home Town will need to discover their own reconciliation. In the Emergency Management/community timeline, reconciliation is somewhat more tangible. Homes can be rebuilt and public utilities replaced. It is far more challenging to determine benchmarks for the behavioral health timeline. It is always a mistake whenever phase theories are proposed for such things as crisis or grief to presume that they are linear, moving in one direction from the event to some type of resolution or reconciliation. Rather, people tend to move back and forth through their various challenges and phases.

Therapists working with persons in Home Town will want to use their skills to diagnose and work with the various challenges an individual presents. Some persons will come to a place where they have reconciled their anxieties on their own. Others will at some point need professional support. Facilitating the emotional support of persons after a disaster needs to combine traditional therapies with and assessment and support for the resilience factors available to the individual (Mancini, A. & Bonanno, G. 2008, p. 585).

Most persons living normal lives have some of the more common resilience factors such as social relationships found in family and friendship circles. Many in the United States will have some measure of religious coping skills. Each of these factors, if they were present prior to the tornado will still be present, but can be facilitated by the community through local events that support family or religious groups to gather and support one another. Reconciliation takes place in the context of the community finding a new equilibrium, both in the form of homes rebuilt and infrastructure reestablished and in emotional/spiritual balance discovered.

### **Notes for Social Workers and Clergy on Emotional/spiritual Care**

Emotional and spiritual care during the phases after the event comes in several forms. First, it should be understood that many psychologists, counselors, and social workers are trained to keep emotional and spiritual care separate. Traditional Adlerian holistic models talk about the integration of the person, but did not include the spiritual. Authors like Granger Westberg have offered the concept of adding the spiritual dimension to our understanding of the whole person (Westberg, 1979). However, Westberg's (1979) concept of the whole person suggests that emotional and spiritual aspects of the person are integrated and thus inseparable. Viktor Frankl often remarked that in his work as a psychiatrist, he leaves religion to the Rabbis and focuses on the emotional aspects of the person (Ellor, 1989). This approach to the whole person and spirituality is common. By this approach, religious and spiritual aspects of the person should be handled by religious professionals but emotional issues should be addressed by trained counselors. The challenge in this separate approach is that there are times when the pastor may not be well enough trained in crisis support. In the same way, counselors are often not adequately trained in working with the religious and spiritual aspects of the person.

One way to consider this dilemma is to think about having the person with the best relationship with the survivor work with him/her on both aspects of the person. However, this may require some just-in-time training on the ethical integration of faith and counseling practice. It may also require a team of one social worker and one pastor to walk with the survivor in order to hear and understand all of the issues (e.g., Brueninger, Dolan, Padilla, Stanford, 2014). In other cases either the social worker or the pastor will need to work with the person. When the survivor is a member of the pastor's church, clergy have the advantage of understanding their faith tradition. For the traditional social worker, spirituality can be understood as a significant coping force that is reflec-

tive of the culture and religious aspect of the person. This is consistent with DSM-5 which clearly points toward the integration of culture and the spiritual needs of clients (APA, 2013).

When the social worker treats spirituality as a part of the cultural experience, the challenge is that culture is a human creation. It often does not allow for miracles or divine intervention. When the survivor of Home Town tells the social worker that most of their house was destroyed, but only one wall still stands and it was the one with the family cross on it, culture alone does not support the survivor's inference that this was God's intervention. In this case it may be easier for the social worker to simply understand this to be the client's perception of the situation and not try to determine the validity of a faith belief.

As social workers support the survivors of the Home Town tornado, it is important that they understand that religion is able to offer an important coping mechanism which offers one source of resilience for that individual (Ellor, 2000). It is also important that the social worker or pastor assess other coping needs, such as the available of an emotional support system. This can include family, close friends, church groups and even groups from their place of employment. Each of these resources will help them to talk about and process their feelings. At times both the pastor and the social worker may be called upon to help families who were not present or did not even live in the community to better understand the needs of the survivor.

Emotional and spiritual recovery may require more than traditional counseling sessions. Other suggestions include:

- Support groups for grief and/or trauma
- Brief educational articles in the local newspaper that address various aspects of emotional spiritual recovery
- Community gatherings, especially at anniversaries
- Offering dinner gatherings where people can just come to talk about their experiences
- Health fairs where both blood pressure and crisis counseling are available for brief interventions
- Publication of the national trauma hotline from SAMHSA
- Encouraging a long-term active role of police and fire chaplains with their first responders
- Encouraging active support for the children of the community through their teachers, counselors and other community volunteers to listen to the children and offer emotional support

It is clearly necessary to be creative to meet the needs of an individual community. In Home Town these and other methods have been employed, yet there are still those who have needs and yet do not seek help.

### Outside Resources

**State and Federal Resources:** The Federal Emergency Management Association (FEMA) offers a wealth of resources during times of recovery. At times in the FEMA declaration they may include funding and other resources for emotional care of a community. While their funding is clearly needed at times of disaster, their website and often their representatives are often offer very valuable resources for emotional support.

**VOAD Resources:** In each state and often in local communities there is a coalition of non-government and faith based resources at times of recovery referred to as Volunteer Organizations Active in Disaster (VOAD). This organization is a coalition of most of the denominational disaster organizations as well as Red Cross who all work in times of disaster. By working with the VOAD a community will find a coordinated partner that offers a wide variety of resources to support the community.

**Role of the Church with Outside Resources:** Churches are critically involved in their own community. In part a reflection that their members *are* the community, religious organizations like the VOAD need to work together to celebrate the various gifts available in each congregation in order to support the entire community. Congregations are traditional sources of emotional support. For pastors, sermons, church newsletters, Sunday school groups and even support groups of various types are important resources for community recovery. Congregations need to determine which services will be open only to their own members and which will be open to the entire community. Denominational disaster organizations can often supply local congregations with suggestions and resources for disaster recovery support.

### Home Town

Home Town is a small rural community. Prior to the tornado, they did not have a lot of local social service resources and their religious resources were unaccustomed to working at times of disaster. They experienced the tornado as coming out of nowhere. Through the flurry of the disaster lives were lost and a large portion of the community lay in the path of the disastrous storm. The community stepped up with the belief that in time they will actually be better off than they were before. In Home Town, replacing homes and community infrastructure offers only one part of the restoration effort that also requires emotional and spiritual support.

