# Clergy Knowledge of Trauma and Intervention with Rural Help-seekers

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**Abstract**

Clergy often serve as frontline mental health workers for their faith communities, particularly in rural areas. Due to the intimate and longstanding nature of the relationships clergy develop with members of their congregation, as well as the stigma surrounding mental illnesses that may prevent rural help-seekers from pursuing traditional mental health care, clergy often provide a source of support and counsel. The tendency to provide care and support for help-seekers places clergy in a position to assist individuals experiencing posttraumatic stress reactions. The responsibility and strain of supporting trauma survivors has the potential to increase rates of burnout and secondary traumatization in clergy. This study utilized a consensual qualitative research design to explore the relationship between clergy knowledge about, and intervention with, trauma in rural areas, as well as the impact this work has on clergy self-care practices and coping.

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# Chapter 1

## Clergy Knowledge of Trauma and Intervention with Rural Help-seekers

Previous research has indicated that both rural and urban persons of faith often seek assistance from clergy when dealing with traumatic experiences of multiple natures (e.g., combat, interpersonal, natural disaster; Weaver, 1993). However, rural locales present unique challenges to rural residents in need of mental health services. In lieu of mental health care, rural residents often rely on informal sources of care, including self-help, family, friends, and religious organizations (Blank, Mahmood, Fox, & Guterbock, 2002; Fox, Merwin, & Blank, 1995). Little is known about the nature of collaboration between clergy members and psychologists serving residents of rural areas. This gap in the literature provides an obstacle to the mission the American Psychological Association's Committee on Rural Health has detailed, including pursuit of collaborative and interprofessional care, and of traditional and nontraditional healing practices (American Psychological Association, 2017). Furthermore, there is little information about the ways in which members of rural clergy intervene with trauma survivors and care for themselves as they provide this type of support and care to help-seekers. This study explored this phenomenon to better understand current systems in operation.

While trauma has been noted to occur across geographical settings (American Psychological Association, 2013), trauma survivors do not always have access to mental health care due to service provider shortages (Lutifyya, Bianco, Quinlan, Hall, & Waring, 2012; U.S. Department of Health and Human Services, 2011). Furthermore, it is unknown how faith leaders in rural areas conceptualize trauma and intervene with survivors. There is a paucity of research examining the consequences of clergy members ministering to rural help-seekers with trauma-related concerns; however, the literature documents that engaging in counseling activities with

trauma survivors can elicit negative consequences for the caregiver (e.g., Galek, Flannelly, Greene, & Kudler, 2011; Hendon, Irving, & Taylor, 2014; Holaday, Lackey, Boucher, & Glidewell, 2001). Thus, this study also sought to increase mental health professionals' and clergy members' knowledge of self-care and coping strategies that rural clergy members utilize in order to promote good work-related psychological health.

**Clergy as Frontline Mental Health Professionals**

Clergy have been described by females from diverse religious groups (Cinirella & Lowenthal, 1999) and by male and female Christians living in the United Kingdom (Mitchell & Baker, 2000) as helpful, caring people who offer long-term and holistic care. Moreover, the literature has suggested that clergy often serve as frontline helping professionals within their community (Weaver, Flannelly, Flannelly, & Oppenheimer, 2003; Weaver, Koenig, & Ochberg, 1996), placing them in a position to respond to many stressors that could evoke symptoms of posttraumatic stress in members of their congregation. Weaver (1995) argued that a member of the clergy is just as likely as a mental health professional to be approached by an individual with a severe mental illness who is seeking assistance and support, particularly in rural areas. In the United States, recent economic downturns have led rural, community-based mental health organizations to experience increased pressure to reduce their operations by closing satellite clinics (Ferdinand, Madkins, McMaughan, & Schulze, 2015). This decrease in service providers may increase the probability that individuals who are suffering from psychological distress will seek the support of clergy members, rather than that of mental health professionals, in addition to cultural factors (e.g., rural residence, spiritual and religious beliefs, stigma).

Wang and colleagues (2006) studied patterns of help-seeking within various service sectors or sources of mental health support. Findings suggested the rural United States

predominantly relies on religious leaders for the mental health care needs of rural residents, while urban areas have increased utilization of mental health services. Thus, it appears that clergy serve an important role within rural areas, both as faith leaders, but also as frontline mental health workers (Ellison, Vaaler, Flannelly, & Weaver, 2006; Leavey, Lowenthal, & King, 2007; Wang et al., 2006).

**Clergy training in mental health.** The literature notes that clergy members are often poorly prepared to identify and address mental health concerns (Hankerson, Watson, Lukachko, Fullilove, & Weissman, 2013; Kramer et al., 2007). With regard to working with survivors of sexual abuse and assault, faith leaders from various religious backgrounds have reported feeling unprepared to respond to these help-seekers because this type of training is not included in their preparation for ministry (Bruns et al., 2008). Thus, clergy often pursue additional training regarding mental health concerns through workshops, seminars, or continuing education events (Orthner, 1986; Rupert & Rogers, 1985; Wright, 1984). Furthermore, faith leaders have recently expressed that specific information on ways to engage in best practices with help-seekers who have a history of trauma, as well as guidance on how and where to refer helps-seekers for further support, would be beneficial (Bruns et al., 2008).

**Clergy intervention with trauma.** Trauma survivors are considered (a) those who have directly been exposed to actual or threatened death, serious injury, or sexual violence, as well as individuals who have witnessed such incidents, (b) those who have learned of such an event happening to a loved one, or (c) persons who are repeatedly exposed to aversive details of traumatic events (e.g., first responders, law enforcement officers; American Psychiatric Association, 2013). While most clergy members do not receive specific training to intervene with trauma survivors in their ministry preparation, they are often sought out by help-seekers.

Additionally, their greater involvement with members of the community may place them in an advantageous position to address issues of trauma (Weaver et al., 1996). It has been noted that traditional mental health care may not address spiritual or religious distress that may develop following a traumatic experience (Mahedy, 1986), resulting in an intervention that is not comprehensive (Decker, 1993; Fallot, 1997).

Clergy members can offer many types of support to trauma survivors. Neighbors, Musick, and Williams (1998) noted that clergy members offer a wide variety of assistance to all help-seekers, such as praying and reading the Bible with help-seekers, allowing them to talk about their concerns, giving general advice, providing comfort and sympathy, providing monetary assistance, and referring the individual to another clergy member for assistance and support. Clergy support provided to trauma survivors has included aiding in creating an integrated narrative or story about a traumatic event (Rynearson, 2010), exploring one's history and experience with religion before and after a traumatic experience, and helping a trauma survivor to discover meaning and purpose in life following a trauma (Wilson & Moran, 1998). Zuniga and Davis (2010) added that clergy members can assist trauma survivors by asking debriefing questions about the event that allow the survivors to disclose their experiences and begin to regain a sense of safety and security.

Everly (2000) noted that clergy members can play a valuable role in responding to crises by integrating religious, spiritual, and counseling resources to intervene with a survivor during crisis by providing him or her with a confidential opportunity to discuss concerns and capitalize on faith-based social support and practices (e.g., prayer, scripture reading). Furthermore, Mahedy (1986) noted that spiritual and traumatic stress often developed simultaneously in the general veteran population. He proposed a treatment program that combined principles of Alcoholics

Anonymous with treatment for posttraumatic stress disorder (PTSD) in order to focus on survivors' lack of control over circumstances surrounding their traumatic experiences, recognition of a higher power, and consideration of their personal responsibility for managing their thoughts, feelings, and actions. Thus, clergy members can play a wide range of roles in supporting help-seekers who have experienced trauma.

**Clergy collaboration with mental health professionals.** The current understanding of collaboration between mental health professionals and clergy members highlights a complex and multifaceted process, with varied perspectives represented in the literature. For example, several early investigations reported that clergy referred less than 10% of individuals they were counseling to mental health professionals (Heng & Vernon, 1974; Larson, 1968; Piedmont, 1968; Virkler, 1979). More recently, Horne and Levitt reported that most clergy expressed the belief that counseling could be helpful for trauma survivors and indicated they would refer these individuals to a mental health provider (2003). Whereas the literature presents an unclear picture of collaboration between members of the clergy and mental health professionals, it seems important to better understand this relationship to address any obstacles that may impede successful partnership between the two professions in service of caring for one's communities.

Many factors have been identified that limit collaboration between clergy and mental health professionals. Bruns and colleagues (2008) found that faith leaders expressed frustration at poor communication with mental health care providers and poor dissemination of information regarding available services for those in need of mental health care. It is possible that some difficulty in communicating with mental health professionals relates to the regulations put forth by the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, which limits the disclosure of patients' information without their express and written permission (U.S.

Department of Health and Human Services, 2015). Concern regarding the ability of mental health professionals to practice competently with clients who endorse religious or spiritual beliefs has also been reported. Pattison (1969) stated that clergy may avoid referrals to secular counselors due to confusion about the therapists' professional role and activities, a perceived lack of respect for clergy by secular counselors, religious beliefs that inhibit referrals, and the difficulty many working-class individuals experience in accessing mental health care. More recently, it has been noted that potential clients may avoid using mental health services when the mental health provider is perceived to have a bias or prejudice against religion and spirituality. The possibility of these attitudes also has continued to limit the referrals clergy are willing to make to mental health professionals, due to concerns that the spiritual or religious aspects of an individual's distress may be ignored, or worse, pathologized, during psychotherapy (Richards & Bergin, 2000; Worthington & Sandage, 2002). Ringel and Park (2008) added that clergy expressed concern that mental health professionals may encourage help-seekers to identify solutions that are not in accordance with their religious values (e.g., separation or divorce from one's partner in the case of interpersonal conflict and violence). Given these concerns, it appears that the relationship between members of clergy and psychologists may remain tenuous in rural areas, potentially limiting collaboration between the two fields for community members in need of psychological and spiritual support following a traumatic event.

**Significance of Rural Areas for the Present Study**

The present study focused on the role rural clergy members fill in providing support to trauma survivors. Additionally, the study aimed to gain greater insight into how this type of work impacts clergy members and the ways in which they manage stresses stemming from working with trauma survivors. Much of the research examining clergy knowledge and skill in addressing

trauma among churchgoers has been conducted in urban settings (e.g., Chalfrant et al., 1990; Horne & Levitt, 2003; Mollica, Streets, Boscarino, & Redlich, 1986), leaving a gap in the literature representing rural areas. Furthermore, mental health professionals practicing in rural areas are more likely to experience isolation and increased role strain (Cohn & Hastings, 2013). Given the many obligations clergy members fulfill (Doolittle, 2007) in addition to intervening with help-seekers who have experienced trauma, it is possible that clergy members could be facing similar vulnerability to role strain and potential burnout.

**Unique characteristics of rural areas.** Despite multiple attempts to create one universal definition of what constitutes rural, there has yet to be the introduction of a uniform classification system (Wagenfeld, 2003). However, Cordes (1990) noted that the consistent theme across rural areas is inherently low population density, meaning that there are fewer residents per unit of measure (e.g., square mile) compared to more populated areas. Wagenfeld, Murray, Mohatt, and DeBruyn (1993) noted that "rural" is a state of mind that is accompanied by unique values and behaviors. For instance, values held by rural communities are reported to differ from those found in urban settings in that they stress self-reliance, conservative attitudes, distrust of outsiders, focus on religion, work orientation, commitment to one's family, individualism, and fatalism (Wagenfeld, 2003). Slama (2004) has argued that conventional attitudes characteristic of rural inhabitants combined with low population density facilitate a "goldfish bowl effect" in which one's personal life is public due to fewer residents, thus limiting the degree to which people are open about aspects of themselves (e.g., psychological distress) and heightening typical levels of stigma surrounding mental illness. This "goldfish bowl" environment, in which noticing the businesses and establishments one's peers frequent is commonplace, can discourage people from

seeking treatment for their psychological distress for fear of being seen at a mental health professional's office and being the subject of gossip or of being ostracized.

In addition to the limitations created by the social environment of rural areas, the literature on utilization of mental health services in rural areas has documented many barriers to accessing mental health care, including mental health care professional shortages (Lutifyya et al., 2012; U.S. Department of Health and Human Services, 2011), shame associated with seeking services (Robinson et al., 2012), limited confidentiality in one's daily life due to living in a "goldfish bowl" (Slama, 2004), as well as the costs of obtaining mental health care (Barker, Londeree, McBride, Kemper, & Mueller, 2013; Mojtabai, Chen, Kaufman, & Crum, 2014; Robinson et al., 2012).

Given the unique atmosphere and challenges rural residents face, those in need of mental health support often rely on informal sources of care including self-help, family, friends, and religious organizations (Blank et al., 2002; Fox et al., 1995). Individuals receiving support from clergy often do not have to negotiate concerns related to stigma, confidentiality, or the financial costs associated with traditional mental health care because of the generally greater acceptance and ease of consulting with a faith leader (Ferdinand et al., 2015). Moreover, Weaver and colleagues (1996) have noted that rural individuals who have experienced trauma seek support from clergy members for many reasons, including the role religion and faith may play in their lives, the often long-term relationships that are formed between clergy and members of their congregation, limited access to mental health professionals in rural areas, and issues of client mistrust toward mental health professionals. Clergy members are able to support trauma survivors as they attempt to make sense of their experiences in relation to their religious beliefs. Furthermore, clergy members often form long-term and emotionally close relationships with

members of their faith communities, allowing them to explore the thoughts and feelings a trauma survivor may be struggling with following a traumatic experience. Finally, rural culture is often characterized by a close-knit community that is not always open to or trusting of "outsiders," which may decrease the likelihood that help-seekers will seek out a mental health professional for support (Weaver et al., 1996).

**Clergy self-care practices.** Given the numerous and varied demands clergy members face in their work (Lewis, Turton, & Francis, 2007), as well as challenges in seeking consultation or supervision within their own organization (Bruns et al., 2008), the active and consistent practice of self-care and coping strategies can offer protective and preventive benefits. Numerous types of clergy self-care or coping strategies have been reported in the literature, including prayer, setting boundaries around one's family time, using caller identification on one's telephone, living away from the church's location, socializing with one's friends and family, and engaging in emotional distancing or compartmentalizing practices (Holaday et al., 2001). Kaldor and Bullpitt (2001) noted that some coping strategies are more effective in preventing stress than others, such as delegating work to others, reorganizing one's time and priorities, and seeking out additional trainings, whereas Doolittle (2007) noted that maladaptive coping strategies may include venting, disengaging from one's work, and engaging in self-blame. Meek and colleagues (2003) reported that clergy members highlight the importance of engaging in intentional activities to maintain well-being, as well as maintaining self-awareness regarding their involvement in their ministry and its impact on their personal faith. Regular practice of coping skills, particularly spiritually renewing activities, has been found to ward off the effects of burnout (Chandler, 2009).

The literature suggests the work of clergy members is often stressful and leads to increased risk for burnout, with some reports as high as a 50 percent rate of burnout among clergy members (Merritt, 2010). The stress associated with the role of a clergy member, coupled with potential isolation in rural areas (Cohn & Hastings, 2013) and limited ability to consult with other members of one's profession (Bruns et al., 2008) may place rural clergy members who are working with trauma survivors at increased risk for developing burnout and other negative consequences. For this reason, the current study seeks to explore this interaction between rural clergy intervention with help-seekers who have experienced trauma and the impact of this work on clergy health and well-being.

**Purpose of Present Study**

Given the American Psychological Association's (2017) recent interest in addressing mental health disparities in rural settings, as well as the knowledge that within rural areas members of the clergy are often preferred by help-seekers (Ferdinand et al., 2015; Weaver et al., 1996) and may be the only helping professional available (Lutifyaa et al., 2012; Weaver et al. 2003), this study sought to broaden the understanding of psychologists of the role rural clergy play in providing support to trauma survivors and the impact of this work on rural clergy members. This study also aimed to understand rural clergy members' perceptions of collaboration with psychologists in rural contexts. These aims were accomplished by collecting interview and questionnaire data from clergy members that were analyzed using consensual qualitative research (CQR) methodology (Hill et al., 1997).

It is believed that information obtained through these efforts will grant a deeper understanding of rural clergy intervention with survivors of trauma and the self-care practices in which they engage in order to cope with the impact of their work. It is hoped that information

gained regarding clergy self-care practices can be used to advocate for (a) increased support within their faith communities and the mental health profession and (b) increased training in self-care and resource provision (e.g., consultation and debriefing with other faith leaders) throughout the course of ministerial work.

It is also hoped that the knowledge obtained through this process can be used in a manner that allows clinicians to practice in a more holistic and culturally sensitive manner characteristic of counseling psychologists (Gelso, Williams, & Fretz, 2014) and expand the literature base and discourse related to religious and spiritual diversity. Furthermore, it is believed that through this process of inquiry and data collection, information can be gained to guide efforts focused on enhancing collaboration between members of clergy communities and mental health professionals in rural areas to benefit clients who experience traumatic stress.