While the community has been held together in part by their Polish cultural roots, over the years, persons of direct Polish lineage have become the minority in the community. Large numbers of Hispanic and African American persons now also live in Home Town. The emotional spiritual recovery effort worked with the community to shape their recovery identity around their resilience features. They are a friendly community that

is highly relational and they are clearly a community of persons who have faith in God. This more inclusive approach is intended to help Home Town to be inclusive in their recovery efforts.

Initially, Home Town has had numerous outside groups providing social work and chaplaincy services and resources to support the community. However, as the immediate needs were met, many of those resources pulled back. While there is clearly still significant emotional spiritual need, the community now needs to be working to develop more indigenous resources as the major trauma resources move on to the next community. The concept of emergency response is not intended to be long term or permanent. With the help of some of the larger non-government social service providers, a local field office of Catholic Charities or one of the other agencies will be coming to Home Town to offer longer term resources that can support the community.

Small children are often attracted to fire engines and other aspects of emergency response. However, children never think they will be the ones who need it. This feeling is inherited by adults who tend to see trauma elsewhere in our modern information and communication dense world. Individual congregations are sub-groups of the community and may require the same sort of trauma management as the community at large. Neighborhoods and other sub-groups of the community may need special attention either due to extreme need or as reflected in the needs of vulnerable populations. At times trauma response can be frustrating as traditional counselors may not wish to work with spiritual needs and some clergy may not see emotional needs. At other times reasonable people are able to offer the incredible support that can only come from caring persons in the community of faith. At the end of the day, a community like Home Town is made up of children of God who need each other, their congregations, community, and even the larger world around them. Trauma stinks, but if there is a silver lining, it is the privilege of working with people who make a difference. ❖

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# Field Test of a Peer Support Pilot Project Serving Federal Employees Deployed to a Major Disaster

Jon R. Wallace

*This article is based on the author's experience in developing and field testing a peer support pilot project designed to enhance operational functioning and promote workforce resilience through encouragement, support, and service to the employees of the Department of Homeland Security's Federal Emergency Management Agency (FEMA) Region VIII, in Denver, Colorado, during the period of September 2010–May 2013. This article presents the framework of a presence-based companionship model serving federal employee disaster responders and highlights the results of a field test of the pilot project. The dynamics of federal workers with military and first responder backgrounds and their potential reluctance to request services from a medical model are discussed as is the potential for the pilot project to serve as a bridge to additional work-life programs and as an individual means of resilience.*

**A**N ORGANIZATION'S MOST IMPORTANT ASSET IS ITS WORKFORCE. TO achieve its mission, the Department of Homeland Security (DHS) needs an informed, well-trained, well-led, and properly supported workforce. The DHS mission, "to ensure a homeland that is safe, secure, and resilient against terrorism and other hazards," cannot be taken lightly, nor can the role of its workforce in meeting that mission. The nature of the DHS work environment is inherently stressful and the responsibilities can weigh heavily on DHS employees at every level and in every facet of the organization (Institute of Medicine, 2013, p. 4).

In 2010 following the tragic death of an employee on disaster assignment and after the arrival of the new Presidentially appointed Regional Administrator who asked employees for ideas that could make FEMA better, I presented a concept proposal for the development of a Peer Support

Specialist pilot project. I was then a Disaster Recovery Division employee of FEMA Region VIII.

The Federal Emergency Management Agency employee ranks consist of many hundreds of retired and former military personnel and persons from the emergency services and disaster response and recovery occupations. FEMA personnel are subject to cumulative multiple disaster exposure and trauma situations throughout their careers and lengthy and extended separation from their family, friends, and local communities of support. With these facts in mind and following the tragic death of a deployed federal disaster relief worker, the Workforce Resilience Peer Support pilot project was designed and field-tested in FEMA Region VIII.

Prior to the development of the concept proposal, I had long been concerned about the stress exposure of federal workers on disaster deployments of every size, especially the effect of continuous deployment during multiple disasters and in those with exposure to extensive death and destruction. I met with a number of co-workers in various departments, engaging them in conversation relative to their perception of the availability of work-life programs and, if utilized, their effectiveness in dealing with such stresses.

A variety of comments were shared, including examples of deployment difficulties and accidents employees had experienced. One said "In all the years I've worked with FEMA I've rarely had anyone check on me if I ended up in the hospital. Get into an accident and you're pretty much on your own." Another, with a military background, said, "After my service on 9/11 I really needed someone to talk to." Still another with a military background said, "People need a place to go and talk. We are in a different type of battle but we are dealing with life safety and health issues all the time. We are people helping people but we really need to do a better job taking care of our own staff."

During these conversations I noted that co-workers with a military or first responder (police, fire, EMT) background said they were reluctant to contact the work-life employee assistance program for fear of it affecting their position. Many explained that, while in the military, they understood that their security clearance would be at risk for engaging mental health assistance and believed this to be true in their federal civilian job as well. Indeed the Institute of Medicine Report (Institute of Medicine, 2013) found that many in the DHS workforce believe that accessing services would adversely affect their positions, security clearances, or suitability. That has resulted in barriers to seeking help, which has an overall adverse effect on workforce readiness and resilience (Institute of Medicine, 2013, p. 13).

It is a persistent and sad reality of North American society that social stigma is one of the principle avoidance factors in the help-seeking process (Deane & Todd, 1996; Kushner & Sher, 1989). Personnel with past military experience believe that receiving treatment from the mental health system or from a mental health practitioner can have a career ending consequence

and may thus be reluctant by association to contact employee assistance program personnel when deployed by FEMA. The Department of Homeland Security (of which FEMA is a part) has a high number of veterans as part of its workforce. In 2012 the percentage stood at 27.4 % of the entire workforce (Office of Personnel Management, 2012). This means that potentially substantial numbers of federal disaster response and recovery workers may not receive the assistance and guidance they need for fear of reaching out to components they perceive as part of a mental health system. Given that FEMA personnel, especially those with a military or first responder background, are familiar with chaplains and peer support personnel, familiarity with these roles and capabilities may enable a level of understanding and trust not immediately elicited for clinical mental health personnel.

In fact, the number of former military members is likely to increase given President Obama's Presidential directive 13518 (2009) that requires federal departments to increase the hiring of veterans to supply the necessary skilled workers for operation of the federal government.

Following the Regional Administrator's consultation with the Disaster Recovery Division Director and other department heads, I was granted permission to develop the concept as Pilot Project Coordinator, a collateral volunteer duty, in addition to my work as a Voluntary Agencies Liaison. Thus the Peer Support pilot project was developed with a vision toward making a significant positive impact on the operational functioning, effectiveness, wellness, and resilience of federal emergency management employees.

### **Authority and Purpose**

The pilot project was developed to facilitate workforce resilience of federal employees specifically and is authorized by the U.S. Office of Personnel Management (OPM) within the provisions of the Employee Assistance Program (EAP). Peer Support is defined by OPM as an EAP Model, Peer-Based Program—an in-house program, typically delivered through trained peer/coworker volunteers. It usually offers education, training, and referrals. Peer Support Personnel are defined as federal employees who have volunteered to participate in an agency's Peer Support Program. Peers are non-professionals who usually have a limited role in assisting their peers when there are traumatic events at work or other personal challenges (OPM, 2008).

In developing the Region VIII Peer Support pilot it was discovered that a number of federal agencies employ chaplain or peer support programs in support of their federal workforces. These include the U.S. Army Corps of Engineers, the United States Coast Guard, and the Department of Homeland Security's Customs and Border Patrol Agency (CBP) among others.

Customs and Border Patrol chaplains provide support and training to employees and offer a ministry of presence to CBP personnel. "Chaplains

help others to find comfort, direction, and peace of mind when they are otherwise unable to find it” says Matt Ferguson, chaplain and Border Patrol National Chaplaincy Program Coordinator (Kinney, 2013, p. 16). According to Jesse Ramirez, program manager for the Border Patrol Chaplaincy and Peer Support programs, “offering employees moral support and education, the Peer Support Program enables employees to make healthy, informed decisions. More than 500 Border Patrol employees are trained and active Peer Support members” (Kinney, 2013, P. 21).

Disaster work can and may have a serious emotional impact on responders. FEMA personnel are exposed to and witness suffering and destruction as a routine part of their duties. They also arrive at their duty station bringing with them everything going on in their lives. This could be the recent death of a parent or spouse, general life challenges, or other issues that might affect job performance. The Peer Support Specialist pilot project provided a service to employees and the organization itself by responding to individual requests and providing encouragement and support needed in response to emergencies and a variety of issues. The Peer Support Specialist helped co-workers bridge these issues, linking them with internal work-life support elements through the sharing of information and by facilitating the employees’ connection with family and other personal support.

### **Military and Federal Civilian Employee Similarities**

In discussions with my coworkers and in my own experience, a number of similarities between deployed military personnel and federal disaster workers were identified. These included extended separation from family, friends, and familiar support systems; extensive and extended contact with disaster- or terrorism-caused destruction, disruption, death, and other injuries; occurrences of vicarious post-traumatic stress, marital challenges, loneliness, and depression; concern from family about employee health and safety; occasional verbal or physical assault; persistent negative media attention; personal illness or health concerns; automobile or other accidents causing hospitalization away from home; and renegotiating familial roles and responsibilities after an extended deployment absence (Meverden, 2010).

Given these similarities and based upon ongoing discussions with coworkers and regional management, I decided to speak to and learn from current and retired military chaplains and also to peer support programs in the fire (Colorado Springs Fire Department) and law enforcement (Colorado State Patrol) services. In addition, many employees spoke of their positive experience with military chaplains, stating their preference to speak to someone like a chaplain who could be in a position of forward deployment and accessible and who, if a chaplain, could bring the assurance of confidentiality.

During discussions with employees I was concerned to note the potential that a large number of employees may not apply to the work-life employee assistance program due to their military or first responder backgrounds. Therefore I decided to develop a peer support system utilizing existing FEMA employees experienced in the helping arts, trained to the standards of their individual professions, and with considerable experience in the field. What we needed were people skilled in listening and capable of providing an employee-focused ministry of presence. We found the qualifications and credentialing process for the United States military and other Department of Homeland Security agencies to be helpful references.

After consultation with regional management, I decided to identify, develop, and field-test FEMA employee peers to serve in the capacity of volunteer collateral-duty peer support specialists. I believed that the utilization of trained, certified, and endorsed co-workers familiar themselves with the rigors of disaster deployment could help navigate and bridge challenging issues and provide support and encouragement to the DHS-FEMA workforce.

### **Peer Support Specialist: A Collateral-Duty Volunteer Role**

The Peer Support Specialist role was designed to ensure that all FEMA employees deployed to Joint Field Offices, Disaster Recovery Centers, Staging Areas, Area Field Offices, Regional Offices, and other settings could be provided support and encouragement. Assistance was given regarding the issues of job and career stress, family concerns, and emergencies such as automobile accidents, serious illness, and hospital visits. The Peer Support Specialist was skilled in connecting with people from a wide range of backgrounds and was prepared to support staff with clarifying challenges, issues of grief and loss, general problems, and stress before these could lead to burnout or compassion fatigue. Peer Support Specialists, when requested by the Regional Administrator, Disaster Recovery Manager, or Federal Coordinating/Recovery Officer, would be deployed within their assigned qualification role and Division in a voluntary frontline collateral-duty. When deployed, the Peer Support Specialist worked closely with the Safety Officer and other internal FEMA work-life program components in the Joint Field Office.

FEMA Region VIII chose to field-test its pilot project by identifying three personnel with a history of service as a military or other chaplain. This provided the pilot project with personnel possessing a level of competence, training, and experience necessary to provide an effective service of encouragement and supportive presence without being perceived as a medical model mental health clinician and outsider. One retired U.S. Army Chaplain (Lt. Colonel), one retired U.S. Air Force Chaplain (Major), and one civilian Hospice Chaplain were identified and selected. All possessed a

Master's degree, were members of and subscribed to their respective professional associations' expectations and codes of conduct, and all were licensed or sanctioned by their supervising/endorsing agency (United Church of Christ, Evangelical Lutheran Church in America, and the United Methodist Church). One peer supporter had a part-time appointment with FEMA through the Rocky Mountain Conference of the United Methodist Church.

### **Project Characteristics**

#### **Mission Focused**

According to the Federal Emergency Management Agency's Publication 1, FEMA's mission is to support our citizens and first responders to ensure that as a nation we work together to build, sustain, and improve our capability to prepare for, protect against, respond to, recovery from and mitigate all hazards (FEMA, 2010). The FEMA Region VIII Peer Support pilot supports this mission by helping to enhance resilience for FEMA's invaluable employee workforce.