The present study seeks to answer the following questions through consensual qualitative analysis of interview data (Hill et al., 1997):

1. What preparation do rural clergy members receive to provide care specifically to trauma survivors?
2. How do rural clergy members approach the process of intervention with rural help-seekers who have experienced trauma?
3. Are rural clergy members able to engage in consultation within their religious organization regarding work with trauma survivors?
4. What is the experience of rural clergy members as they interface with mental health professionals?
5. How does intervening with rural help-seekers who have experienced trauma affect the health and well-being of rural clergy members?

6. How do rural clergy members cope with the stress of intervening with rural help-seekers who have experienced trauma?

## Method

### Participants

For the purpose of this study, given the prevalence of Christian churches and faith communities within Appalachian rural areas, Christian clergy members were recruited (Vaaler, 2008) throughout rural areas of Southwestern Virginia. Selection criteria for participants included completion of Christian seminary training, a current active leadership role within a church, and current service in rural churches and communities. The final sample (N = 8) was predominantly male (62.5%), with an average age of 48.6 years (SD = 13.9). Overall, 75% of participants identified as White, with 12.5% African American and 12.5% as Sri Lankan. Seventy-five percent of the sample had completed the majority of their ministerial experience in rural settings. Fifty percent of participants had obtained a Master of Divinity, whereas 25% of the sample was currently in seminary and the remainder of the sample had completed training in less formal venues (e.g., online coursework and denominational trainings). One participant had completed zero courses pertaining to counseling, four had completed between one and three classes; one completed six, and two completed more than 15 courses. Half of the sample rarely discussed issues related to trauma during their coursework, while the remainder reported frequent discussions of this topic during training. One third of the sample had sought additional training related to trauma separate from their seminary training. Notably, all participants endorsed some type of personal traumatic life experience (see Table 1).

## Interview Protocol

The semi-structured interview protocol was developed from available literature based on clergy intervention with trauma survivors, clergy experiences interfacing with mental health professionals, and clergy self-care practices. The interview protocol consisted of open-ended questions pertaining to clergy respective knowledge of trauma, experience in working with survivors of trauma, consultation with other clergy members and/or with community mental health professionals, the impact of working with trauma survivors on their relationships and health, and coping strategies employed to manage these reactions (see Appendix C). All participants were asked the same questions and the interviewer pursued new or additional areas that arose from participants' responses.

## Instruments

**Demographic questionnaire** (see Appendix B). In order to have a more detailed context within which to consider interview responses, information on the following areas was gathered: locale of ministry, age, sex, ethnicity, religious denomination, years in the ministry, size of current congregation, training received to become a minister, number of seminary classes pertaining to counseling, frequency of discussions about trauma in coursework, trainings pertaining to trauma completed since seminary, and personal history of trauma.

## Procedures

Following approval from the Radford University Institutional Review Board, a recruitment email was disseminated through a local Christian clergy listserv. Nine individuals expressed interested in participation; one individual was excluded due to lack of fit with the inclusion criteria, as reflected by his non-rural background and history of practice, limited experience working with rural populations, and limited knowledge of trauma and encounters

with help-seekers who had experienced trauma. In-person interviews were coordinated via email or telephone. As part of the scheduling procedure, participants were given a brief summary of the purpose of the study and completed a brief screening questionnaire (see Appendix A) to verify their fit with the study's inclusion criteria. During the interview meeting, participants were oriented to the informed consent document and completed a brief demographic questionnaire (see Appendices E and B). All interviews were audio recorded with the written permission of participants (included in the informed consent document) for transcription purposes. Following the demographic questionnaire, participants were guided through the semi-structured interview protocol (see Appendix C). One interviewer completed the data collection process in order to ensure consistency across interviews and to provide relatively constant stimuli for each participant. Additionally, the researcher kept a record of the length of each interview session, the atmosphere of the interview itself, and interviewer impressions of, or reactions to, interviewees. These notes were utilized during the analysis portion of the study to help maintain an awareness of biases on the part of the researcher that could influence interactions with participants, as well as the conceptualizations of data that were presented (Hill, Thompson, & Williams, 1997).

**Analysis**

CQR methodology was utilized to identify domains, categories, and core ideas that were present across interviews. CQR conceptualizes the qualitative concept of saturation (Strauss & Corbin, 1990) as "stability of findings" (Hill et al., 1997). If the results obtained with a specific sample size appear to explain the phenomenon for a defined group of interest, stability of findings can be assumed. CQR utilizes a research team to organize individual participant responses from open-ended interview questions and questionnaire items into domains or topic areas. The goal of CQR is for the team's understanding of the data to be arrived at through

consensus, following discussion and deliberation about the inherent meanings within the data. Using the domains identified for each participant's responses, core ideas or brief summaries were constructed for all the material in each domain. Finally, a cross analysis was conducted, in which categories were developed to describe consistency in core ideas within domains found across participants (Hill et al., 1997).

For the present study, three doctoral students (one male and two females) and a doctoral-level counseling psychologist (female) served as the judges. A male doctoral student served as the auditor. All members of the research team had previous experience providing clinical services to members of rural communities. Research team members were familiarized with CQR method via reading and discussion of seminal CQR literature prior to engaging in the current study. As CQR analysis was conducted, each member of the research team independently analyzed each participant's data and then contributed to team discussions of conceptualizations and conclusions about each case until consensus was reached by the entire team. Attention was given to group dynamic throughout the analysis process; efforts were taken to ensure that all team members had equal power in the process (e.g., taking turns opening discussion, asking for clarification about a conceptualization). Additionally, members of the research team also shared their initial reactions to transcripts, including disagreement with the methods utilized by some participants to encourage help-seekers to address their posttraumatic responses, feelings of inspiration at the support provided by some participants to rural help-seekers, and confusion about aspects of participants' interventions with help-seekers. These reactions were discussed prior to initiating the coding process for each transcript. Those reactions that were particularly strong (e.g., disagreement with participants) were highlighted and team members challenged one another to ensure that their own biases were not influencing the consensual process. For

reactions related to confusion about the interventions provided, team members discussed their own understanding of the information in context of the participants' demographic information in order to enhance the coding process.

The auditor reviewed the individual consensual summaries for each interview, as well as the cross analysis to ensure that all of the important themes were represented within each domain. The auditor also assessed if the wording of core ideas within each domain was concise and reflected the content of the raw data (Hill et al., 1997). He provided feedback to the research team following each auditing process. Following the initial auditing phase, the research team made modifications to the names of domains and clarified the content of domains focused on referrals to mental health and reaching out to other clergy. One preliminary domain titled "pastor's role" was removed due to its focus on demographic information. After completion of the auditing process for the cross-analysis data, the following modifications were made to the summary: "consolidation of the help-seeker's concern that therapy does not complement their faith" and "lack of compatibility between therapist and clergy worldview" into one category, and modifications to final category titles.

## Results

The analysis of interview data using CQR (Hill et al., 1997) revealed eight domains (see Table 2): (a) Definition of trauma, (b) How pastors get involved with help-seekers, (c) How pastors assist help-seekers, (d) Reaching out to other clergy, (e) Barriers to mental health care, (f) Referrals to mental health professionals, (g) Impact of trauma-work on pastor, and (h) Pastors' coping that were consistent with the research questions. Each domain contained multiple categories, representing more detailed aspects of a domain. CQR methodology offers a classification system to indicate how frequently categories are observed across interviews.

Categories that are found to apply to all interview cases can be considered *general*. Those categories that are found to apply to half or more of the interview cases can be considered *typical*. Categories that apply to either two or three or less than half of all interview cases can be labeled *variant*. Finally, those categories that are found to apply to only one or two cases are considered *infrequent* and are generally dropped from the analysis as independent categories because they are not considered to be descriptive of the sample (Hill et al., 1997). However, the researchers did not want to silence the voice of any participant in reporting findings. Thus, *infrequent* responses are included in the results, but are designated as such. A summary of the categories within each domain is presented in the following sections, with illustrative quotations from the interview narratives (e.g., P1 represents participant 1; Bradley, 2011).

**Definition of trauma**. Within this domain, two *typical*, two *variant*, and one *infrequent* categories captured clergy's conceptualization of trauma. More than half the participants described trauma as a negative physical, emotional, or spiritual experience. Multiple participants characterized trauma as something that would have a lasting impact, with one individual describing this as "being so immersed in it that you can't see how much of a difference has been made over time" (P6). A *variant* theme emerged capturing the perspective that trauma may present as an injury or "deep wound" (P4) that requires a recovery process. One clergy member observed that "[trauma is] anything that physically, emotionally, or mentally makes you bleed. It's the wounds that never completely heal" (P7). Some participants discussed their understanding that individual responses to trauma could vary. One individual commented, "for some people it [traumatic experience] is the end of their world, others can move on" (P4). Others referred to the role that perceptions play in responding to traumatic events: "What is traumatic

for one person may not be for somebody else" (P5, P6). One clergy member shared an *infrequent* response: "Trauma is wounding, but can also lead to growth" (P7).

**How pastors get involved with help-seekers.** Participants described becoming aware of help-seekers' needs in the following ways: word of mouth (*typical*), phone calls, innate sense (*variant*), with the person at the time of the event, and concerns voiced during service or meeting (*infrequent*). More than half the sample discussed receiving word of a help-seeker's need from a family or community member sharing on another's behalf. One participant who ministers primarily to adolescents mentioned efforts to cultivate connections with members of the community. He observed "[our] relational connections and investments in the community … lead students to gravitate toward us or … some of their friends will introduce us" (P1). A fourth of the sample mentioned receiving phone calls that alert them to the needs of a help-seeker. Two participants discussed having an ability to sense that something was troubling an individual that they used to start a dialogue about their concern for this person. One clergy member noted:

> If you just sit and pay attention to body language, what they say, how they say it, and you can offer "you know, I'm here" … I've always found the people I need to find when I need to find them. (P7)

Although *infrequent* for the current sample, one individual shared that she had been with help-seekers at the time of a traumatic event (e.g., being in the emergency room with a congregation member), while another participant mentioned designating time during weekly services and meetings to share joys and concerns. With regard to learning of needs during weekly meetings, this participant stated, "… If I hear something I think I need to follow up on, I'll make a note of it and try to follow up on it later" (P8).

**How pastors assist help-seekers**. Two *general* and six *variant* categories described the ways in which pastors reported their intervention with trauma survivors. All participants valued the ability to provide face-to-face meetings for help-seekers. One pastor shared, "I try to be attentive and available to talk… A lot of times what people need is for others to care and walk with them and be available" (P4). Another said, "I bring my presence, to remind you that you are not alone" (P5). The value of using good listening skills was mentioned by all participants. One participant stated, "A lot of times it's just listening and letting them talk it out" (P2). Another noted, "I encourage people to talk because it often seems cathartic for people to share their experiences" (P5). One individual noted the challenge to avoid the urge to immediately provide solutions: "The biggest thing is just trying to shut up and listen… sometimes listening is the hardest thing to do because we want to fix… That's a process you learn" (P7).

Multiple participants reflected on the importance of being authentic when providing support to trauma survivors. One participant noted the impact this can have on people struggling with reactions to trauma:

> Building a relational bond of trust so people will feel comfortable sharing and opening up… No one really wants to be honest and transparent, if they are, they're selective. Around trauma, it's a really unique time… the barriers to emotions come tumbling down and we get a glimpse of the raw emotion they're feeling… if we're gentle and responsible with it, we can trace those things to a lot of different places. (P1)

Another clergy member shared, "I try to preface with 'it doesn't matter what you say, I'm not going to be surprised, I'm not going to judge you" (P2). Another *variant* category within this domain captures efforts clergy members take to help trauma survivors develop ways to cope.

One participant said, “I try to give permission for people to figure out what works for them and support people as they move out of the dark place” (P8).

Incorporating the help-seeker’s faith into the intervention process was a *variant* category within this domain. One participant characterized spirituality as a priority in the process of healing from a traumatic experience. She noted, “I pray with them, even before they open up to me… After that we go straight to the scriptures” (P2). Two clergy members shared their use of a personal connection with the Holy Spirit while working with help-seekers in order to more effectively assist them. One clergy member stated,

> I listen to them and what God is saying to tell them… I will say to them “this is what the Lord just said to me” and nine times out of 10 they’ll open up and be like “I don’t know how you knew that.” (P2)

Another described a shift in his way of engaging with help-seekers as he gained more experience in ministry:

> There’s this certain point when you’re actively listening… you’re hearing everything, but you’re able to also have other things happening in your mind and spirit to [better understand]. Some people would call that the movement of the Spirit, others call it experience. (P7)

A few participants mentioned using their lives as testimony when working with help-seekers. One pastor described the following process: “I try to accumulate my own and others’ success stories to tell of how God’s shown up, to say ‘I trust that He’s going to pull you through and be there” (P4). Finally, a few clergy members discussed awareness of crisis resources in their community that could be utilized if needed. One observed, “The greatest responsibility I have is

to watch whether or not they may harm themselves or someone else… If their trauma is so insufferable for them, I'll refer them to ACCESS or the local community service board" (P4).

**Reaching out to other clergy**. Participants mentioned interacting with clergy peers for consultation in the following ways: informal conversations as needed (*typical*), monthly clergy groups (*variant*), and individual mentoring (*variant*). Half of the sample reported using informal conversations with other church leaders when needed to gain assistance and perspective in their work with difficult cases. One participant stated, "I get together with other church leaders and … process how to approach situations" (P1). Another commented, "I have ministers whom I'm very close with; I seek their advice" (P2). Two participants (P7, P8) had spouses who were also clergy members and served as sources of consultation when needed. One of these individuals (P8) noted, "I bounce a lot of stuff off my husband… we respect confidentiality that comes with being pastors of separate churches." She added, "It's a scary thought, me trying to pastor without some conversation partners" (P8).

Some participants mentioned their involvement in monthly clergy groups and their ability to obtain support and consultation through these meetings. One participant said, "I meet with a group of clergy once a month and we discuss counseling issues" (P7). Another commented, "Pastors get together monthly… I can ask them 'do you have any suggestions on how to intervene and be a helpful presence?'" (P6). One clergy member characterized her monthly meetings as "we present case studies and check in about any situation where we need help or advice" (P8). Two participants used individual mentoring relationships for consultation and support in their work with trauma survivors. One individual characterized her mentor as her "spiritual mother," with whom she could discuss ministerial needs, as well as ways to better manage the demands of her work, (e.g., "you need to learn how to rest", P2). Another participant

described being placed with a mentor as part of his ordination process: "We talk a couple times a week and get together monthly… we're always consulting with one another about something" (P6).

**Barriers to mental health care**. One *typical* and five *variant* categories were identified pertaining to barriers to collaborating with mental health professions. More than half the sample identified the stigma associated with mental illness as an obstacle to pursuing mental health care. Participant 4 characterized stigma as "the greatest barrier" to help-seekers engaging in mental health care. Another described the general attitude of his church community toward mental health services as "I'm a little crazy, but I don't need to seek a counselor" (P6). Similarly, another clergy member commented, "Nobody wants to be crazy" (P7). Several participants discussed concerns that therapy is opposed to the Christian faith and ways that this fear may limit pursuit of mental health services. One participant observed,

> Secular therapists who have an agenda and try to steer clients in a direction that is not complementary to their faith, that is a really hard place for people who experienced trauma and are in need of mental health to sort through. (P1)

Another described the intersection between faith and seeking psychotherapy as, "There is this theological sense that counseling isn't Christian. There's a fear that somehow [psychotherapy] isn't faithful" (P6).

Three participants reflected on a help-seeker's readiness to address trauma through psychotherapy as a barrier to seeking care. As Participant 5 observed, "Not everyone is ready to talk about trauma. The young and the old are. The middle-aged adults have compartmentalized it and won't talk about it." Another said, "It depends on how desperate they [help-seekers] are" (P7). A few clergy members highlighted the impact of limited income or lack of health insurance

coverage in restricting access to mental health care among their congregations. Two participants mentioned difficulties in accessing mental health care due to a provider shortage. Participant 8 observed, “It can be frustrating, ‘cause often times there aren’t many places, especially in a rural setting, to send people [for mental health services].” Another clergy member stated, “The whole service capacity is inadequate, there are way too few counselors to meet the need” (P4). A few clergy members reflected on help-seeker concerns about confidentiality within the rural communities. One commented, “People know what your car looks like and will see you parked at an office” (P6). The other reflected, “People won’t go to a counseling center because the community is small, and they don’t want their car to be seen” (P5).

**Referrals to mental health care.** Clergy’s responses generated the following categories within this domain: used when an issue is beyond comfort level or scope (*typical*), limited knowledge of trusted providers, desire for help-seekers to trust in counseling, comfort with making a mental health referral (*variant*), use of crisis resources, and appreciation of learning when a referral has been used (*infrequent*). Four clergy disclosed using mental health referrals to address problems outside their knowledge base. One participant said, “I stay in my lane… I’ll go as far as I can and then I’ll refer to somebody else” (P2). Similarly, another stated, “If at some point it feels like it’s more than I can handle, I refer them” (P8). Two participants expressed frustration when seeking to make a referral, because they are unsure of who would be receptive to a help-seeker’s needs. One said, “I don’t have a good referral base to pull from. A lot of times, general practitioners are the source of referral. Other times, people have found their own way to a counselor and I breathe a sigh of relief” (P4). Another participant reflected on the impact of changing church assignment on his ability to refer to area mental health providers: “I’m fairly

new to this congregation, I'm still trying to figure out the mental health resources in this area" (P5).