#### **FEMA Region VIII Peer Support Vision Statement**

Seeking to strengthen operational effectiveness and employee resilience, FEMA Peer Support Specialists are trained, certified, endorsed, or licensed mission ready volunteers demonstrating the highest commitment to compassionate service and maturity providing frontline encouragement, support, and service to their coworkers in FEMA Region VIII (Wallace, 2013).

#### **FEMA Region VIII Peer Support Mission Statement**

The region mission is to encourage, support, and serve the employees of the DHS-Federal Emergency Management Agency in FEMA Region VIII (Wallace, 2013).

#### **Workplace Peer Support**

The workplace puts people in close contact for the longest part of a person's waking hour workday. Because of the amount of time they spend together co-workers come to know each other and can often spot changes in functioning that might indicate personal difficulties. Co-workers can be effective in encouraging a person experiencing a personal challenge to get the help needed. Co-workers also provide a present and listening ear (California Peer Support Association, retrieved 2011).

In the workplace peer support is about co-workers, known as "peers" helping one another. In the general population an employee's personal

problems can affect their job performance and, if left unchecked, may lead to decreased functioning. The main objective of a peer support program is to resolve employee and workplace problems before they escalate to crisis levels by providing an extra network of support in the workplace (California Peer Support Association, retrieved 2011).

Peer Support Specialists give co-workers an opportunity to offer support and encouragement to the people they work with who are having personal challenges. *The basic principle of peer support is that coworkers provide a bridge between an employee with a problem and the people who can help them.* Peer support can offer help to a troubled coworker but not press them for details about “the problem” instead encouraging them to seek help in finding a solution or help them to reach out (California Peer Support Association, retrieved 2011).

### **Scope of Practice**

The FEMA Region VIII Peer Support Specialist has primary responsibility to every FEMA employee coworker:

1. To encourage, support, and serve FEMA employees based upon a model of companioning, assistive presence, listening, and information sharing in adherence to principles of confidentiality excepting only duty to warn situations.
2. To avoid and refrain from using a medical model or any kind of diagnostic classification system to determine employee wellness.
3. To encourage employee peer access to internal support including Alternative Dispute Resolution, Equal Employment Opportunity, and Employee Assistance and other work-life programs and assist peers to link with their own resources of support. (Wallace, 2013).

### **Centrality of Voluntary Inquiry**

Voluntary inquiry, made by an employee, was at the heart of the Peer Support Specialist's efforts. A Peer Support Specialist may become aware of coworkers needs while going about their duties and may inquire generally of coworker welfare but an employee's voluntary inquiry and request for the listening ear, support, and encouragement from a Peer Support Specialist is paramount (Wallace, 2013).

### **Core Responsibilities of the Peer Support Specialist**

The Peer Support Specialist contributes to the operational functioning, effectiveness, and wellbeing of federal emergency management personnel by performing, providing, identifying, and securing support, encourage-

ment, and assistance for federal government personnel. FEMA Peer Support Specialists are primarily involved with meeting the voluntary requests of coworkers, on occasion members of their families, and the occasional needs of operational leadership. Responsibilities of Peer Support Specialists include (Wallace, 2013):

- Serving as an on-site calm, listening, and supportive presence.
- Sharing information with the employee applicant and making referrals as requested.
- Supporting the coworker in his/her own effective and healthy methods of coping.
- Refrain from proselytizing or coercion of any kind. Such is prohibited.
- Provide immediate frontlines emergency support as needed or requested.
- Provide accompaniment and hospital visitation.
- Attend death and injury notifications in cooperation with the Safety Officer.
- Support operational functioning by providing workforce resilience training.
- Provide general consultation to leadership on employee morale, operational trends, new procedures or policies, and workplace environments.
- Attend situations involving accidents, serious injury, and death.
- Provide frontlines education, suicide prevention information, and, with additional internal work-life mechanisms, further support.

### **The Core Goals of the FEMA Region VIII Peer Support Specialist Pilot**

Core goals included (Wallace, 2013):

- Enhance employee operational functioning, resilience, and wellness.
- Enhance employee operational effectiveness and productivity.
- Increase employee retention, morale, and satisfaction.
- Facilitate increased camaraderie and help reduce employee stress.
- Increase employee morale and a sense of teamwork.
- Facilitate employee loyalty and commitment to FEMA's goals and objectives.
- Promote stronger teamwork and cross-departmental collaboration.
- Provides a fast, frontline, effective, and low cost collateral duty conducted by volunteers.
- Work towards positive attitudes and help reduced employee conflict.

- Build a sense of perceived management appreciation and community support.
- Help improve workplace safety.
- Facilitate the valuing of FEMA's most precious resource – its employees.

### **Guiding Principles and Volunteer Code of Service for Peer Supporters**

In addition to standard federal ethics requirements of all federal employees, the peer support specialists were specifically guided by principles and a code of volunteer service. These included maintenance of confidentiality, recognition of personal and professional limitations, avoidance of coercion or proselytizing, demonstration of sensitivity and respect for all, avoidance of speculation, and maintenance of flexibility and awareness of all who are affected by the disaster and emergency situations (Wallace, 2013).

### **Companioning versus Treatment Model**

In accordance with our priority to avoid any semblance of a mental health treatment approach a decision was made to adopt a companioning versus treatment philosophy. We found Alan D. Wolfelt's *Eleven Tenets of Caring for the Bereaved* (Wolfelt, 2015) a good reference.

Wolfelt defines companioning as the art of bringing comfort to another by becoming familiar with their story (experiences and needs). To companion the grieving person, therefore, is to break bread literally or figuratively, as well as listen to the story of the other. If your desire is to support a fellow human...you must create a "safe space" for people to embrace their feelings... This safe place is a cleaned-out, compassionate heart (Wolfelt).

Dr. Wolfelt says companioning is about being present to another person's pain; it is not about taking away the pain. Rather, companioning is about going to the wilderness of the soul with another human being; it is not about thinking you are responsible for finding the way out. Companioning is about walking alongside; it is not about leading or being led. Companioning is about listening with the heart; it is not about analyzing with the head. Companioning is about respecting disorder and confusion; it is not about imposing order and logic. Companioning is about compassionate curiosity; it is not about expertise (Wolfelt, retrieved 2015).