A few participants mentioned working with help-seekers to encourage trust in the benefit of counseling prior to making a referral for psychotherapy. Participant 5 described his process of referring help-seekers as, "I learned a responsible model of referral that parishioners might build trust in the concept of counseling through me and then I refer them out to someone else." Another clergy member said, "I build enough trust with my congregation to say, 'I think the best thing would be for you to have someone who's trained in helping these very specific things' and I'll be there alongside that" (P6). One pastor described establishing a relationship with a college counseling center to facilitate referrals when needed. He said, "We have them [college counselors] over here at different times to have dinner with us and get to know each other" (P7). Two participants expressed comfort in making referrals for mental health care and described themselves as "not afraid to refer" (P6) and "keen to refer… for a few sessions" (P1).

Two pastors reflected on confirmation of referrals being used. Participant 6 commented that hearing from a therapist, "This person said you'd referred them to me," was very helpful and allowed him to know that "the connection has been made." This kind of communication helped him to combat feelings of "screaming into the darkness" without feedback or observable outcome. Another pastor expressed a desire to know if help-seekers are "participating" or utilizing referrals he has made to mental health professionals (P9). One *infrequent* response emerged within this domain related to the use of crisis resources. One participant shared, "The greatest responsibility I have to somebody is to watch whether they may harm themselves or someone else. If their trauma is so insufferable, I'll refer them to ACCESS [local crisis hotline] or the local Community Resource Board" (P4).

**Impact of trauma-work on pastor**. Four *typical* categories emerged within this domain. Six participants described a feeling of increased confidence as they gained experience assisting trauma survivors. Clergy members described a shift in their response to trauma stories over their careers:

> [Initially] it was unfamiliar, there was a welling up of anxiety, fear, and sadness… [now] I have an internal peace of mind and ability to accept that it's part of life instead of trying to fight against it, to experience the range of emotions that come with it, sadness, fear, anxiety, instead of blocking them out. (P1)

One individual provided the following metaphor for his experience with trauma work over time: "The only way I can describe this is an actual callus… It's still heartbreaking, but for me at this point, I've got more [of my reaction] under control. I'm at least able to take a few breaths and center myself" (P6).

More than half the sample mentioned an increased awareness of their responses while working with trauma survivors, along with an increased awareness of their lives and the world. One participant reflected on developing an increased insight into his need for additional training: "There have been times that I have felt so over my head that I could do harm, so I sought out more training [e.g., seminary]" (P5). Another said, "As I've seen other people process trauma and as I've been part of the solution… I've realized my own ability to process through as well" (P6). Half the sample reflected on the positive impact of their work with trauma survivors on their own faith. One participant said, "It solidifies my faith. Faith is essential for processing and filtering emotions because it gives us hope outside ourselves, hope in God" (P1). Similarly, another remarked, "Watching other people go through hard times and how they cope… strengthens my faith" (P8).

Four participants mentioned experiencing stress related to their work with trauma survivors. One clergy member commented, “It’s a little draining sometimes, any minister will tell you that ministry is hard emotionally” (P2). Another participant characterized this:

> It’s heart wrenching and burdensome. It makes me want to cuss, kick something, spit. It’s shocking to the system. I grieve with them, that’s how it impacts me… You get some fatigue from being around a lot of trauma and sorrow. (P4)

**Coping**. Participants’ responses related to coping fell into the following categories: social support, making time to recharge and rest, specific activities, religious practices (*typical*), creating boundaries and limits, and reflection on sense of calling (*variant*). More than half the sample mentioned using social support as source of renewal. One clergy member described seeking specific types of social support that allow him to reflect on his own experiences: “I find people I can process my own personal emotions with and acknowledge when I don’t feel supported. I need to know I have a safe space to land when I need help” (P1). Another participant highlighted the reciprocal support she receives from her congregation:

> I am blessed with long-term relationships with them [congregation]. It is very therapeutic because you can survive with their survival and rejoice with their accomplishments and victories... Generally, if they can get through, then I come out vicariously stronger, inspired, and empowered. (P4)

Five participants discussed creating time for themselves to rest and recover from the stresses of addressing trauma-related needs. One individual said, “I make time to replenish my tank- mentally, emotionally, and spiritually” (P1). Another participant described himself as, “I’m pretty rabid about taking all of my vacation” (P6). Several clergy members mentioned specific activities they use to care for themselves and de-stress. Activities utilized included journaling,

yoga, meditation, and exercise. More than half the sample highlighted the role of religious practices in coping with the demands of their work. One individual mentioned seeking out the following: “My own private time of worship with just me and God is when I replenish and let Him fill me back up” (P2). Another expressed the benefit of prayer in continuing to “stay in love with God” (P5). The benefit of reading scripture was highlighted as well: “I try to start and end my day with scripture and devotion” (P8).

Three pastors mentioned the use of boundary setting in order to maintain good self-care practices. One individual said, “I set personal boundaries because dealing with trauma and its weight is about finding places to be really disconnected from it in a healthy way” (P1). Another stated, “I try to be grounded in my life outside of ministry” (P6). Some participants mentioned reflecting on their sense of “being called” to their ministry as a way to cope and manage their stress. One clergy member, who joined the ministry as a second career, said, “People tell me, ‘you waited a long time to hear the call.’ I answered the call I had, and I knew I was ready” (P9). Another acknowledged how her work confirms her calling: “I’m walking in the calling I know I’m supposed to be in” (P2).

## Discussion

Clergy members often serve as frontline helping professionals within their community (Weaver et al., 2003; Weaver et al., 1996). Rural residents struggle with access to mental health services as a result of mental health provider shortages (Lutifyya et al., 2012; U.S. Department of Health and Human Services, 2011). Additionally, many rural residents have been characterized as engaging more with religion than more highly populated areas (Wagenfeld, 2003). For rural help-seekers searching for assistance with posttraumatic stress, their only available resource may be a member of the clergy. This study sought to understand rural clergy members’ experiences in

intervening with issues related to posttraumatic stress, as well as their own self-care practices related to this area of ministry. The current study was guided by six research questions aimed at an increased understanding of the ways in which rural clergy members navigate responding to issues of posttraumatic stress.

Information gathered via the demographic questionnaire offered insight into the depth and breadth of training clergy members receive related to issues of traumatic stress. Additionally, information gathered from the interviews yielded a total of eight domains and 44 categories using CQR (Hill et al., 1997). Within a respective domain, all categories that were derived were included, even if they were found for only one interview case. This decision was made in order to avoid silencing the voice of any research participant. The themes discovered remained closely linked to the questions asked of each participant and are therefore able to be tied to the original research questions.

**Research Question 1. What preparation do rural clergy members receive to provide care specifically to trauma survivors?** Previous literature suggests that clergy feel poorly equipped to assist survivors of trauma, including those parishioners who have experienced sexual abuse or assault. Bruns and colleagues (2008) attributed this finding to the lack of focus on responding to the needs of trauma survivors during seminary or other types of preparation for ministry. The range of counseling classes clergy members in the current sample completed was zero to approximately 20. Half of the sample described rarely discussing trauma and its sequelae during completion of coursework, while the remaining half described frequent discussions of trauma in their coursework. The experience of the current sample with training in trauma-specific issues is consistent with other findings related to clergy preparation to address mental health issues. It has previously been noted that faith leaders are often poorly trained in the

identification of mental illness and appropriate interventions (Hankerson et al., 2013; Kramer et al., 2007). The lack of training was true for over 50% of this study's participants who had not completed additional training in trauma-related issues after completion of seminary; however, the remainder of the sample endorsed completing at least one continuing education course to enhance their competency with trauma-related issues. This willingness to seek additional training through workshops, seminars, and/or continuing education to more effectively identify and intervene with mental health issues is consistent with findings reported by Weaver et al. (1996).

Participants were also asked to describe their understanding of trauma. Within the domain of *definition of trauma*, six categories emerged representing a range of conceptualizations of traumatic experiences. These categories included negative experience, lasting impact, physical and/or psychological injury, individual responses vary, and can lead to growth. At least half of the participants identified trauma as a negative experience that has lasting impact on an individual's functioning, while three participants described trauma as a form of physical or psychological injury. Although these definitions consider several aspects of posttraumatic stress, they do not encompass all the variables *Diagnostic and Statistical Manual* (DSM-5) considers essential for a diagnosis of posttraumatic stress disorder (American Psychiatric Association, 2013). When asked to give specific examples of traumatic experiences, participants gave a wide range of events, including bullying, childhood neglect, divorce, physical and sexual abuse, death of loved ones, car accidents, end-of-life decisions, worsening physical health, stillborn children, violent crime, suicide, and chronic stress about one's financial stability. This broader categorization of trauma may represent an artifact of spiritual conceptualizations of trauma, which frequently include a need to reevaluate one's spiritual beliefs and values following a traumatic or stressful event (Decker, 1993; Parlotz, 2002). Interestingly, none of the

symptomology, avoidance behaviors, or hyperarousal (American Psychological Association, 2013).

Three participants highlighted the possibility that not everyone will react in the same way to a given traumatic or stressful event. The mental health literature acknowledges that numerous factors impact one's ability to cope with traumatic experiences, including previous traumatic experiences, anxiety difficulties, lower intelligence, minority racial and/or ethnic status, and degree of social support available (American Psychological Association, 2013). Furthermore, Pargament and colleagues (1998) reported the predictive power of positive religious coping on outcome following a traumatic experience, with those who drew upon their religious coping skills endorsing less psychological stress, more cooperative interactions with others, and greater subjective experience of psychological and spiritual growth post-trauma. In conversation about what constitutes trauma, one participant observed that traumatic experiences can lead to growth. While this was a unique response in the current sample, it is consistent with previous research examining the possibility and process of posttraumatic growth (Calhoun & Tedeschi, 1998; Calhoun, Cann, Tedeschi, & McMillan, 2000).

**Research Question 2. How do rural clergy members approach the process of intervention with rural help-seekers who have experienced trauma?** Two domains emerged from the interview data related to how rural clergy members assist individual with a trauma-history: (1) how pastors get involved with help-seekers and (2) how pastors assist help-seekers.

***How pastors get involved with help-seekers***. Clergy members have been described as making themselves available to their congregations during their times of need (Vaaler, 2008). Five participants stated they were made aware of an individual in need of support through word of mouth, typically from a network of family or community members, which likely reflects the

interaction of cultural strengths and challenges characteristic of rural areas (e.g., close familial relationships, reduced privacy and confidentiality; Slama, 2004; Wagenfeld, 2003). Although the sample described this phenomenon as common, it is important to consider the implications of this for a help-seeker's privacy and readiness for assistance. Not all individuals a clergy member is made aware of may be ready for intervention. Their circumstances may be a source of shame and embarrassment that must first be acknowledged and addressed prior to targeting issues related to traumatic stress.

Some participants described efforts to cultivate a relationship with members of their congregation to promote this connection for the benefit of the community. Two participants acknowledged receiving phone calls from help-seekers or on behalf of someone in need. One person mentioned being with members of their congregation at the time of a traumatic event (e.g., in the emergency room). The responses obtained during this study appear consistent with prior reports that clergy members are contacted for support at higher rates than psychiatrists and/or general medical doctors (Wang, Berglund, & Kessler, 2003; Weaver, 1995). Additionally, previous studies examining patterns of help-seeking across various population densities have reported continued reliance of rural help-seekers upon the guidance and support of religious leaders, even when mental health professionals were available in these locations (Wang et al., 2006).

Two participants discussed having an innate ability to notice when something is troubling an individual and respond to this information accordingly. One clergy member attributed this to observations of a person's "body language." Multiple researchers have observed that clergy members often form long-term relationships with their congregants (Oppenheimer, Flannelly, & Weaver, 2004, Weaver et al., 1996). It is possible that this ability is reflective of ongoing and

emotionally close relationships that clergy members develop with members of their congregations. One participant discussed becoming aware of the needs of her congregation through concerns voiced during weekly services and meetings. Some Christian denominations, such as the United Methodist Church, utilize a structured approach to worship services that creates an opportunity to share one's concerns and offer prayers (United Methodist Publishing House, 1992). The individual who shared this aspect of information gathering in her ministry identified as a United Methodist minister, thus this finding likely reflects her training background. It is unclear, based on the current study and lack of literature regarding the order of service for other denominations, if other pastors use similar structures to learn of hardships within their congregation.

***How pastors assist help-seekers***. All participants characterized their approach to supporting trauma survivors as being physically present and listening to help-seekers. Three participants mentioned the importance of authenticity, which was described as allowing clergy to build a trusting relationship with help-seekers to better assist them. These characteristics of intervention are consistent with basic counseling skills that are often the focus of early training in the mental health profession (Kuntze, van der Molen, & Born, 2009) and may represent the influence of general counseling coursework completed during seminary studies, as reported in the demographic summary. Similarly, Everly (2000) described the added benefit of clergy response to traumatic situations as possibly offering opportunity for cathartic ventilation about an experience and providing social support post-event.

Three participants discussed the value of engaging help-seekers in the development of coping strategies following a traumatic experience. Neighbors and colleagues (1998) documented the role of clergy in helping members of their community address their situations

through discussion of specific ways in which to manage a concern. Other researchers have acknowledged the ability of clergy members to engage trauma survivors in problem solving around an individual's response and adaptation following a traumatic experience (e.g., Everly, 2000). Three participants highlighted their use of faith-based principles during intervention with trauma survivors, which is consistent with previously described strategies for assisting help-seekers (e.g., Everly, 2000; Neighbors et al., 1998; Ringel & Park, 2008).

Two participants described their use of the "movement of the Spirit" as a guide when intervening with a trauma survivor. Both individuals described their process as listening to what a help-seeker is saying while simultaneously attending to what God is telling them to do. Previously within the literature, this type of intervention has been described as "spiritual direction" and is intended to develop and enhance the spiritual health and well-being of a help-seeker (Sperry, 2003). This intervention involves a collaborative interaction between a spiritual director (e.g., faith leader or clergy member), a directee (e.g., help-seeker), and God or the Holy Spirit. During intervention, the spiritual director listens to the directee's life story for indications of the movement of God in his or her daily life. Prayer is often used to enhance a directee's relationship with God (Sperry, 2003). This practice is similar to that described by one clergy member: "I listen to them [help-seeker] and what God is saying to tell them… I will say to them, 'this is what the Lord just said to me,' and nine times out of 10 they'll open up and be like, 'I don't know how you knew that'" (P2).

Two individuals identified connecting help-seekers to crisis resources, when necessary (e.g., danger to self or others), as part of their role in intervening with trauma survivors. It has previously been documented that clergy members are sought out by 25% of people struggling with a mental illness (Ellison, Vaaler, Flanelly, & Weaver, 2006; Wang et al., 2003). The

likelihood that a clergy member will be approached by a member of a rural community is even greater, due to the current shortage of mental health professionals in these locales (Lutifyya et al., 2012; U.S. Department of Health and Human Services, 2011). Thus, these responses represent the magnitude of the responsibility assumed by rural faith leaders when they intervene with a trauma survivor and further emphasize the gatekeeping role clergy often assume when interacting with the mental health field on behalf of their parishioners (Gorsuch & Meylink, 1988). Given the increased probability that clergy will be approached by someone in crisis for assistance and support, it is crucial that they are aware of local resources and are able to utilize them to direct help-seekers to them when they are imminent risks to themselves or others. Additionally, continued efforts to foster a more integrative view of mental health is warranted among mental health professionals, as mental illness impacts all domains of an individual's life, including spiritual and religious functioning.

**Research Question 3. Are rural clergy members able to engage in consultation within their religious organization regarding work with trauma survivors?** One domain emerged from the data related to rural clergy's opportunity to consult with their colleagues.

***Reaching out to other clergy***. Half of the current sample described utilizing their professional network for informal conversations about how to address challenging situations. Some participants were married to an individual who also served as a faith leader and described utilizing their partner as a source of consultation, in addition to other members of their professional network. Three participants mentioned involvement in monthly clergy groups that allowed them to gain support and consultation from their peers, as it pertained to working with trauma survivors. These monthly meetings ranged from opportunities to "discuss counseling issues" to "present case studies and check in about any situation where we need help or advice."

A previous survey of approximately 400 senior Christian pastors found the use of accountability groups that met regularly provided an opportunity to engage in consultation with one's peers about ministerial duties (Meek et al., 2003). However, McMinn and colleagues (2005) described the complexity of relying on one's peers for consultation, stemming from the potential for competition and/or vulnerability within these relationships. It is also possible that the low population density characteristic of rural areas (Slama, 2004; Wagenfeld, 2003) complicates the use of peer consultation among clergy members, particularly if one shares struggles he or she is facing related to work with a clergy peer and does not receive the support needed.

A third category that was found in this domain describes individual mentoring relationships that offer clergy members the opportunity for ongoing consultation and discussion about current professional needs and activities, including counseling of help-seekers. This is consistent with findings reported by Meek and colleagues (2003), who interviewed 26 exemplar Christian clergy members about their coping strategies. Of this sample, 30% mentioned the benefit of obtaining perspective and feedback from a peer mentor (Meek et al., 2003). While at least half of the current sample mentioned utilizing some form of consultation with one's peers related to their work with trauma survivors, it is unclear how the remainder of the sample resolve the need for consultation or support in their work with this population. Increasing interdisciplinary consultation with mental health professionals may provide an additional opportunity for clergy members to gain perspective and guidance when working with rural trauma survivors.

**Research Question 4. What is the experience of rural clergy members as they interface with mental health professionals?** Two domains emerged from the interview data

related to rural clergy members' experience with mental health professionals: (1) referrals to mental health and (2) barriers to mental health.

***Referrals to mental health***. Three participants mentioned their use of referrals to mental health professionals when a help-seeker's needs were beyond their comfort level or scope of practice. Openshaw and Harr (2009) have previously discussed limitations clergy face when balancing the multiple responsibilities that accompany their position. These include limited time to provide support to help-seekers, insufficient training, and lack of expertise with mental health concerns. Despite these limitations, clergy often are the first professional approached by someone struggling with a diagnosable mental health condition (Hohmmann & Larson, 1993).

Two participants discussed limitations in their ability to make referrals to mental health professionals because they were unsure of providers in the area that would be receptive to the intersection of a help-seeker's faith and mental health concerns. McMinn and colleagues (1998) described the importance of shared beliefs and values between clergy members and psychologists engaged in collaborative relationships. Faith leaders with conservative theological backgrounds and small congregations may view referring help-seekers to secular providers as especially risky (McMinn et al., 1998). Furthermore, the recommendations made by mental health providers may be in conflict with a help-seeker's religious beliefs, creating a need to choose between the two (Sullivan et al., 2013). Based on the consistency of the current findings with the literature base, it is important to consider ways to enhance trust and transparent communication between the two professions to promote the health and well-being of help-seekers.

A fourth of the sample described efforts they took to instill a help-seeker's trust in the psychotherapy process prior to making a referral to a mental health professional. Previous

findings from a survey of Southern California pastors indicated a sentiment of, “Each referral is a lesser or greater risk of trusting our congregants’ emotional, relational needs to outside mental health professionals” (Bledsoe, Setterlund, Adams, Fork-Trela, & Connolly, 2013). This need to bolster a help-seeker’s buy-in and confidence in the benefit of psychotherapy may be heightened by the contributions of rural culture to help-seeking behavior (e.g., self-reliance, reduced anonymity and confidentiality, heightened stigma of mental illness; Jones, Cassidy, & Heflinger, 2012; Slama, 2004; Wagenfeld et al., 2003). Although an infrequent response among the current sample, one individual highlighted appreciation of learning from a mental health professional that a referral had been used. When possible (e.g., as permitted by clients), communication of this information with clergy members could further enhance interdisciplinary collaboration of rural helping professionals.

Two participants expressed comfort in making a referral for mental health services. Bledsoe and colleagues (2013) found most Southern California pastors were comfortable in making a referral to secular mental health professionals. In a similar study, conducted with clergy residing in Kent, Michigan, VanderWaal, Hernandez, and Sandman (2012) reported a majority (82%) of Christian clergy members were willing to refer congregants to a mental health professional when a situation was beyond their scope of practice. In addition to referring to mental health professionals, two-thirds of participants also reported making referrals to medical doctors, and less than half mentioned making a referral to an emergency department. A minority of participants endorsed providing only prayer and spiritual counsel when faced with help-seeker concerns beyond their scope. Participants provided an important caveat to their considerations when making a mental health referral, with more than 85% of clergy expressing a desire to make referrals to Christian counselors (VanderWaal et al., 2012). Approximately 25% of the current

sample expressed comfort in making a referral to mental health professionals when needed, which is a smaller proportion than has been previously documented. It is possible that rural clergy members have less interactions with mental health professionals in their communities due to the shortage of providers (Lutifyya et al., 2012) and differences in conceptualizing distress (McMinn et al., 1998; Sullivan et al., 2013). Further research is needed to determine what factors may be limiting the comfort of rural clergy members in making referrals to mental health professionals, as the current, small sample may not be representative of all rural clergy, restricting generalizability to a larger population. Research designs that provide an opportunity to determine the benefit of various forms of social contact between rural clergy members and mental health professionals could prove particularly useful in forging collaborative relationships between the two disciplines.

Although an infrequent finding for the current sample, one participant discussed utilizing crisis intervention resources within her community as needed. This finding is surprising and encouraging, as previous literature has described limitations in the ability of clergy members to identify emotional distress and suicidality among help-seekers (Domino, 1990).

***Barriers to mental health***. Five of the participants discussed the impact of the stigma associated with mental illness on help-seekers' willingness to pursue psychotherapy. One aptly commented, "Nobody wants to be crazy." Generally, it is known that mental illness is associated with stigmatization (Rusch, Angermeyer, & Corrigan, 2005); however, when mental illness intersects with rural cultural values, there are often additional feelings of shame related to the perception of being unable to solve one's problems independently (Hauenstein et al., 2007; Robinson et al., 2012).

Three participants mentioned difficulty connecting help-seekers with mental health services due to concern that psychotherapy is not complementary to religious beliefs and values. Additionally, two participants mentioned difficulty interfacing with mental health professionals who do not acknowledge or are adversarial to the role faith plays in the life of religious help-seekers. These concerns have consistently been documented within the literature (Pattison, 1969; Ringel & Park, 2008) and represent an ongoing need for cultural awareness and competence on the part of mental health professionals (American Psychological Association, 2010). Previous reports of clergy frustration at poor communication with mental health providers, as well as limited clergy knowledge of available mental health resources (Bruns et al., 2008), offers a potential inroad to address this ongoing challenge. Through transparent communication and efforts to create a professional collaboration between religious leaders and mental health professionals serving rural communities, there is the opportunity to enhance service provision and reach a greater number of help-seekers.

The importance of considering whether a help-seeker is ready to address a trauma when making referrals to mental health professionals was addressed by three participants. Within the psychological research base, the benefit of examining an individual's level of motivation and interest in change is well documented (e.g., Rollnick & Allison, 2004; Ruback, Sandbaek, Lauritzen, & Christensen, 2005). In fact, ambivalence is recognized as a natural part of the change process and should be treated as such rather than resistance or refusal to change (Rollnick & Allison, 2004). Additionally, it is expected that psychologists providing mental health care abide by the field's ethical code, to respect client autonomy, promote beneficence, and avoid maleficence (American Psychological Association, 2010). Whereas the current sample was

comprised of clergy members, their responses evidence attitudes that are consistent with mental health professionals about assisting help-seekers address posttraumatic stress.

Two participants mentioned difficulties pursuing psychotherapy due to financial limitations experienced by help-seekers, shortages of mental health professionals within rural areas, and concerns about confidentiality unique to rural settings. Rural residents often have lower yearly incomes and higher rates of being uninsured than urban residents (Barker et al., 2013). Robinson and colleagues (2012) mentioned ongoing challenges rural patients face in paying for their health services, despite insurance coverage. This is likely reflective of additional expenses incurred by traveling to health appointments, including the cost of fuel for one's vehicle, taking time off from work, and finding childcare when needed (Mojtabai, Chen, Kaufmann, & Crum, 2014; Robinson et al., 2012). The expense associated with seeking mental health care often leads rural residents to rely on informal sources of support, including faith leaders and family members (Blank et al., 2002; Fox et al., 1995), which is further supported by the findings of the present study.

The shortage of mental health professionals in rural settings is well documented in the literature and continues to present challenges for rural residents in need of mental health care (Gamm, Stone, & Pitman, 2003; Goldsmith, Wagenfeld, Manderscheid, & Stiles, 1997; Holzer, Goldsmith, & Ciarlo, 1998; Lutifyya et al., 2012; U.S. Department of Health and Human Services, 2011). One participant commented, "The whole service capacity is inadequate, there are way too few counselors to meet the need." With regard to the unique interaction between population density and confidentiality of one's mental health treatment, rural residents have previously been found to experience high rates of visibility within their communities that often leads to a "goldfish bowl effect" and reduced privacy and confidentiality (Slama, 2004).

Participants in the current study discussed examples of one's car being recognized at a mental health clinic, limiting the willingness of trauma survivors to pursue psychotherapy within their community.

**Research Question 5. How does intervening with rural help-seekers who have experienced trauma affect the health and well-being of rural clergy members?** One domain emerged from the data related to the impact of work with trauma survivors upon rural clergy members.

***Impact of work on pastor***. Six participants observed a transition in their response to working with trauma survivors over the course of their ministry. Each of these individuals described initial feelings of being overwhelmed by the needs of trauma survivors, but had gained increased comfort and confidence in their work with this population over time. This trend is similar with findings reported by Randall (2007), who found that as clergy members matured in their work, they reported less emotional exhaustion and depersonalization from their work. The researcher speculated that this may be the result of older clergy members having more opportunities to develop a greater range of coping strategies and a more realistic expectation for one's work (Randall, 2007). It is possible the findings of the current study reflect similar processes at work in the participants' lives.

Five participants described arriving at a greater self-awareness and perspective on life through their work with trauma survivors. One individual remarked, "I've learned to pull back. I didn't know how to do that earlier in my ministry." Another discussed insights about his own ability to persevere through the challenges of life by witnessing resilience in help-seekers he assisted. Half of the participants reflected on ways in which their work with trauma survivors had enhanced their faith. These experiences highlight the potential for work with trauma survivors to

positively impact helping professionals. Previously, researches have introduced concepts of vicarious resilience (Engstrom, Hernandez, & Gangsei, 2008) and vicarious posttraumatic growth (Arnold et al., 2015) to describe this outcome. Vicarious resilience is defined as experiencing positive influence related to clients' growth, alterations in one's personal perspectives, and valuing the work performed (Engstrom et al., 2008). Vicarious posttraumatic growth is described as psychological growth that occurs because of vicarious exposure to trauma (Arnold et al., 2015). While not included in the definition of vicarious posttraumatic growth, the role that religion and spirituality play in making meaning of a traumatic experience (Calhoun et al., 2000) may also contribute to vicarious posttraumatic growth and lead to enhanced personal faith, as described by the participants in the current study.

Interestingly, the literature suggests that vicarious resilience can be promoted through several external factors, including social and organizational support (Linley & Joseph, 2007; Tedeschi & Calhoun, 2004), personal relationships and a collaborative work environment (Pack, 2014), and organizational qualities such as training, provision of supervision, and positive professional relationships (Hernandez-Wolfe et al., 2015). Furthermore, a personal trauma history has been postulated to create an opportunity for personal growth in the lives of helping professionals (e.g., Linley & Joseph, 2007; Tedeschi & Calhoun, 2004). Among the current sample, all participants reported some type of previous traumatic experience in their personal life. Thus, it is possible that the findings of positive outcomes of working with trauma survivors disclosed by the current sample is an interaction between personal and professional histories of trauma exposure.

Despite the growth in their own faith related to working with trauma survivors, half of the sample also described their work with this population as stressful. Participants mentioned the

following difficulties related to the stress of their work with trauma survivors: sleep deprivation, feeling emotionally drained, difficulty being present due to worries about help-seekers, being shocked by the experiences help-seekers had survived, and frustration with problems that cannot be resolved immediately. Previous literature has documented the potential for helping professionals involved with those who have experienced trauma to develop compassion fatigue, vicarious trauma, or secondary traumatic stress (Cerney, 1995; Stamm, 2002). Thus, it is possible that rural clergy members who are not active in self-care, or those who are limited in their coping strategies and abilities, may be vulnerable to compassion fatigue and/or secondary traumatic stress. The next section focuses on ways in which ministers in the current study managed their feelings of stress evoked by working with trauma survivors.

**Research Question 6. How do rural clergy members cope with the stress of intervening with rural help-seekers who have experienced trauma?** One domain related to the coping strategies of rural clergy emerged from the data.

***Coping***. Five participants identified using social support, creating time to rest, using specific activities, and using religious practices to cope with the stress of their work with trauma survivors. Social support, particularly that of one's family, has been reported to predict faith leaders' sense of personal accomplishment and overall well-being (Chandler, 2009). Kaldor and Bullpitt (2001) also mentioned the tendency of clergy members to rely on their family and friends for social support. Previous studies of clergy coping practices have found that nearly half of clergy find ways to "get away" or take time off from their work (Kaldor & Bullpitt, 2001). This trend is also present in the current findings.

Active involvement in spiritually renewing practices (e.g., prayer, worship, devotional reading or study, meditation, journaling, or fasting) has been found to protect against emotional

exhaustion and burnout related to the stresses clergy members face (Chandler, 2009). Participants in the current study reported utilizing the following spiritual practices to manage their work-related stress: private worship with God, prayer, scripture reading, and representing God to others. Similarly, members of the current sample reported the use of intentional, specific activities to cope, including journaling, yoga, meditation, staying busy, and exercise. The benefit of regular involvement in intentional activities as part of self-care and renewal has previously been acknowledged (e.g., Meek et al., 2003).

Three participants mentioned creating boundaries around their personal time to promote personal coping. This practice has been discussed previously by Holaday et al. (2001), who provided additional examples of boundary setting, including taking only emergency calls after working hours, using caller identification on one's personal telephone, and living away from the church's location; socializing with one's family and friends outside of the church community; and engaging in emotional distancing or compartmentalizing practices. Similarly, Doolittle (2007) observed that more benefit from active coping strategies, such as planning ways to manage stress and promote relaxation, led to higher levels of personal accomplishment and lower levels of emotional exhaustion and depersonalization of one's work.

Three clergy members reported engaging in reflection on their sense of calling to ministry as an additional manner of coping. Meek and colleagues (2003) highlighted the role of intentionally maintaining an awareness of one's calling as beneficial and helpful in staving off the negative impact of work-related stress. There is potential for burnout among rural clergy members called upon by trauma survivors (Chandler, 2009); however, the results of the present study indicate active efforts to care for oneself and manage the ongoing stress related to one's work. Doolittle (2007) noted that clergy members must use all their coping strategies to manage

the stress of their job. His findings suggest it is possible for clergy members to be engaged with their work, have a rich spiritual life, and high levels of personal accomplishment, but still experience emotional exhaustion. Thus, it is important that clergy develop effective strategies to cope and actively utilize them.

**Limitations and Opportunities for Future Research**

Whereas the current study confirms findings documented previously in the literature and expands knowledge related to rural locals, it is not without limitations. The current sample was comprised of nine participants, with one being excluded due to limited experience working with rural populations, limited knowledge of trauma, and few encounters with help-seekers who had experienced trauma. Given the small sample size, most of the themes were found in at least half of the cases, but not all. In fact, the only domain in which *general* (e.g., occurring in all cases; Hill et al., 1997) categories was found was in the *how pastors assist help-seekers* domain, with all participants reporting being physically present and listening to help-seekers as part of their process. Thus, future research should strive to obtain a larger sample size to promote greater consensus among responses when possible, as the current study did not reach saturation across all categories derived through the CQR process. Additionally, future researchers are encouraged to consider the impact of variability in responses across various Christian denominations, as well as between faith leaders of different religious backgrounds (e.g., Judaism, Muslim).

It is possible that the experiences and perspectives offered by this study's participants are not representative of all rural clergy members' experiences in assisting trauma survivors and interfacing with the mental health care system. Participants were recruited through a university contact who had connections to the Christian clergy community. The awareness of psychological distress and need for psychological intervention at higher levels of severity may indicate the

influence a higher learning institution can have on a region, particularly when there is ongoing collaboration between disciplines. Similarly, it is important to note that whereas rural locales are often assumed to be homogenous in their atmosphere, this is not the case. The current sample was drawn from a portion of Appalachia, located in southwestern Virginia. This region has been described as a "chronically poor" rural locale (Hamilton, Hamilton, Duncan, & Colocousis, 2008); however, Hamilton and colleagues identified three additional types of rural areas: amenity rich, declining resource-dependent, and transitional. These categorizations take into consideration the diversity of a region's residents and changes in economic, political, and environmental factors (Hamilton et al., 2008). In light of these distinct types of rural areas, additional research is needed to determine if there are regional differences in rural trauma survivors' reliance upon clergy members for assistance. Additionally, it is unknown if there is variability in clergy interactions with the mental health profession across the different types of rurality, leaving questions for future research.