### **Field Test**

Utilizing an existing FEMA disaster assistance employee who was trained, certified, and endorsed by her credentialing agency as a hospice chaplain, the Peer Support Pilot Project was field-tested operationally on DR-1981-ND in 2011, a catastrophic and Presidentially declared disaster

occurring in Minot, North Dakota, during which the death of a FEMA employee occurred. The field test was initiated at the request of the Regional Administrator and with the approval of the Federal Coordinator Officer and the Recovery Division Director.

During the entire field-test period of August 3-October 14, 2011, there was a cumulative total of 430 emotional support meetings consisting of informal visits, and conversations between the Peer Support worker and requesting deployed personnel, 23 crisis interventions, 25 visits to hospitals, 36 visits to federal operational centers (Joint Field Office, Disaster Recovery Centers, Area Field Offices, and Staging Areas), and three staff trainings held on the topic of grief and dealing with the death of a co-worker, with a total of 45 employees trained. Referrals to additional federal support consisted of 4 referrals to alternate dispute resolution, 7 to the employee assistance mental health support, 7 to the equal rights officer, and 8 to the safety officer. Also, the Peer Supporter travelled more than 1,700 miles to meet with requesting employees at various operational sites.

While the field test couldn't be conducted scientifically, statistical information and feedback from operational elements and requesting employees were considerable.

Comments from operational elements included:

I was excited to know a peer supporter had been deployed and would be available to support FEMA staff. At times, we do refer a person to the EAP, however; having a person who can advise and support on premises is value-added for an employee who does not want to discuss personal issues with their manager or use an external resource.

From a Branch Director:

An example of positive work during this event was when we had a couple of medical transports from our center. In each case the peer supporter offered and accompanied the individual to the hospital and provided support and transportation back. The fact that she lived and worked day to day next to everyone else here earned her a level of credibility and acceptance that an outside counselor probably could not have achieved.

From a hospitalized FEMA employee:

I'm so glad you're here! I didn't think I'd have anybody to talk to except the emergency room doctor and my pillow!

Following the field test an after action report was produced that included observations and recommendations:

1. The presence of the Peer Supporter as a resident alongside her co-workers at the Responder Support Camp (RSC) located outside Minot, North Dakota, afforded immediate peer support access by requesting FEMA employees and afforded multiple opportunities to provide encouragement, support, and service.
2. Mobility of the peer supporter was critical and enabled contact in multiple locations in both Minot and Bismarck, North Dakota.
3. From the moment of her arrival at the RSC the Peer Supporter was immediately requested (even before her bag was unpacked) to provide support by both the Equal Employment (EEO) Officer and the Camp Director. The pace of requests for service continued at a high level for the entire field test.
4. Being in close proximity to co-workers on a 24-hour basis at the RSC and worksites required the Peer Supporter to set limits and pay attention to her own self-care.
5. Confusion existed as to where in the incident command organizational chart the Peer Support position should reside. A recommendation was made that the Peer Support Specialist should report directly to the Federal Coordinating Officer in the field and to the Regional Administrator in the regional office thereby enhancing leadership visibility of workforce functioning, resilience, and needs. This also would give the Peer Support Specialist operational authority from the highest levels of the Command Staff.
6. Upon the death of an employee the Federal Coordinating Officer did immediately call for the assistance of the Peer Support Specialist. At a memorial service for the employee at a local funeral home the Peer Supporter greeted and gave support to 30 attending coworkers.
7. The Federal Coordinating Officer requested the Peer Supporter meet with the four Section Chiefs on a one-on-one basis to assist them with developing active listening skills in order to assist their employees in dealing with grief over the unexpected death of their coworker.
8. A handout entitled "Active Listening Skills Following a Death Incident" was developed and shared with all Section Chiefs. A recommendation was made for this handout to be reproduced and made routinely available on future deployments.
9. It was determined that additional training would be helpful and so discussions were held with the FEMA Regional Administrator and the Federal Law Enforcement Training Center's Peer Support Training Program.
10. It was found that the Peer Supporter was often sought out to listen as coworkers blew off steam in trying circumstances. Recommendation was made that the Pilot Project Coordinator work

with the Mission Support Division to develop some measure of role effectiveness and employee satisfaction.

11. Recommendations were made to continue development of the Pilot Project with a view to working with FEMA employees to identify Disaster Assistance Employees and other FEMA employees who are already known as trusted coworkers that may desire to be trained for volunteer collateral duty as Peer Supporters.
12. Recommendation was made to look for opportunities to integrate Peer Support into future operations and drills or exercises so as to continue to field-test the model.

### **Implications of the Companionship Model**

The companionship model proved itself effective in field tests in a variety of settings, including in a disaster-affected community and in the regional office setting, both following the death of co-worker federal employees. Of critical importance to the success of the field tests was the utilization of a model familiar to federal personnel with first responder and military backgrounds—a person trained and endorsed to provide employee focused companionship and a supportive presence—the familiar role of a peer supporter. Also of critical importance was the design of the model to act not as a panacea of assistance on its own but as a supportive bridge to other work-life programs in support of federal disaster workers, including Alternative Dispute Resolution and the Employee Assistance Program among others.

In the realm of disaster response and recovery organizations, a number do provide spiritual and emotional care support to their workers. The Salvation Army and Samaritan's Purse are two such organizations. Others, like the American Red Cross, provide similar support provided by volunteer mental health professionals. The companionship model described in this article could be generalized for use in many organizations, even congregations and various faith communities involved in disaster work, but the model may be found especially useful in organizations employing large numbers of former military personnel and first responders familiar with service chaplains and other peer support personnel.

Whether in the field or walking through the hallways at FEMA Region VIII, I found that the consistent reaction of federal workers was one of surprise and delight that regional leadership had made a resource available specifically with workforce resilience and their support in mind. Such was also the reaction when National Guard chaplains were mission assigned in simulation during a preparedness exercise involving a catastrophic earthquake in a major metropolitan area.