The inclusion criteria for the current study sought Christian faith leaders who had completed seminary training or were currently enrolled in a seminary training process. However, in small, rural communities, not all churches are able to attract a pastor who has completed formal seminary training. Lummis (2003) discussed the reality that many vacant clergy positions across Christian denominations are in small congregations that are often unable to pay a full-time salary; these congregations are typically located in rural areas. In order to fill the need for pastoral leadership of small, rural congregations, some denominations are developing various levels of ordination that allow ministerial work without completion of formal seminary training, often referred to as lay pastors (Wood, 2010). Lay pastors rarely have a seminary degree and may not have a college degree. They are, however, required to have some

official ministerial training and certification for the services they provide, typically delivery of sermons on a weekly basis (Lummis, 2003). Although the use of lay pastors varies across denomination, ranging from 30-60%, it is clear that this type of clergy member fills a need that would otherwise go unmet among small, rural Christian congregations (Wood, 2010). Thus, the current study is unable to speak to the experience lay pastors have in responding to the needs of rural trauma survivors.

Whereas it has been noted in the literature that Christianity is the predominant religion in rural American areas (Vaaler, 2008), not all rural residents identify as Christian. It is likely that non-Christian rural residents are less open to seek assistance from Christian clergy members post-trauma. Future research studies would benefit from an examination of the informal support non-Christian, rural residents rely on, particularly following a traumatic experience, as previous research has found rural residents to seek out their family and friends in times of need (Fox et al., 1995). Additionally, exploration of the openness of rural clergy to intervene with non-Christians who are recovering from a traumatic experience would be informative. Finally, exploration of the variation in patterns of responding to trauma survivors across leaders of other faith traditions would inform efforts to enhance faith leader knowledge and competence when intervening with trauma survivors.

**Recommendations and Conclusion**

The findings of the current study highlight the role that rural clergy members play when responding to the needs of trauma survivors. These professionals are charged with responding to the needs of trauma survivors in their communities, in addition to their other ministerial duties (Openshaw & Harr, 2009). Additionally, clergy are also responsible for maintaining their own health and well-being. Findings from the current study suggest that rural clergy are able to create

strategies to manage the impact of assisting trauma survivors, but are still susceptible to feelings of stress as a result of this type of work. With regard to interfacing with the mental health system, ministers in the current study commented on the difficulty of locating mental health professionals within their respective area due to shortages of providers. Participants also described difficulty knowing which mental health professionals would be receptive to the spiritual values of their congregants. Taken together, these findings offer the opportunity to provide recommendations aimed at ameliorating the current status of collaboration between clergy and mental health professionals in the interest of providing holistic care to rural help-seekers.

The findings of the current study reflect the dynamics of two groups that serve the same area, but often do not understand or appreciate one another. From the perspective of rural clergy members who participated, referring help-seekers to secular mental health professionals presents multiple concerns, including determining appropriate referral sources and navigating recommendations that conflict with religious values. It is important for psychologists to consider avenues to address these concerns to develop and strengthen relationships with rural clergy members to better serve help-seekers. Previous research has highlighted the benefit of social contact between differing groups to influence the attitudes and beliefs of the groups about one another (Allport, 1954, 1979). Pettigrew (1998) added that change occurs due to learning about members of other groups, reconsidering one's beliefs about the other group, and altering one's behaviors and affective responses to another group. Within the literature, researchers have proposed multiple strategies with which psychologists can develop partnerships with rural clergy members to better serve help-seekers. It is also important for psychologists to consider the value of asking religious leaders to offer trainings related to spiritual and religious values, and issues

and channels through which referrals to religious leaders can be made. Finally, for those psychologists who also hold religious or spiritual values, the risks and benefits of serving as a "cultural broker" between the academic and religious worlds should be evaluated.

Sullivan and colleagues (2013) explored strategies to promote clergy partnerships with Veterans' Affairs (VA) mental health professionals in rural Arkansas to enhance care of returning veterans. These researchers observed that one of the largest barriers to collaboration between these two professions stemmed from clergy and mental health providers not knowing each other. They suggested opportunities such as an informal lunch meeting to allow clergy and mental health professionals to meet one another, leading to an increased number of referrals to and from clergy members (Sullivan et al., 2013). Additionally, collaboration on community events (e.g., providing breakfast to soldiers during drill weekends) allowed clergy and mental health providers to increase their trust of one another and decrease stigma. Finally, Sullivan and colleagues observed that focusing on the needs of mental health professionals for clergy expertise in addressing issues like guilt, shame, and moral injury may prove more effective in promoting inter-disciplinary collaboration. While these strategies were developed and implemented to promote clergy partnerships with VA mental health professionals, they could be easily adapted for the needs of non-VA mental health professionals in rural settings. Recently, Vermaas and colleagues (2017) reflected on the above-mentioned activities, as well as offering low-cost services to clients who could not afford formal treatment when referred by their clergy; they further reflected on providing access to counseling research and information via local clergy listservs and data bases, as potential ways to promote clergy mental health literacy and increase collaboration. These suggestions could easily enhance interactions between rural clergy members and mental health professionals.

Bledsoe et al. (2013) proposed a series of seminars for clergy, addressing the following topics: knowing when and how to refer to mental health professionals, developing a congregation-specific resource list, mental health issues (e.g., depression, suicidality, family violence, and anger management), and working with non-mental health professionals to offer financial and job assistance to help-seekers. These seminars were to be offered at a local university's community counseling center in Southern California (Bledsoe et al., 2013). Vermaas and colleagues (2017) also discussed the possibility of mental health professionals offering post-graduate training opportunities for clergy members in the local community. Seminars covering the above-mentioned and related topics could also prove very beneficial for rural clergy members serving as frontline mental health professionals. Future examination of the comfort level of clergy members with these types of interventions and the frequency of referrals to mental health professionals could speak to additional needs rural clergy may have. Furthermore, examination of the openness of mental health professionals to receive training from faith leaders about issues of cultural competence when working with spiritual or religious clients would provide an inroad to enhance reciprocity between the disciplines and increase collaborative care.

Furthermore, Bledsoe and colleagues (2013) advise that faculty at undergraduate and seminary institutions should incorporate supplementary information and materials into the training curriculum of pastors to prepare them for the practical realities of the pastoral role. While the current sample reported completing anywhere from zero to 20 counseling classes during their training to be a minister, it is unclear if these courses also provided practical knowledge of how to interface with the mental health system when needed. Additional training related to these aspects of ministerial work may help to offset the stress related to meeting the counseling needs of one's congregants.

Previous research has documented the ability of social and organizational support (Linley & Joseph, 2007; Tedeschi & Calhoun, 2004), as well as a collaborative work environment (Pack, 2014) to promote vicarious resilience among those who respond to the needs of trauma survivors. Many participants in the current study described the use of monthly clergy meetings and/or accountability partners as part of their coping strategy. Given the documented impact of organizational support on the well-being of individuals engaged in trauma work, it is likely that increased denominational support (e.g., additional training, provision of supervision, and positive professional relationships; see Hernandez-Wolfe et al., 2015) would promote rural clergy members' resilience and well-being. This area of need may offer a viable inroad for increased collaboration between rural clergy members and mental health professionals, particularly in light of opportunities to offer additional trainings as discussed above. Furthermore, it is important for mental health professionals to consider what they may learn from clergy members, as the mental health field has become increasingly aware of the need for cultural competence, including within the domain of religious and spiritual identities (American Psychological Association, 2010; Delgado-Romero, Lau, & Shullman, 2012).

Whereas the literature offers many suggestions for psychologists to provide education and trainings to clergy members, there is little guidance for how psychologists might invite clergy members to educate them about spiritual and religious values, as well as issues with which people of faith may struggle. Future research could benefit from the use of a participatory action research model (PAR; Brydon-Miller, 1997) that would allow for psychologists and clergy members to work together to develop solutions to the issues they face in working with rural trauma survivors and evaluate the outcomes collaboratively. This type of research design would allow for shared dialogue and power among psychologists and clergy members as they work

together to solve shared struggles in their work with rural trauma survivors. Additionally, psychologists and clergy members may also develop a greater understanding and respect for one another through such collaborative efforts.

For those psychologists who also hold religious or spiritual values, it is worthwhile to consider the risks and benefits of serving as a "cultural broker" between the academic and religious worlds. Those with knowledge of both systems of viewing the world may provide unique insights that could enhance the cultural competence of their mental health colleagues and create open dialogue with faith leaders. This may be especially salient to rural mental health professionals who hold religious values and are pursuing inroads to collaboration with local faith leaders.

The findings of this study suggest that rural clergy members may be open to collaboration with mental health professionals. However, results also highlight a need for mental health professionals to be cognizant of the religious and spiritual values an individual brings to the therapy process. Intervening with trauma survivors can be inherently challenging and stressful; however, it appears that rural clergy members, who are a de facto part of the rural trauma treatment team, are aware of the need to monitor their own well-being and engage in regular self-care practices.

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**Table 1**

*Demographic Information*

| **Denomination** | ***n*** | **Mean** | **SD** |
|---|---|---|---|
| United Methodist | 3 | | |
| Nondenominational | 2 | | |
| Evangelical Lutheran | 2 | | |
| Presbyterian | 1 | | |
| **Years in Ministry** | | 11.8 | 6 |
| **Congregation Size** | | 123.1 | 49.7 |
| **Majority of Ministry Locale** | | | |
| Rural | 6 | | |
| Suburban | 2 | | |
| Urban | 0 | | |
| **Age** | | 48.6 | 13.9 |
| **Sex** | | | |
| Male | 5 | | |
| Female | 3 | | |
| **Ethnicity** | | | |
| White | 6 | | |
| Black | 1 | | |
| Sri Lankan | 1 | | |
| **Ministerial Training** | | | |
| Master's Divinity | 4 | | |
| Seminary in Progress | 2 | | |
| Alternative training | 2 | | |
| **Counseling courses** | | 6 | 7.4 |
| **Post-seminary trauma training** | | | |
| Yes | 3 | | |
| No | 5 | | |
| **Personal Trauma History** | | | |
| Yes | 8 | | |
| No | 0 | | |

**Table 2**

*Cross Analysis Summary*

| Domain & Category | Interview | Frequency w/in Interviews | Core Ideas |
|---|---|---|---|
| **Definition of trauma** | | | |
| Negative experience | 1, 2, 5, 8, 9 | 5 | Intense physical, emotional, or spiritual experience |
| Lasting impact | 1, 4, 6, 7 | 4 | For some it is the end of their world; leads to immersion in the experience that limits recognition of change |
| Physical and/or psychological injury | 4, 6, 7 | 3 | Leaves a deep wound that is difficult to recover from |
| Individual responses vary | 4, 5, 6 | 3 | What is traumatic for one may not be for another |
| Can lead to growth | 7 | 1 | Trauma is wounding but can also lead to growth |
| **How pastors get involved with help-seekers** | | | |
| Word of mouth | 1, 4, 6, 8, 9 | 5 | Network of family and community members share concerns; hear about event in conversation |
| Phone calls | 5, 6 | 2 | People call asking for a visit from clergy or prayers for themselves or on behalf of someone |
| Innate sense | 2, 7 | 2 | Can spot a hurting person; if you pay attention to body language |
| With person at the time of the event | 4 | 1 | "Usually I'm with them." |

| | | | |
|---|---|---|---|
| Concerns voiced during service or meeting | 8 | 1 | Time set aside during weekly meetings for any concerns to be shared |
| **How pastors assist help-seekers** | | | |
| Being physically present | 1, 2, 4, 5, 6, 7, 8, 9 | 8 | Letting help-seekers know that they are not alone; in-person or digitally dependent upon age of help-seeker |
| Listening to help-seeker | 1, 2, 4, 5, 6, 7, 8, 9 | 8 | Letting the help-seeker "talk it out"; "talking often seems cathartic" |
| Authenticity | 1, 2, 7 | 3 | Being honest and transparent |
| Help individual develop ways to cope | 4, 6, 8 | 3 | Watching for ways help-seekers will manage distress; "finding and developing a new normal"; help them figure out what works for them |
| Incorporating the help-seeker's faith | 1, 2 | 2 | Speaking to what one's beliefs mean for the afterlife with loved ones of a deceased; praying with the help-seeker; reading and discussing scriptures with help-seeker |
| Using "movement of Spirit" as a guide | 2, 5 | 2 | "This is what God just said to me to tell you"; "truly listening to things happening in the Spirit" |
| Using own life as a testimony | 2, 4 | 2 | "This is how God helped me"; Trying to accumulate God's "track record" |
| Connect help-seeker to crisis resources | 4, 5 | 2 | Frank discussion about crisis and sharing of local emergency resources; point person for crises |
| **Reaching out to other clergy** | | | |
| Informal conversations as needed | 1, 2, 7, 8 | 4 | Talking with other church leaders to process how to approach situations |

| | | | |
|---|---|---|---|
| Monthly clergy groups | 5, 6, 8 | 3 | Monthly discussions with clergy about counseling issues |
| Individual mentoring | 2, 6 | 2 | Using one's mentor for advice |
| Infrequent | 4 | 1 | Time with colleagues is rare and focused on "nuts and bolts" |
| **Barriers to mental health care** | | | |
| Stigma of mental illness | 4, 5, 6, 7, 8 | 5 | Stigma is one of the largest barriers to counseling; "nobody wants to be crazy" |
| Help-seekers' concern that therapy does not complement their faith | 1, 2, 6 | 3 | Secular therapists may have a non-Christian agenda; recommendations from providers and clergy are not always compatible; fear that counseling is not faithful to God |
| Help-seekers' readiness to address trauma | 5, 7, 8 | 3 | Not everyone is ready to talk about the trauma; "people just don't want to admit it's something they need" |
| Financial limitations | 4, 8 | 2 | Limited income; lack of insurance coverage |
| Too few mental health providers | 4, 8 | 2 | Too few providers to meet the need; in rural areas there are not many places to send people |
| Help-seeker concerns about confidentiality | 5, 6 | 2 | Concern in small communities about one's vehicle being seen at counselor's office |
| **Referrals to mental health professionals** | | | |
| Used when issue is beyond clergy's | 1, 2, 8, 9 | 4 | Clergy aren't fully equipped to deal with major issues; go to the edge of scope and then refer |

| | | | |
|---|---|---|---|
| comfort level or scope | | | |
| Clergy's limited knowledge of trusted providers | 4, 5 | 2 | Lack of a "good referral base to pull from"; changing church assignments creates challenges in knowing local mental health resources |
| Desire for help-seekers to trust in counseling | 5, 6, 7 | 3 | Work with help-seeker to build trust in the idea of counseling before referral so that it is seen as the best solution; creation of a relationship with counseling centers |
| Comfortable making mental health referral | 1, 6 | 2 | Keen to refer for a few sessions; not afraid to refer |
| Appreciation of learning when a referral has been used | 6, 9 | 2 | Confirmation of referral follow-through gives a sense that the connection has been made |
| Use of crisis resources | 4 | 1 | Monitor help-seeker for risk and refer them to local crisis services |
| **Impact of trauma-work on pastor** | | | |
| Transition from overwhelmed to greater confidence | 1, 4, 5, 6, 7, 8 | 6 | Initially an unfamiliar and overwhelming experience, but now accept that it is part of life; increased feelings of comfort in supporting trauma survivors; initial need to have an answer always, but now value being present; metaphor of physical callus to represent increased confidence |
| Greater self-awareness and perspective | 2, 5, 6, 7, 8 | 5 | Increased awareness of when trauma-work leads to feelings of depletion and emptiness; awareness of when "over my head" led to more training; recognition of one's ability to process difficult emotions; increased openness with one's own life |
| Faith enhanced | 1, 2, 4, 8 | 4 | Working with trauma survivors solidifies faith through hope and inspiration; continues to exercise faith |

| | | | |
|---|---|---|---|
| Stressful | 1, 2, 4, 9 | 4 | Difficulty being present when worried about someone; draining; heart-wrenching; frustration with problems that cannot be easily fixed |
| **Coping** | | | |
| Social support | 1, 2, 4, 5, 7 | 5 | Network of people to process personal emotions; use of spiritual mentor; celebrating successes with congregations; accountability partner |
| Making time to recharge and rest | 1, 2, 5, 6, 7 | 5 | Time to replenish mental, emotional, and spiritual tank |
| Specific activities | 5, 6, 7, 8, 9 | 5 | Journaling; yoga; meditation; working outside; exercise |
| Religious practices | 2, 4, 5, 8, 9 | 5 | Private time of worship; representing the love of God to everyone; prayer; scripture readings; devotional readings |
| Creating boundaries and limits | 1, 6, 8 | 3 | Set boundaries around time that allows disconnection from work; “rabid” about taking all of vacation |
| Reflection on sense of calling | 2, 7, 9 | 3 | Feeling that one is doing exactly what they were meant to do; “it’s what I have to do” |

# Chapter Two

## Review of the Literature

Trauma affects people living across a variety of geographic domains. The effects of trauma are varied, with some individuals recovering quickly without significant psychological distress, while others experience prolonged effects that are often associated with clinically significant psychological distress (American Psychiatric Association, 2013; Brewin, Andrews, & Valentine, 2000; Briere, Scott, & Jones, 2015). Working with trauma survivors is unique in comparison to the treatment of other mental health disorders (e.g., depression, anxiety, schizophrenia) in that psychological interventions for posttraumatic stress disorder (PTSD) are time limited and effective when implemented correctly (Ball, Karatzias, Mahoney, Ferguson, & Pate, 2013), as compared to the often long-term nature of treatment success for other mental health disorders (Olfson, Marcus, & Wan, 2015). While clergy members are able to provide empathic listening and advice, they typically do not receive in-depth training regarding the provision of treatment for PTSD (Smith, 2004; Weaver et al., 1996). Moreover, the treatment of PTSD symptoms is also time consuming, placing considerable demand upon faith leaders who may already be managing numerous duties related to their position. This is particularly problematic for clergy members serving rural communities, as many rural areas fall within mental health service provider shortage areas (U.S. Department of Health and Human Services, 2011; Lutifyya et al., 2012), limiting the ability of rural help-seekers to pursue mental health treatment.

Little is known about the nature of collaboration between clergy members and psychologists serving residents of rural areas. Furthermore, it is unknown how faith leaders in rural areas conceptualize trauma and intervene with help-seekers who have experienced trauma.

There is a paucity of research examining the consequences of clergy members ministering to rural help-seekers with trauma-related concerns; however, the literature warns that engaging in counseling activities with trauma survivors can elicit negative consequences for the caregiver (e.g., Galek et al., 2011; Hendon et al., 2014; Holaday et al., 2001). Thus, it is important to review known ways with which clergy manage potential stress and burden that may come from providing counseling services. This stress may be particularly present for rural clergy members who may be expected to serve both as a faith leader and as a counselor for a wide range of mental health concerns, including posttraumatic stress.

This literature review aims to discuss the role of clergy members as frontline mental health workers, including reasons clergy members are approached for social and emotional support, mental health training clergy members receive in their preparation for ministry, and clergy collaboration with mental health professionals. The nature of rural areas will be discussed, including what is considered "rural," values and cultural aspects of rural communities, and mental health care trends in rural areas. Additionally, trauma will be defined, in conjunction with a consideration of the role of faith in individual trauma recovery and interventions clergy may provide for trauma survivors. Finally, the impact of human services work will be outlined, including concepts of burnout, secondary traumatic stress, and vicarious victimization. Attention will also be given to the application of these concepts to support clergy provide to survivors of trauma, along with reported self-care practices clergy utilize to maintain positive work-related psychological health. Given the literature that will be discussed, the main focus of this study is to better understand the way rural clergy members intervene with trauma survivors, the ways in which they care for themselves during the process of supporting trauma survivors, and potential

interest and opportunities for rural clergy members and mental health professionals to increase collaboration as it relates to providing care for help-seekers.

**Clergy as Frontline Mental Health Workers**

Clergy members have been noted to include rabbis, priests, pastors, and nuns (Weaver et al., 1996). Clergy receive a variety of training to perform the duties of their position, including professional training (e.g., seminary or divinity school) or training through a faith denomination's organization (Openshaw & Harr, 2009), such as retreats or workshops. Other members of clergy serve as "lay leaders" or individuals who are appointed to a leadership position within their faith community but have not necessarily received formal training to fulfill a given role (Openshaw & Harr, 2009). The role filled by clergy members is characterized by many demands, including public speaking (i.e., presenting sermons and/or lessons), providing pastoral counseling, facilitating teamwork within the congregation to achieve various goals, and managing the budget allotted for the congregation (Doolittle, 2007). Thus, there are a variety of obligations and responsibilities a clergy member must manage on a day to day basis to fulfill their duties; this process of juggling one's responsibilities can heighten stresses associated with this particular role (Doolittle, 2007).

Mental health professionals have been noted to include psychiatrists and psychologists across occupational settings, as well as social workers working in a mental health specialty setting (e.g., a mental health treatment facility) and those providing hotline services (Wang et al., 2007). The American Psychiatric Association (2016) includes psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and other counselors in its definition of mental health professionals. These individuals have received

specific training regarding the assessment of a variety of presentations of psychological distress and psychological disorders, as well as the creation and implementation of treatment plans.

There are similarities and differences in the roles that clergy members and mental health professionals fill. Both clergy members and mental health professionals engage in counseling activities with a diverse range of people. Additionally, both professionals engage in forms of public speaking to educate and advocate for their help-seekers. However, clergy members and mental health professionals complete distinctly different trainings in preparation to subsume their roles and obligations. Mental health professionals are qualified to assess, diagnose, and treat a variety of mental health disorders, while clergy members are prepared to intervene with help-seekers who are experiencing distress of a spiritual or religious nature. Whereas both types of professionals are able to engage in empathic listening as part of their process of intervention, mental health professionals are able to integrate additional aspects of psychological treatment that clergy members are typically not able to offer.

The following section of this review will address literature bases regarding (a) motivations for approaching clergy members rather than mental health professionals for support, (b) clergy training to identify and address mental health concerns, and (c) factors involved in collaboration between clergy members and mental health professionals.

**Why do people approach clergy rather than mental health professionals for support?** Help-seekers, or individuals who pursue assistance and support from others (Pickard & Guo, 2008), often seek out clergy when dealing with traumatic experiences of multiple natures (e.g., combat, interpersonal, natural disaster; Weaver, 1993). In the literature, clergy have been described by urban females from diverse religious groups (Cinirella & Lowenthal, 1999) and Christians living in the United Kingdom (Mitchell & Baker, 2000) as similar in approachability

as mental health professionals in that they are considered to be helpful, caring people who offer long-term and holistic care. Vaaler (2008) added that many faith leaders are known for being respectful and making themselves available to their congregations in times of need. Given these qualities, clergy are often accessible at a level of frequency that other potential caregivers may not be (Vaaler, 2008). The literature has suggested that clergy often serve as frontline helping professionals within their community (Weaver et al., 2003; Weaver et al., 1996), placing them in a position to respond to many stressors that could evoke symptoms of posttraumatic stress in members of their congregation. Weaver (1995) argued that a member of the clergy is just as likely as a mental health professional to encounter an individual suffering from a severe mental illness who is seeking assistance and support.

In the United Kingdom, it has been noted that the shift of psychological care from institutions to community-based programs has added to the case load of faith leaders (Leavey, Loewenthal, & King, 2007). Similarly, the economic downturn in the United States has resulted in rural community-based mental health organizations feeling more pressure to reduce their operations than urban counterparts (e.g., closing satellite clinics; Ferdinand et al., 2015). This increased lack of service providers has potentially compounded a pre-existing disparity in mental health service availability within rural areas (Ferdinand et al., 2015), further increasing the likelihood that individuals who are suffering from psychological distress will seek the support of clergy members.

The American Psychological Association has acted to address the needs of rural populations for physical and mental health care through the formation of the Committee on Rural Health in 1996 (Riding-Malon & Werth, 2014). Since the formation of the Committee on Rural Health, the American Psychological Association has identified rural health as a priority and has

worked to increase the availability and utilization of mental health care providers in rural areas by advocating for the use of interdisciplinary and collaborative care teams that are often imbedded within primary care settings or other organized settings. This approach allows help-seekers access to mental health professionals and also creates a setting in which patients are perceived as receiving general health care, rather than risking self-disclosing their use of mental health services by their presence at a private practice that provides mental health services (American Psychological Association, 2001). In addition to creating meaningful ways to impact the mental health infrastructure within rural and frontier settings, the American Psychological Association Rural Health Initiative has also emphasized cultural competence within rural mental health care and encourages rural practitioners to consider and include community-based values, traditions, and customs in order to create interventions, support groups, and outreach programs that are meaningful and beneficial to the rural population (American Psychological Association, 2001). Given that religious beliefs and communities are often a central aspect of rural culture (Wagenfeld, 2003), it is imperative that mental health professionals are aware of this aspect of rural life and are able to engage in consultation and collaboration with clergy, as indicated and permitted by one's clients and patients.

The literature has investigated the motivation of members of various populations to seek support from the clergy. Pickard and Guo (2008) examined the patterns of help-seeking from clergy among older adults living in the Midwestern United States. They found that older adults who reported having less social support were more likely to seek assistance from clergy members. Additionally, results indicated that those individuals who attended religious services more frequently were more likely to rely on their faith leader, as opposed to seeking the services of another helping professional (Pickard & Guo, 2008). Bonner and colleagues (2013) studied

the predictors and prevalence of help-seeking from clergy by the veteran population. Participants were asked to describe their openness to seeking help for emotional problems from clergy members and their actual contact with clergy members over the past 6 months. Almost half of participants (47.2%) reported being "very" or "somewhat likely" to pursue support from clergy. Veterans who were experiencing current symptoms of PTSD or who had visited a mental health provider within the last 6 months were more likely to report openness to, and pursue, actual help-seeking from clergy (Bonner et al., 2013). The researchers noted that veterans may view clergy members as less stigmatizing sources of support than mental health professionals (Bonner et al., 2013), specifically due to concerns about potentially compromising one's military career (Kim et al., 2010).

Wang et al. (2003) sought to describe recent patterns and correlates of pursuing mental health care from clergy members. They conducted an examination of data from the National Comorbidity Study, a large general population survey completed in the United States during the early 1990s, to better understand this pattern of help-seeking. Additionally, the researchers also studied the functions clergy members play in service provision, as well as the characteristics of those they serve (Wang et al., 2003). It was found that 25% of individuals who had ever pursued treatment for a mental health disorder relied upon clergy members to meet this need. Additionally, clergy were contacted for assistance at higher rates than psychiatrists or general medical doctors, with 23.5% of participants seeking support from clergy compared to 16.7% seeking support from psychiatrists and 16.7% consulting with general medical doctors (Wang et al., 2003). Furthermore, nearly one quarter of those individuals seeking support from clergy members in a given year were suffering from the most severe and impairing psychological disorders (e.g., substance/alcohol use disorder, psychoses). Additionally, the majority of

individuals with a severe mental illness were seen exclusively by a clergy member, without additional support from a mental health professional or physician (Wang et al., 2003).

In a follow-up study, Wang and colleagues (2006) sought to understand patterns of help-seeking within various service sectors or sources of mental health support. The researchers noted changes in profiles of service sectors use for mental health care in the United States, showing that in spite of an observed decrease in urban areas, seeking support from faith leaders only did not decline in rural areas. Based on these findings, the researchers suggested that the rural United States represents a predominant reliance on religious leaders for the mental health care needs of rural residents, while more urban areas were found to rely most often on general medical providers and psychiatrists for mental health care (Wang et al., 2006). Thus, it appears that clergy serve a key role in rural areas both as faith leaders, but also as frontline mental health workers for a variety of populations and needs.

**Clergy training in mental health.** Research has noted that clergy are often poorly equipped to properly identify and address mental illness (Hankerson et al., 2013; Kramer, Blevins, Liller, Phillips, Davis, & Burris, 2007). Yet Weaver et al. (1996) reported that many pastors appear to understand the limits of their abilities and are willing to take part in additional mental health training. Historically, clergy have expressed the need to improve their counseling skills, with a survey of Protestant clergy in 1986 indicating that pastors felt "the overall quality of pastoral counseling is poor" (Orthner, 1986, p. 53) and multiple seminal studies reported a majority of clergy seeking out additional training concerning mental health issues through workshops, seminars, or continuing education events (Orthner, 1986; Rupert & Rogers, 1985; Wright, 1984). More recently, Bruns and colleagues (2008) reported that faith leaders from multiple religious backgrounds participating in focus groups expressed that they did not feel

prepared to respond to victims of sexual abuse and assault due to a lack of training in their preparation and ministry. Furthermore, participants shared that the training they did receive, as well as guidelines for response to survivors of sexual abuse, were often inconsistent and provided little guidance. Members of these focus groups indicated a desire for trainings regarding basic information about types of sexual abuse and assault, as well as risk factors and common presenting problems that survivors face. Additionally, these faith leaders noted that further information on best practices in addressing past and present abuse, as well as instruction on how and where to refer survivors for further support, would be beneficial to their work (Bruns et al., 2008).

Similarly, Rudolfsson and Tidefors (2009) investigated the reported readiness among Swedish clergy to address the psychological and existential needs of sexual abuse survivors. Participants completed questionnaires regarding their readiness to assist survivors of sexual abuse with psychological and spiritual distress related to their trauma and to disclose cases of ongoing abuse in order to assist a survivor to obtain additional appropriate assistance. Respondents indicated that their readiness to disclose ongoing sexual abuse was largely influenced by their level of knowledge about sexual abuse received outside of seminary training through additional trainings in behavioral science and/or pastoral care. Additionally, other variables were found to influence ratings of clergy readiness to report ongoing abuse, including previous experience of disclosing abuse and caring for survivors professionally and outside of one's work as a clergy member, previous reflection on the issue, and degree of knowledge about authorities and organizations that could provide support for a survivor (Rudolfsson & Tidefors, 2009).

With regard to participants' self-rated readiness to care for the psychological and existential concerns of survivors of sexual abuse, three factors were found to have the strongest influence: clergy knowledge about sexual abuse obtained in training, knowledge about sexual abuse obtained outside of trainings, and knowledge of authorities and organizations that could provide additional assistance to survivors. Interestingly, a majority of participants (86%) expressed a desire to obtain more information about disclosing sexual abuse to authorities and organizations that could assist survivors. These participants also indicated a strong wish for increased knowledge of how to care for survivors of sexual trauma (Rudolfsson & Tidefors, 2009).

With regard to the information about trauma that is provided to clergy during their training, Rudolfsson and Tidefors noted that many of the participants in their investigation were trained during the 1970s to 1990s, a time in which there was limited empirical knowledge about sexual trauma. The authors argue that due to this limited knowledge about the impact of sexual trauma, as well as best practices in treating its psychological and spiritual aftermath, many clergy members did not receive specific information and training regarding this concern during their seminary training (Rudolfsson & Tidefors, 2009). In a follow-up study, Rudolfsson (2015) reported that Swedish Christian clergy members wished to provide the best care possible for their faith communities, but felt insecure in their ability to do so due to their lack of psychological knowledge and skill. Furthermore, these participants indicated that they felt limited in their ability to make referrals for their community members due to the vow of silence, or a cleric's obligation to keep information discussed in confession or individualized pastoral care confidential (Church of Sweden, 2010). Sigmund (2003) asserted that due to the impact of trauma across domains of functioning, including mental health and spirituality, it is imperative

that professionals involved in the treatment of trauma survivors be aware of and trained in interventions capturing needs within both of these domains.

Based on a review of the literature base, it appears that clergy continue to feel inadequately prepared to meet the needs of individuals struggling with mental health concerns. Previous research has also documented clergy's concern that they are not well-prepared to meet the needs of trauma survivors, despite contact with these individuals as part of ministerial duties. Given the likelihood that rural residents will seek out a clergy member rather than a mental health professional when faced with psychological distress, it is important to understand the readiness of rural clergy to address these issues and bolster skill and comfort where needed.

**Clergy collaboration with mental health professionals.** Collaboration between mental health professionals and clergy members remains a multifaceted process, with conflicting perspectives documented in the literature. For instance, several seminal investigations found that clergy referred less than 10% of individuals they were counseling to mental health professionals (Heng & Vernon, 1974; Larson, 1968; Piedmont, 1968; Virkler, 1979). However, Horne and Levitt (2003) have more recently reported that clergy in urban areas expressed the belief that counseling could be helpful for trauma survivors. Furthermore, most participants in their study indicated that they would refer trauma survivors to a mental health professional (Horne & Levitt, 2003). At present, there is no evidence of similar attitudes within a rural setting, which may be reflective of rural cultural values and attitudes toward seeking mental health services (Wagenfeld, 2003; Slama, 2004). Thus, although clergy report openness to engaging with mental health professionals in a collaborative manner, historically this does not appear to have necessarily been the case.

Openshaw and Harr (2009) reported that while clergy members are often the first source of support sought by individuals struggling with substance abuse, thoughts of suicide, and/or issues related to child or spousal abuse and neglect, these professionals are often restricted in the support they can provide. Limitations reported included time constraints, insufficient training, and lack of expertise to effectively address mental health concerns (Openshaw & Harr, 2009). Interestingly, a nationwide study conducted by the National Institute of Mental Health found that clergy are more likely than psychologists and psychiatrists *combined* to be approached for help by someone suffering from a diagnosable mental health concern (Hohmann & Larson, 1993). In the past 15 years, it has been reported that one in four adults who have sought mental health treatments for a mental illness have gone to a member of the clergy for assistance (Ellison et al., 2006; Wang et al., 2003;). Furthermore, of those seeking treatment from clergy annually, one in four have a severe mental illness and are not being seen by a mental health professional (Wang et al., 2003). The literature suggests that members of the clergy are not exempt from involvement in providing mental health support across the United States. Within a rural context that is likely characterized by a shortage of mental health professionals (Lutifyya et al., 2012; U.S. Department of Health and Human Services, 2011), the likelihood of clergy members being the first-line of mental health professionals is even greater. Thus, it is essential that collaboration between members of the clergy and mental health profession be better understood in order to provide individuals suffering from mental health concerns with effective support and interventions.