Congregations and voluntary and faith-based disaster recovery organizations that wish to develop the companionship model in support of their

personnel must keep in mind that the focus must remain on the providers. In disaster and emergency situations tremendous support and resources are made available by local, state, and federal agencies and by a myriad of voluntary organizations to individuals, families, and communities directly impacted by disaster, the victims and the survivors. But what about the responders and recovery workers? The first responders, retired and current military personnel and paid and volunteer professionals exposed to the sights, sounds, smells, and feelings generated by disaster caused trauma? These individuals also must be prioritized for support and through the companioning model be bridged to additional specialized services when needed. Companioning can promote community and mutuality, camaraderie and an understanding of self-efficacy, and a sense of confidence and perceived social support among peers (Heisler, 2006).

Selection, training, credentialing, and supervision of peer support specialists will be critical in any setting. Standards of conduct and practice are available from a number of professional organizations and other sources, including those sanctioned by endorsing organizations or followed by military chaplains of the armed forces. The FEMA workforce is highly skilled and consists of many individuals with backgrounds in the helping professions. Once identified, interest and qualifications confirmed, training given, and consistent supervision provided, the Peer Support Specialist/Team has great potential to favorably impact FEMA's whole community goals and operational efficiency.

To have a companioning model in place and personnel identified and trained as a component of a comprehensive trauma prevention program could be invaluable in any community.

### **Conclusion**

With the vision and support of the FEMA Region VIII Regional Administrator and the senior regional management team and with the input of regional employees, the field test proved the value of a concept that was once but an idea and at the conclusion of May of 2013 was, according to the FEMA Human Capitol Office and U.S. Fire Administration, the first of its kind in FEMA. The sad events of the disaster deployment that included the accidental death of an employee were the type of circumstances that are dreaded and are hoped to be always avoided but for which the pilot project intentions and efforts proved providential.

Further opportunity for field-testing occurred in the summer of 2012 following the tragic death of a former regional employee who had been promoted to a job in another state. On this occasion the Regional Administrator requested the Pilot Project Coordinator check on regional coworkers and over 100 FEMA employees working throughout the Denver area were provided a listening ear and given a comforting visit of supportive presence.

In its report “A Ready and Resilient Workforce for The Department of Homeland Security: Protecting America’s Front Line,” the Institute of Medicine of the National Academies committee found, in 2013, that members of the DHS workforce were largely unaware of existing resources and services that were available to them that may enhance readiness and resilience or that of their families (Institute of Medicine, 2013).

The FEMA Region VIII Peer Support Pilot project proved its value in furthering employee knowledge of the support available to federal employees deployed on disaster assignment. Field tests proved the efficacy of the model and its effectiveness in providing support and service to the employees of the DHS-Federal Emergency Management Agency in Region VIII, Denver, Colorado.

While efforts to replicate the model are in development in other FEMA regions, it is hoped that the model will someday become a companion system of peer support available throughout the FEMA system within the Department of Homeland Security’s employee assistance and traumatic incident management systems. ❖

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**Jon R. Wallace**, MSW, M.Div., *following more than forty years of service in social work and disaster response and recovery is a candidate for ordination through the Denver Metro Association of the United Church of Christ. He has responded to multiple national disasters, most notably the Oklahoma City Bombing, the 911 Terrorist Attacks in New York City, the 2002 Statewide Colorado Fires, and Hurricane Katrina through service with the American Red Cross, The Salvation Army, and the Federal Emergency Management Agency. He resides in Concord, NC. Email: jonrwallace@me.com.*

**Keywords:** **Keywords:** disaster response and recovery, trauma exposure, workforce resilience, first responder and military experience, supportive presence, companioning, and peer support

## **Why I Am a Social Worker: 25 Christians Tell Their Life Stories**

NACSW is pleased to announce the July, 2015 publication of *Why I Am a Social Worker: 25 Christians Tell Their Life Stories* (2015) by Diana R. Garland. *Why I Am a Social Worker* describes the rich diversity and nature of the profession of social work through the 25 stories of daily lives and professional journeys chosen to represent the different people, groups and human situations where social workers serve.

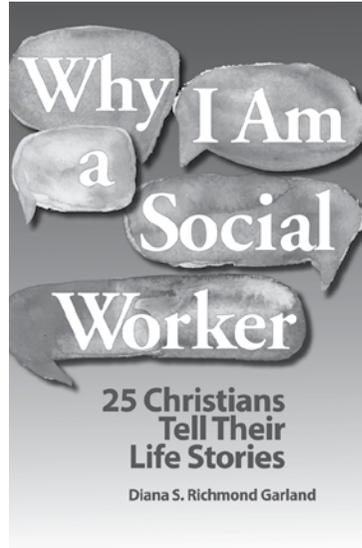
Many social workers of faith express that they feel “called” to help people – sometimes a specific population of people such as abused children or people who live in poverty. Often they describe this calling as a way of living out their faith. *Why I Am a Social Worker* serves as a resource for Christians in social work as they reflect on their sense of calling, and provides direction to guide them in this process.

*Why I Am a Social Worker* addresses a range of critical questions such as:

- How do social workers describe the relationship of their faith and their work?
- What is their daily work-life like, with its challenges, frustrations, joys and triumphs?
- What was their path into social work, and more particularly, the kind of social work they chose?
- What roles do their religious beliefs and spiritual practices have in sustaining them for the work, and how has their work, in turn, shaped their religious and spiritual life?

Dr. David Sherwood, Editor-in-Chief of *Social Work & Christianity*, says about *Why I Am a Social Worker* that:

I think this book will make a very important contribution. . .  
. . . The diversity of settings, populations, and roles illustrated by the personal stories of the social workers interviewed



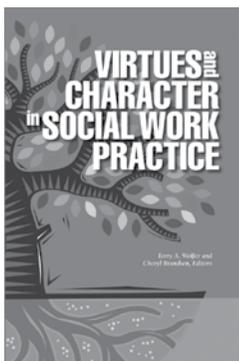
will bring the possibilities of social work to life in ways that standard introductory books can never do. The stories also have strong themes of integration of faith and practice that will both challenge and encourage students and seasoned practitioners alike.

**Dr. Diana Garland, PhD** was inaugural Dean of the Diana R. Garland School of Social Work, Baylor University, Waco, Texas. She authored, co-authored, or edited 19 other books, including *Congregational Social Work: Christian Perspectives* (NACSW, 2014), and *Family Ministry: A Comprehensive Guide* (InterVarsity Press, 2012). Dr. Garland published more than 150 professional articles and book chapters.

*Why I Am a Social Worker: 25 Christians Tell Their Life Stories* (2015), (ISBN # 978-0-9897581-0-9) is 220 pages long, and is now available at NACSW's on-line bookstore for \$29.95 - or only \$23.95 for NACSW members (plus shipping).

#### **VIRTUE AND CHARACTER IN SOCIAL WORK PRACTICE**

*Edited by Terry A. Wolfer and Cheryl Brandsen. (2015). Botsford, CT: NACSW. \$23.75 U.S., \$19.00 for NACSW members or orders of 10 or more copies). For price in Canadian dollars, use current exchange rate.*

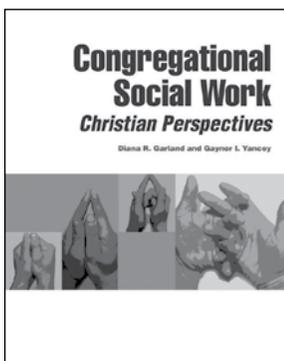


*Virtues and Character in Social Work Practice* offers a fresh contribution to the Christian social work literature with its emphasis on the key role of character traits and virtues in equipping Christians in social work to engage with and serve their clients and communities well.

This book is for social work practitioners who, as social change agents, spend much of their time examining social structures and advocating for policies and programs to advance justice and increase opportunity.

**CONGREGATIONAL SOCIAL WORK: CHRISTIAN PERSPECTIVES**

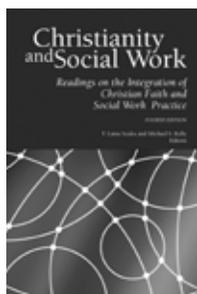
Diana Garland and Gaynor Yancey. (2014). Botsford, CT: NACSW. \$39.95 U.S., \$31.95 for NACSW members or orders of 10 or more copies). For price in Canadian dollars, use current exchange rate.



*Congregational Social Work* offers a compelling account of the many ways social workers serve the church as leaders of congregational life, of ministry to neighborhoods locally and globally, and of advocacy for social justice. Based on the most comprehensive study to date on social work with congregations, *Congregational Social Work* shares illuminating stories and experiences from social workers engaged in powerful and effective work within and in support of congregations throughout the US.

**CHRISTIANITY AND SOCIAL WORK: READINGS ON THE INTEGRATION OF CHRISTIAN FAITH & SOCIAL WORK PRACTICE (FOURTH EDITION)**

T. Laine Scales and Michael S. Kelly (Editors). (2012). Botsford, CT: NACSW \$55.00 U.S., \$42.99 for NACSW members or orders of 10 or more copies. For price in Canadian dollars, use current exchange rate.

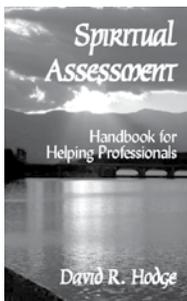


At over 400 pages and with 20 chapters, this revised fourth edition of *Christianity and Social Work* includes six new chapters in response to requests by readers of previous editions. We have included new chapters on issues of sexual orientation, Evidence-based Practice (EBP) as well as an enhanced section on the role of Christianity in social welfare history. It is written for social workers whose motivations to enter the profession are informed by their Christian faith, and who desire to develop faithfully Christian approaches to

helping. The book is organized so that it can be used as a textbook or supplemental text in a social work class, or as a training or reference materials for practitioners. Readings address a breadth of curriculum areas such as social welfare history, human behavior and the social environment, social policy, and practice at micro, mezzo, and macro levels.

**SPIRITUAL ASSESSMENT: HELPING HANDBOOK FOR HELPING PROFESSIONALS**

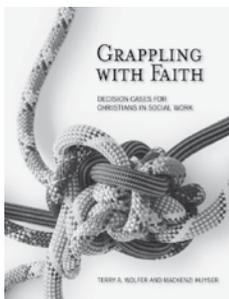
David Hodge. (2003). Botsford CT: NACSW \$20.00 U.S. (\$16.00 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.



A growing consensus exists among helping professionals, accrediting organizations and clients regarding the importance of spiritual assessment. David Hodge's *Spiritual Assessment: Helping Handbook for Helping Professionals*, describes five complementary spiritual assessment instruments, along with an analysis of their strengths and limitations. The aim of this book is to familiarize readers with a repertoire of spiritual assessment tools to enable practitioners to select the most appropriate assessment instrument in given client/practitioner settings. By developing an assessment "toolbox" containing a variety of spiritual assessment tools, practitioners will become better equipped to provide services that address the individual needs of each of their clients.

**GRAPPLING WITH FAITH: DECISION CASES FOR CHRISTIANS IN SOCIAL WORK**

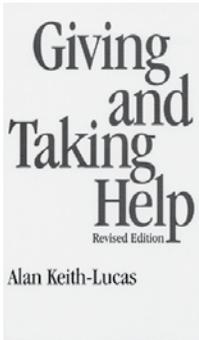
Terry A. Wolfer and Mackenzi Huyser (2010) \$23.75 (\$18.99 for NACSW members or for orders of 10 or more). For price in Canadian dollars, use current exchange rate.



*Grappling with Faith: Decision Cases for Christians in Social Work* presents fifteen cases specifically designed to challenge and stretch Christian social work students and practitioners. Using the case method of teaching and learning, *Grappling with Faith* highlights the ambiguities and dilemmas found in a wide variety of areas of social work practice, provoking active decision making and helping develop readers' critical thinking skills. Each case provides a clear focal point for initiating stimulating, in-depth discussions for use in social work classroom or training settings. These discussions require that students use their knowledge of social work theory and research, their skills of analysis and problem solving, and their common sense and collective wisdom to identify and analyze problems, evaluate possible solutions, and decide what to do in these complex and difficult situations.

**GIVING AND TAKING HELP (REVISED EDITION)**

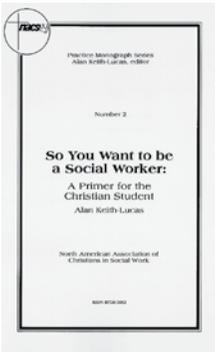
Alan Keith-Lucas. (1994). Botsford CT: North American Association of Christians in Social Work. \$20.75 U.S. (\$16.50 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.