Many factors have been shown to interfere with collaboration between clergy and mental health professionals over the past 50 years. Pattison (1969) reported that clergy may avoid referrals to secular counselors due to confusion about the therapists' professional role and

activities, a perceived lack of respect for clergy by secular counselors, religious beliefs that inhibit referrals, and the difficulty of many working-class individuals to access mental health care. More recently, participants in a series of focus groups conducted by Bruns and colleagues (2008) expressed frustration with poor communication between service providers and faith leaders. Additionally, faith leaders noted that limited dissemination of information about resources available for survivors of sexual assault limited their ability to provide referrals for these individuals. Furthermore, participants expressed concern that in the event an individual disclosed a history of sexual abuse, they might not be able to assist the individual, due to other obligations and duties related to their occupation (Bruns et al., 2008). In a similar series of interviews, Ringel and Park (2008) found that clergy expressed significant concern at the likelihood that mental health professionals would not demonstrate sufficient cultural competence in working with Evangelical Christian clients. Participants added that this lack of cultural competence with this particular population may lead mental health professionals to encourage survivors of interpersonal violence to seek separation or divorce from their partners, which may directly oppose the values of some Christian clients and their faith leaders (Ringel & Park, 2008).

The concerns expressed by religious leaders about the cultural competence of mental health professionals in the treatment of religious clients are not to be overlooked. Whereas the field of psychology does not endorse the same level of religiosity as the general public (e.g., 72% of the general population claims religious faith as the most important influence in life versus 29% of mental health professionals; Bergin & Jensen, 1990), psychologists are obligated to provide culturally sensitive and competent care to each of their clients (American Psychological Association, 2010). Additionally, counseling psychologists emphasize a focus on a person's

entire context, including his/her strengths, cultural identities, and values, as well as promoting his/her dignity throughout the course of treatment (Delgado-Romero et al., 2012; Packard, 2009). Multiple researchers and clinicians have noted that a holistic clinical conceptualization of an individual must include consideration of any religious or spiritual values that person holds (Hawkins, Siang-Yang, & Turk, 1999; Hays, 2009). Given the value placed on one's religious faith within many rural settings (Wagenfeld, 2003), incorporation of religion into the course of psychotherapy is crucial to holistic care, as well as ethical and culturally competent practice (American Psychological Association, 2010).

Openshaw and Harr (2009) explored how clergy members in urban and rural areas navigate the numerous requests for support they receive from individuals experiencing mental health concerns. The findings of qualitative interviews with faith leaders from a diverse range of religious backgrounds indicated that in general, clergy address mental health issues they feel competent to target, while seeking a trusted mental health professional who had demonstrated sensitivity to religious values to intervene with more severe or intensive mental health concerns. In particular, rural clergy members reported feeling isolated and also expressed a desire to collaborate with mental health professionals when addressing a severe mental illness; however, the participants qualified this desire by voicing a preference to refer help seekers to a mental health professional they knew personally (Openshaw & Harr, 2009).

Gorsuch and Meylink (1988) observed that clergy members function as gatekeepers to mental health professionals; this is consistent with the findings reported by Openshaw and Harr (2009), particularly from the perspective of a rural clergy member. Similarly, McMinn and colleagues (1998) noted that trust between clergy members and mental health professionals is a function of familiarity and proximity. Thus, the literature suggests that mental health

professionals who are interested in increasing collaboration with clergy members must be able to demonstrate awareness of, and competence in working with, the religious values of their clients. Additionally, the available research suggests that clergy members may be interested in collaborating with mental health professionals, but may be unsure of how to engage in the referral process and may lack an understanding of the services a mental health professional can provide.

## Significance of Rural Areas for the Present Study

The present study is focused on the role rural clergy members fill in providing support to trauma survivors, with an interest in the role that psychologists may play during this process. Additionally, the study also aims to gain greater insight into how this type of work impacts clergy members and the ways in which they manage stresses stemming from working with trauma survivors. Much of the research examining clergy knowledge and skill in addressing trauma among churchgoers has been conducted in urban settings (e.g., Chalfrant et al., 1990; Horne & Levitt, 2003; Mollica et al., 1986), leaving a gap in the literature representing rural areas. Furthermore, mental health professionals practicing in rural areas are more likely to experience isolation and increased role strain (Cohn & Hastings, 2013). Given the many obligations clergy members fulfill (Doolittle, 2007) in addition to intervening with help-seekers who have experienced trauma, it is possible that clergy members could be facing similar vulnerability to role strain and potential burnout.

**Unique characteristics of rural areas.** Mohatt (2006) noted that there is no consistent definition of what physical characteristics of a community are associated with one that is rural. However, the Office of Management and Budget (OMB) and the Census Bureau (Mohatt, 2006) furnish the two most commonly used definitions. The OMB released a new definition system in

2003 to classify areas based on census data collected in 2000; this definition describes non-metro or rural areas as those counties located outside the boundaries of metro or urban areas. Furthermore, the definition classifies rural areas as those with a population of no more than 10,000 persons. In comparison, the Census Bureau (2003) defined rural areas as consisting of settlements with less than 2,500 people. Information collected in the 2000 census indicated that 21% of United States citizens resided in rural areas based on this definition. An additional conceptualization of rurality is offered through the Rural-Urban Continuum Codes (RUCC), which define nine levels of rurality/urbanicity (Butler & Beale, 1994). The RUCC classify counties into metropolitan and non-metropolitan groups. Metropolitan areas are broken into three levels based on population size, while non-metropolitan areas are divided into six levels of rurality based on the county's adjacency to an urbanized area and the population of its largest urban area (Butler & Beale, 1994).

Rural areas across the United States have been noted to differ from urban areas in many ways. For instance, rural areas have been reported to consist of a larger elderly population, with fewer minority residents and children than urban areas (Hoyt, Conber, Valde, & Weihs, 1997). Additionally, rural areas are reported to have higher poverty rates, lower net income, and lower levels of insurance coverage. These concerns are complicated by the fact that there are fewer and less well-trained health care providers, as well as fewer optimal health care facilities within rural areas (Hoyt et al., 1997). These disadvantages make it difficult for residents to obtain any type of health services, including assistance for mental health concerns. Moreover, research has identified potentially greater social stigma, or negative appraisals, associated with mental illness in rural areas (Hoyt et al., 1997), further limiting rural dwellers' access and motivation to seek out mental health care.

Previous research has noted that values held by rural communities differ from those found in urban settings in that they stress self-reliance, conservative attitudes, distrust of outsiders, focus on religion, work orientation, commitment to one's family, individualism, and fatalism (Wagenfeld, 2003). Wagenfeld and colleagues (1993) noted that "rural" is a frame of mind that is accompanied by behavioral differences. These researchers further argued that this mindset reflects the presence of fewer people within one's community, leading to more involvement in one another's lives than is experienced in urban communities (Wagenfeld et al., 1993). Furthermore, Slama (2004) argued that conventional attitudes characteristic of rural inhabitants, combined with low population density, facilitate a "goldfish bowl effect," or social environment where each community member's life is public knowledge, resulting in reduced anonymity in one's daily activities. This relative lack of privacy limits the degree to which people are open about aspects of themselves (e.g., psychological distress) and heightens typical levels of stigma surrounding mental illness. For instance, many people in rural areas are familiar with the cars others drive and notice the typical route an individual may drive on a daily basis. Thus, a community member might be alerted to a familiar car being parked at a mental health provider's office and make assumptions about the individual's current situation.

**Rural mental health care.** There are many barriers to accessing mental health care in rural areas, including social environment and cultural values, limited availability of trained mental health professionals, and limited awareness of mental health issues on an individual level. Given these barriers, community members can be reluctant to seek help due to skepticism of mental health professionals who often are not familiar with the area or culture (Bischoff et al., 2014), as well as a sense of pride in one's ability to address individual and family needs without assistance (Wagenfeld, 2003). Furthermore, the literature documents that seeking services for

mental illness can elicit feelings of shame (Robinson et al., 2012), as rural residents are characterized by an innate sense of self-reliance and independence (Hauenstein et al., 2007). Additionally, the limitations to one's privacy and confidentiality that are created by the "goldfish bowl" effect of living in areas with low population density (Slama, 2004) may also discourage rural residents from seeking support mental health professionals for fear of being the subject of gossip or being ostracized.

In addition to the limitations created by the social environment of rural areas, the literature regarding rural areas and mental health services has documented the limited availability of licensed and trained mental health professionals to whom referrals can be made (e.g., Gamm et al., 2003; Goldsmith et al., 1997; Holzer et al., 1998). Throughout the literature, there have been mixed reports of the proportion of mental health care professional shortage areas that fall in rural areas, with estimates ranging from 60 to 85 percent (Lutifyya et al., 2012; U.S. Department of Health and Human Services, 2011). Nevertheless, there are less than half as many psychologists in rural areas as in urban and suburban areas, with 16 psychologists per 100,000 people in rural areas, compared to 39 psychologists per 100,000 people in urban and suburban areas (Advancing Suicide Prevention, 2005).

Many factors related to rural locales may influence a mental health professional's decision to seek employment in these particular areas. Hargrove (1991) proposed multiple reasons for psychologists to prefer urban environments for their practice, including limited ability to meet the diverse needs of rural clientele due to specialized training, frequent shift into administrative roles when practicing in rural settings limiting direct intervention with patients, limited ability to be reimbursed in private practice due to higher rates of service provision through public sectors, and a lack of cultural richness or diversity that may have been

characteristic of other areas of residence in a clinician's life. DeLeon, Wakefield, and Hagglund (2003) added that psychologists practicing in rural areas may also report lower job satisfaction due to cultural barriers to treatment and a general lack of respect for their professional judgment that increases the difficulty of maintaining a steady client load. With regard to the stressors associated with providing mental health care to rural residents, Cohn and Hastings (2013) noted that rural practitioners are more likely to work in isolation, have fewer emergency or crisis resources to provide clients after-hours, and are more likely to experience role strain. These stresses are further complicated by the need to establish and maintain culturally appropriate boundaries with community members and between one's work and personal roles, given the low population density that is characteristic of rural areas (Slama, 2004).

Furthermore, the cost of obtaining mental health care often limits the rate at which rural inhabitants utilize this service. Robinson and colleagues (2012) noted that even with insurance, many rural patients were unable to afford their copays for medications. Furthermore, the cost of traveling to appointments, which takes many forms (e.g., paying for gas, finding childcare if needed, taking time off from work), also limits the ability of rural inhabitants to utilize mental health care, when available (Mojtabai et al., 2014; Robinson et al., 2012). Additionally, Barker et al. (2013) reported that in comparison to urban residents, a larger number of rural inhabitants are uninsured and have a lower yearly income. The literature has also mentioned that rural inhabitants are less likely to have health insurance coverage for prescription drugs (Ziller, Coburn, & Yousefian, 2006), further limiting mental health treatment options. Thus, rural residents in need of mental health support often rely on informal sources of care, including self-help, family, friends, and religious organizations (Blank et al., 2002; Fox et al., 1995), rather than utilize outpatient mental health services.

Community leaders, such as clergy and law enforcement personnel, are more likely to interact with individuals suffering psychological distress than are mental health professionals (Kirchner, Farmer, Shue, Blevins, & Sullivan, 2011). Furthermore, multiple researchers have noted that members of the clergy are frequently the first professionals to be approached for help by those who are experiencing psychological distress within the general population (Wang et al., 2003) and the African American community (Young et al., 2003). Individuals seeking support from clergy typically do not have to negotiate issues of stigma, confidentiality, or the financial costs of traditional psychological counseling (Ferdinand et al., 2015) due to the greater acceptability of consulting with a religious leader. Indeed, seeking support from one's community clergy member may be less threatening to one's reputation with regard to experiencing stigma or lack of privacy in one's visit, as there are many reasons an individual may visit a church. Furthermore, it is not uncommon for clergy members ministering in rural areas to pay a visit to one's home. This type of outreach on the part of clergy members in effect reduces the need for rural community members to disclose their current struggles, including psychological ones, and provides a supportive relationship that may not otherwise be accessible for residents of these locales (Ferdinand et al., 2015).

With regard to the appeal of seeking clergy support for trauma survivors, Weaver and colleagues (1996) have noted that clergy offer a viable avenue for receiving care. Individuals who have experienced trauma seek support from clergy members due to the role religion and faith may play in their lives, the often long-term relationships that are formed between clergy and members of their congregation, and because of limited access to mental health professionals in rural areas, of service shortages and financial limitations, and of issues of community members' mistrust toward mental health professionals (Weaver et al., 1996). Furthermore, clergy can assist

trauma survivors in making meaning of their experiences and helping to integrate this new perspective into their belief systems. Additionally, clergy often form long-term and emotionally close relationships with members of their congregation, providing a natural opportunity to explore difficult thoughts or feelings with which a trauma survivor may be struggling. Finally, the culture of rural areas creates a tight knit community that is not always welcoming or trusting of "outsiders," which may limit willingness of help-seekers to pursue mental health treatment, when it is available (Weaver et al., 1996).

Whereas the prevalence of mental illnesses has been found to be generally similar across rural and urban settings, with the exception of rural areas reporting higher rates of alcohol use disorders (General Accounting Office, 1990), rural inhabitants with a mental illness may be less likely than those from urban areas to describe themselves as needing psychological care (Fox, Berman, Blank, & Rovnyak, 1999; Rost et al., 2002). Fox and colleagues (1999) reported that the primary reason rural inhabitants endorsed for not seeking help was that they "felt there was no need." This evaluation of one's situation was observed even when participants had been informed that they had a mental health disorder (Fox et al., 1999). Individuals who do not describe themselves as needing psychological care are less likely to pursue support of any kind for a psychological concern, with only 5.8% of the participants reporting having sought professional help since being informed that they had a mental illness (Fox et al., 1999).

Although the prevalence rates of mental illness within urban and rural areas have been reported to be similar (Kessler et al., 1994; Wagenfeld et al., 1993), with the exception of alcohol use disorders (General Accounting Office, 1990), the cultural, financial, and systemic barriers that are characteristic of rural areas have led to consistent reports of mental health services utilization rates in rural areas that are lower than those observed in urban areas (Lambert, Agger,

& Hartley, 1999; Rost, Owen, Smith, & Smith, 1998; Sullivan, Jackson, & Spritzer, 1996). Thus, it appears that gaining insight into the practices of rural clergy members when working with trauma survivors could be informative and allow for additional trainings and support to be provided if needed. Additionally, increasing knowledge of any efforts in collaboration could aid in improving care received by help-seekers.

**Definition of Trauma and Posttraumatic Stress**

Traumatic experiences can take multiple forms and may lead to a range of outcomes following exposure, including PTSD. Currently, the *Diagnostic and Statistical Manual* (DSM-5, American Psychiatric Association, 2013) description of posttraumatic stress includes the following: (a) exposure to actual or threatened death, serious injury, or sexual violence; (b) presence of intrusive symptoms and avoidance of reminders of the trauma, (c) negative alteration in thought or mood associated with the trauma, and (d) change in arousal and reactivity. The criteria also include specifiers to indicate the presence of dissociative symptoms when applicable (American Psychiatric Association, 2013). Previous editions of the *DSM* (e.g., DSM-IV-TR; American Psychiatric Association, 2000) described the diagnosis of posttraumatic stress as including exposure to a traumatic event in which the person experienced, witnessed, or was confronted by a death or serious injury and the person felt intense fear, helplessness, or terror; with persistent re-experiencing and avoidance of reminders of the traumatic event and ongoing symptoms of increased arousal (American Psychiatric Association, 2000). Using DSM-IV (American Psychiatric Association, 2000) diagnostic criteria, the 12-month prevalence rate of PTSD in U.S. adults was estimated to be approximately 3.5%. It has been noted that the highest rates of PTSD (ranging from one-third to more than one-half of those who are exposed) are

found among survivors of rape, military combat and captivity, and ethnically or politically driven incarceration or genocide (American Psychiatric Association, 2013).

Parlotz (2002) noted that trauma can be conceptualized as a spiritual experience in that it creates a situation in which a survivor must reexamine previously held values and worldviews through spiritual questioning and a potential shift in, or loss of, faith. Given the unsettling nature of trauma, it has been found that many trauma survivors are compelled to reexamine the meaning they have for their lives and the purpose they believe their life serves (Decker, 1993). This process often leads trauma survivors to seek the support of a clergy member in order to make sense of their experiences. Given this particular set of needs, Weaver et al., (1996) noted that caring for those who have experienced trauma is a large part of pastoral work.