Alan Keith-Lucas' *Giving and Taking Help*, first published in 1972, has become a classic in the social work literature on the helping relationship. *Giving and taking help* is a uniquely clear, straightforward, sensible, and wise examination of what is involved in the helping process—the giving and taking of help. It reflects on perennial issues and themes yet is grounded in highly practice-based and pragmatic realities. It respects both the potential and limitations of social science in understanding the nature of persons and the helping process. It does not shy away from confronting issues of values, ethics, and world views. It is at the same time profoundly personal yet reaching the theoretical and generalizable. It has a point of view.

**SO YOU WANT TO BE A SOCIAL WORKER: A PRIMER FOR THE CHRISTIAN STUDENT**

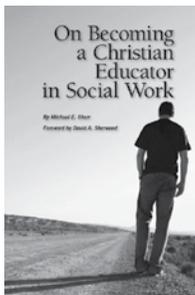
Alan Keith-Lucas. (1985). Botsford, CT: NACSW. *Social Work Practice Monograph Series*. \$11.50 U.S. (\$9.00 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.



*So You Want to Be a Social Worker* has proven itself to be an invaluable resource for both students and practitioners who are concerned about the responsible integration of their Christian faith and competent, ethical professional practice. It is a thoughtful, clear, and brief distillation of practice wisdom and responsible guidelines regarding perennial questions that arise, such as the nature of our roles, our ethical and spiritual responsibilities, the fallacy of “imposition of values,” the problem of sin, and the need for both courage and humility.

**ON BECOMING A CHRISTIAN EDUCATOR IN SOCIAL WORK**

Michael Sherr (2010) \$21.75 (\$17.50 for NACSW members or for orders of 10 or more). For price in Canadian dollars, use current exchange rate.



*On Becoming a Christian Educator* is a compelling invitation for social workers of faith in higher education to explore what it means to be a Christian in social work education. By highlighting seven core commitments of Christian social work educators, it offers strategies for social work educators to connect their personal faith journeys to effective teaching practices with their students. Frank B. Raymond, Dean Emeritus at the College of Social Work at the University of South Carolina suggests that “Professor Sherr’s book should be on the bookshelf of every social work educator who wants to integrate the Christian faith with classroom teaching. Christian social work educators can learn much from Professor Sherr’s spiritual and vocational journey as they continue their own journeys and seek to integrate faith, learning and practice in their classrooms.”

**HEARTS STRANGELY WARMED: REFLECTIONS ON BIBLICAL PASSAGES RELEVANT TO SOCIAL WORK**

Lawrence E. Ressler (Editor). (1994). Botsford, CT: North American Association of Christians in Social Work. \$9.25 U.S. (\$7.50 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.

*Hearts Strangely Warmed: Reflections on Biblical Passages Relevant to Social Work* is a collection of devotional readings or reflective essays on 42 scriptures pertinent to social work. The passages demonstrate the ways the Bible can be a source of hope, inspiration, and conviction to social workers.

**THE POOR YOU HAVE WITH YOU ALWAYS: CONCEPTS OF AID TO THE POOR IN THE WESTERN WORLD FROM BIBLICAL TIMES TO THE PRESENT**

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**ENCOUNTERS WITH CHILDREN: STORIES THAT HELP US UNDERSTAND AND HELP THEM**

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To order a copy of any of the above publications, please send a check for the price plus 10% shipping and handling. (A 20% discount for members or for purchases of at least 10 copies is available.) Checks should be made payable to NACSW; P.O. Box 121, Botsford, CT 06404-0121. Email: [info@nacsw.org](mailto:info@nacsw.org) 203.270.8780.

## CALL FOR PAPERS: SPECIAL ISSUE OF *SOCIAL WORK AND CHRISTIANITY*

**Topic:** Faith, Religion and Migration  
**Date of Issue:** Spring 2017  
**Guest Editors:** Breanne Grace and Benjamin Roth  
**Deadline:** September 1, 2016

Three percent of the world's population are international migrants. Whether they are immigrants who cross nation-state borders voluntarily, refugees who are displaced by conditions in their home country, or asylees who are fleeing persecution, a greater percentage of the global population than ever before is living in a country that is not originally their own. The reception that migrants receive varies considerably.

Given the magnitude of migration, the complexity of the migratory process, and the multiple factors affecting integration, there is no single migration experience. However, religion and faith are woven into contemporary migrations in ways that have significant implications for immigrants, their families and the places where they settle. This special issue of *Social Work and Christianity* will explore the role of religion, religious institutions, and/or faith in contemporary migratory processes (including why individuals leave, their migration experience itself, and/or the challenges of adjusting to a new home once they arrive).

Submissions in the following areas are particularly requested:

- **Conceptual** offerings providing definitional clarity and theoretical frameworks related to how religion, religious institutions, and/or faith intersects with contemporary migration.
- Articles that apply social work **practice** to working with migrants, with a special focus on religion/faith, at the micro, mezzo, and macro levels.
- Articles focused on **research** or **research methods** related to religion/faith and migration.
- Articles focusing on the **history** of religion/faith and migration in social work education and practice.

### **Guidelines for submitting manuscripts:**

All authors are strongly encouraged to contact the special edition editors by email (see contact information below) by June 1, 2016 to discuss ideas for paper submissions. **The deadline for all paper submissions is September 1, 2016.**

Articles submitted to SWC should begin with a title page, including the author's name, address, phone number, email address, abstract of no more than 200 words, a list of key words, and an indication of whether or not the author would like the manuscript to be peer-reviewed. The article text should be double-spaced and limited to 20–25 pages, including all references and appendices (please use the 6<sup>th</sup> edition of the American Psychological Association Style Manual format for in-text references and reference lists). Manuscripts should be submitted electronically as email attachments, preferably in Microsoft Word, to either Benjamin J. Roth (rothbj@sc.edu) or Breanne Grace (breanne.grace@sc.edu) **by September 1, 2016.**



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## NORTH AMERICAN ASSOCIATION OF CHRISTIANS IN SOCIAL WORK

NACSW's mission is to equip its members to integrate Christian faith and professional social work practice.

Its goals include:

- Supporting and encouraging members in the integration of Christian faith and professional practice through fellowship, education, and service opportunities.
- Articulating an informed Christian voice on social welfare practice and policies to the social work profession.
- Providing professional understanding and help for the social ministry of the church.
- Promoting social welfare services and policies in society which bring about greater justice and meet basic human needs.