**Role of faith in trauma recovery.** Researchers have conceptualized one's relationship with God as an attachment relationship (Kirkpatrick, 1995); in the same way that children look to their parents for protection and stability, people may also look to God as a source of safety and protection in times of stress. Working from the assumptions offered by attachment theory, Hill and Pargament (2003) argued that individuals who experience a secure connection with God would also experience greater comfort in stressful situations, as well as greater strength and confidence in day-to-day events. They further suggested that a secure relationship with God should predict lower levels of physiological stress and lower levels of loneliness. Empirical evidence has supported the beneficial impact of a secure relationship with God such that individuals who report a closer connection to God report less depression and higher self-esteem (Maton, 1989), less loneliness (Kirkpatrick, Kellas, & Shillito, 1993), and greater psychosocial competence (Pargament et al., 1988). In particular, a close and stable relationship with God has predicted better psychological adjustment among people who face a variety of major life

stressors, including transplant surgery (Tix & Frazier, 1998), medical illness (Koenig, Pargament, & Nielsen, 1998), and natural disasters (Smith, Pargament, Brant, & Oliver, 2000).

Jordan (1995) noted that trauma defies human faith in a loving, caring, and powerful God. Thus, a secure relationship with God (Kirkpatrick, 1995) can be damaged by trauma. Traumatic experiences are characterized by a lack of control and are often hostile in nature, which can prompt the experience of existential crisis in which an individual engages in questioning, including "Why me?" and "How could God let this happen to me?" (Sigmund, 2003). Crisis and confusion may also extend to topics such as personal identity, responsibility, justice, guilt, suffering, and forgiveness, and may trigger a survivor to reexamine his or her worldview regarding each of these concepts (Grant, 1999). As a trauma survivor attempts to resolve these conflicting emotions, struggles may emerge in the form of anger, despair, confusion, guilt, and complete withdrawal. Moreover, if the survivor is unable to resolve these conflicts, he or she may have significant difficulty maintaining an intact faith belief system, further adding to feelings of guilt and shame (Parlotz, 2002). Given the spiritual nature of these questions and reactions, it is not uncommon for trauma survivors to turn to their clergy for assistance in dealing with their trauma and subsequent stress reactions (Sigmund, 2003).

In general, religion can provide trauma survivors with a wide range of resources with which to cope and find empowerment in situations where there is very little personal control (e.g., traumatic experiences and subsequent traumatic stress reactions; Smith et al., 2000). These resources stem largely from the structural and social aspects of faith and religious practices, including support from one's congregation or faith community, receiving the ministry and guidance of one's clergy or faith leaders, and reflecting on the messages in relevant religious literature or texts (Hill & Pargament, 2003).

Religious coping has been defined as religious behavior or thoughts that take place in response to a stressful or traumatic situation (Smith, 2004). It has been noted that religious coping can facilitate both positive and negative spiritual exchanges, with actions and thoughts indicative of a secure and trusting relationship with God being considered forms of positive religious coping, while spiritual interactions characterized by anger, fear, or doubt suggest negative religious coping (Pargament et al., 1998; Smith et al., 2000). Patterns of positive religious coping engaged in by trauma survivors have been found to facilitate more positive outcomes, including less psychological stress, cooperative interactions with others, and subjective report of psychological and spiritual growth (Pargament et al., 1998). In comparison, it has been argued that many religions, such as Christianity and Islam, have role models that followers are encouraged to emulate, such as Jesus and Mohammad (Decker, 1995). However, due to the perfect nature and conceptualization of these role models, those who try to imitate these role models are destined to fall short and experience feelings of failure and inadequacy. This concept may present especially detrimental consequences for trauma survivors, who may hold themselves to blame when they do not measure up to their role models, despite significant efforts to do so (Decker, 1995).

Furthermore, Smith and colleagues (2000) noted that interpretations of one's traumas as divine punishment or wrath exemplify negative coping and predict less favorable outcomes for the trauma survivor. Negative religious coping styles have been found to be associated with depression and other psychological symptoms, poorer quality of life, callous attitudes toward others, and physical health concerns, as well as a greater risk for PTSD (Pargament et al., 1998). Pargament et al. (2003) added that there are signs or "red flags" of religious coping in people who are experiencing crisis that are associated with poorer mental health outcomes, including

religiously based apathy, inappropriate self-condemnation, doubts about one's religious beliefs, and feeling at odds with one's God and religious community. Similarly, Reeves (2001) noted that trauma exposure can lead to feelings of alienation from God, as well as beliefs such as "bad things only happen to bad people" and "God really doesn't love me." It seems that those with a stronger, more stable relationship with a higher power before a traumatic experience are more likely to benefit from their faith and overcome the effects of their experiences, while those with a more unstable relationship with a higher power tend to find that their faith is easier to lose and presents fewer benefits (Pargament et al., 1998; Smith et al., 2000). Spirituality can prove beneficial during and after traumatic experiences, if the spiritual relationship is perceived as constructive and stable (Smith, 2004); thus, it appears that those individuals with spiritual beliefs who are seeking to recover from a trauma would benefit from assistance in making sense of their experiences in order to feel stable and secure in their spiritual beliefs.

Furthermore, trauma and spirituality are domains that interact as a survivor attempts to make sense of and recover from a traumatic experience; both may serve as a catalyst for growth and greater understanding or may lead to isolation, confusion, and despair (Smith, 2004). Calhoun et al. (2000) studied the interaction of religion and posttraumatic growth, an individual's experience of significant positive change during struggle with a major life crisis (Calhoun & Tedeschi, 1998), in a sample of college students who had experienced a major traumatic event in the past 3 years. They found that individuals who engaged in greater amounts of deliberate rumination about the traumatic event, a component of posttraumatic growth (Calhoun & Tedeschi, 1998), were more likely to find meaning from their experience and to draw strength from their recovery process. Additionally, individuals who were more open to religious change, or endorsed viewing their religious beliefs and practices as an ongoing

existential dialogue, were also more likely to report posttraumatic growth (Calhoun et al., 2000). More recently, Parks, Smith, Lee, Mazure, and McKee (2017) explored the impact of religious coping on the development of posttraumatic stress symptoms and perceived growth among U.S. veterans returning from Iraq and Afghanistan. The researchers reported that negative religious coping appeared to increase the presence of PTSD symptoms and decrease an individual's perception of posttraumatic growth. Positive religious coping was found to be related only to perceived posttraumatic growth (Parks et al., 2017). Thus, it appears that individuals whose worldview is influenced by a religious belief system that involves an ongoing existential dialogue are more likely to find meaning in major traumatic events and experience posttraumatic growth, while those who have a religious framework that is characterized by anger, fear, or doubt are more likely to report symptoms of PTSD and less posttraumatic growth.

However, not everyone who experiences trauma is able to find or make meaning of it and may in fact experience greater alienation and despair as a result. Dresher and Foy (1995) interviewed 100 veterans who were receiving inpatient treatment for trauma. The interview focused on religious orientation following combat exposure. Results showed that many Vietnam combat veterans who were suffering from PTSD were much lower than average on measures of religious orientation or investment in a religious affiliation. Furthermore, approximately 60% of participants reported that religious faith was a vital component of life during their childhood, while 74%indicated that they were struggling to reconcile their religious beliefs with the traumas they witnessed and experienced while deployed to Vietnam. Additionally, 51% noted that they had abandoned their religious faith while in Vietnam, while an additional 45.1% noted that they had abandoned their religious faith since their return from Vietnam (Dresher & Foy, 1995). Interestingly, a fourth of the sample (25.8%) reported that they had experienced a strengthening

of their faith following their deployment to Vietnam. A minority of the sample (26.1%) reported currently attending religious services more than twice per month, suggesting that for some, religion offered a helpful coping strategy and/or an outlet for social support (Dresher & Foy, 1995).

Among Christian and Jewish civilians, researchers have reported a decrease in religious beliefs following traumatic events. Falsetti, Resick, and Davis (2003) noted that among a sample of Christian men and women who had experienced a traumatic stressor, those who endorsed symptoms of PTSD also reported a decrease in religious beliefs following exposure to their first or only traumatic experience, while those without PTSD symptoms did not report a substantial change in religious beliefs post-event. Similarly, Ben-Ezra and colleagues (2010) explored changes in religious beliefs following sexual assault among Jewish women. Approximately half of the women who reported having experienced sexual assault also endorsed a decrease in religious beliefs post-assault, whereas those without a history of sexual assault did not endorse any change in religious beliefs. Interestingly, women who had experienced sexual assault and also reported perceived stigmatization related to their trauma history were twice as likely to experience a decrease in their faith beliefs post-assault (Ben-Ezra et al., 2010).

These findings suggest that religion and spirituality can provide a helpful means of recovering from traumatic experiences and making sense of one's disrupted worldview (Calhoun et al., 2000), but may also present the potential for the development of less favorable outcomes (Smith et al., 2000). Thus, care must be taken when addressing a help-seeker's religious and/or spiritual needs and concerns within the context of a traumatic stress reaction among veteran and civilian populations.

**Clergy Intervention with Trauma**

Smith (2004) argued that the inclusion of religion and spirituality in the course of trauma treatment may be beneficial for survivors by providing more holistic care that addresses the psychological and spiritual needs of a survivor; however, this practice is not very common within the realm of traditional psychotherapy. Most clinicians do not receive training in techniques for incorporating religion and spirituality into treatment (Parlotz, 2002; Weaver et al., 1996). However, multiple researchers (Decker, 1993; Fallot, 1997) have noted that failure to address issues of spirituality and religion in the context of trauma treatment can result in an intervention that is not comprehensive. Additionally, the values held by counseling psychologists include the use of a holistic frame of reference to conceptualize the cultural context and strengths a client brings to the course of therapy, as well as provide respectful and culturally competent treatment for all individuals (Delgado-Romero et al., 2012). These aims are also consistent with the ethical code of conduct put forth by the American Psychological Association, which acknowledges religion and spirituality as a type of diversity that must be considered and respected throughout the course of psychotherapy and assessment (American Psychological Association, 2010). Thus, it is imperative that psychologists engage in multiculturally competent care when offering trauma work to a client who holds religious or spiritual beliefs.

Clergy have historically provided pastoral counseling and support to members of their faith communities, but there has been very little collaborative engagement between clergy and mental health providers in addressing more intense or severe mental health concerns including posttraumatic stress reactions (Weaver et al., 1996). Yet, clergy often are in advantageous roles, as compared to traditional mental health professionals, to address issues of trauma (Weaver et al., 1996). For instance, clergy often have greater access and involvement with individuals who

need treatment through interactions in the faith community and network. Additionally, clergy often have a longer and more personal relationship with members of their faith community, are perceived as less stigmatizing providers of counsel and support, and are often more accessible than mental health providers when assistance is needed (Oppenheimer et al., 2004). Due to the nature of their occupation, clergy are often exposed to situations that involve trauma and are often called in response to situations including car accidents, domestic violence, family illnesses, natural disasters, sexual assault, and gang violence (Weaver et al., 1996). This combination of prompt response to traumatic incidents, as well as training in addressing spiritual concerns, makes clergy valuable resources for those in need of support and counsel following a traumatic experience (Smith, 2004). Furthermore, Mahedy (1986) noted that traditional treatment of the psychological symptoms of PTSD may not address the spiritual and religious distress that can develop following a traumatic experience. Thus, the acknowledgement and inclusion of spirituality in treatment can facilitate providing clients with the most holistic care possible (Mahedy, 1986).

Although involvement of clergy in targeting concerns of trauma survivors presents several potential benefits, this form of care has been met with concern and criticism. The literature reports that clergy are no better at evaluating emotional distress than students enrolled in an introductory college psychology course (Weaver et al., 1996). Smith (2004) noted that while some seminary programs include exposure to general counseling skills, such as empathic listening, these courses typically do not cover detailed information about the etiology and presentation of PTSD. Furthermore, the training provided to clergy during their seminary coursework does not provide the skills to intervene with individuals suffering psychological distress following a traumatic experience (Smith, 2004). Weaver and colleagues (1996) noted

that this is not only an issue of ability to intervene with trauma survivors; it also presents difficulty in making successful referrals to mental health professionals. If a clergy member is unable to make an accurate assessment of the nature of an individual's presenting problem, this limits his/her ability to make appropriate referrals and recommendations for care (Weaver et al., 1996). It has been suggested that if clergy were made more aware of the nature of PTSD and matters related to its treatment, clergy could acknowledge and address both the spiritual and psychological components of an individual's presenting concerns, as trauma survivors seeking help from clergy tend to share only the spiritual concerns related to their trauma (Reeves, 2001). As a result of limited knowledge and familiarity with psychological aspects of trauma, it is not uncommon for clergy to focus primarily on spiritual concerns related to a trauma, such as feelings of being alienated from God, without exploring the possibility of psychological concerns, such as flashbacks or hypervigilance, that may also be present (Reeves, 2001).

Bruns et al. (2008) examined Christian, Muslim, and Universal Life faith leaders' experiences and needs related to responding to victims of sexual abuse and assault. The researchers conducted focus groups with faith leaders from urban and suburban areas of Maryland to gain greater understanding of faith leader experiences in working with sexual abuse and assault victims in terms of the number and types of interactions with survivors, the type of training and preparation received to support victims of sexual abuse, feelings of preparedness to engage in this type of work, and knowledge and access to community resources for survivors. With regard to the frequency of encounters with survivors of sexual assault, the faith leaders shared that they rarely worked with cases involving this type of concern and added that they were rarely involved in direct response to an incident in which sexual assault had occurred. The participants further elaborated that when sexual abuse was disclosed to them, it typically was

shared in the context of other immediate stressors in the life of a survivor (Bruns et al., 2008).

Faith leaders also mentioned avoidance of acting proactively when there is evidence that sexual abuse is taking place in the life of a member of their faith community (Bruns et al., 2008). The participants further elaborated that they were aware of their lack of training and skill related to appropriate responses to these types of situations. Participants expressed difficulty knowing to whom referrals could be made and also expressed feelings of being overwhelmed with daily tasks, in addition to the potential needs of addressing sexual abuse within their faith communities (Bruns et al., 2008). Additionally, faith leaders observed avoiding discussions of sexual assault may prevent alienation of parishioners who have experienced or perpetrated an assault. It was also noted that discussing sexual abuse within one's religious community is often considered "taboo" and is a topic that is typically absent from discussions within local leadership of faith communities (Bruns et al., 2008).

In spite of the limited training clergy typically receive to intervene with individuals who have had a traumatic experience, multiple researchers have explored the skills and specific types of assistance that clergy can offer in these cases. Rynearson (2010) illustrated multiple techniques that could be used by clergy to intervene with individuals who have experienced the violent death of a loved one. He noted that in working with this type of traumatic experience, clergy can play a stabilizing role by assisting relatives and friends in creating an integrated narrative around the death of their loved one. This process involves aiding the bereaved to balance their narratives surrounding the loss, with details of the traumatic event as well as comforting images and memories of the deceased; this process is believed to allow the bereaved to shift their focus from solely reflecting on aspects of the trauma to a more balanced narrative of the deceased's life (Rynearson, 2010). In consideration of the frequency with which bereaved

individuals seek out clergy for support during times of loss, this type of assistance and support offers opportunity to promote increased psychological support and comfort for these individuals (Rynearson, 2010).

Wilson and Moran (1998) suggested that it may benefit trauma survivors to explore their experience and history with religion prior to trauma and following the traumatic event with their faith leader. This process allows a trauma survivor to engage in a dialogue with a clergy member, creating an opportunity for his/her reactions following the trauma to be acknowledged and normalized. These reactions may include feelings of abandonment by one's God, anger, bitterness, feelings of being unprotected, and guilt at having experienced and survived one's trauma (Wilson & Moran, 1998). In the context of this exploratory process, the authors noted that the clergy member should focus on alleviating any existential chaos a survivor is experiencing, including confusion and anxiety, by connecting his/her pre-trauma faith with post-trauma feelings and beliefs in an integrated fashion. As noted by Mahedy (1986), trauma survivors often experience an altered religious consciousness and changed awareness of the nature of God; thus, Wilson and Moran (1998) stated that it is imperative for clergy working with survivors to assist them in securing answers to questions of "why" in order to allow them to make meaning of their experiences. The ultimate goal for pastoral counseling with trauma survivors is to allow them to resume their lives through discovering and securing meaning and purpose for life after the trauma (Wilson & Moran, 1998).

Zuniga and Davis (2010) described the types of support that clergy can provide when issues of sexual abuse are disclosed within the faith community. The authors suggested that asking debriefing questions (e.g., "Please tell me what happened," "What did you hear," "How have you reacted") of an individual who discloses an experience of sexual abuse can serve to

assess the situation, as well as allow the survivor to begin to regain a sense of safety and security. Additionally, this process may allow survivors the opportunity to explore their emotions surrounding trauma and receive validation for these feelings from their faith leaders (Zuniga & Davis, 2010). The authors also noted the benefit of faith leaders developing a comfort level in talking about issues related to sexual assault and abuse, as "silence is dangerous and creates space where abusers can exploit the embarrassment of their victims to ensure secrecy" (p. 38). Thus, creating an atmosphere in which survivors of sexual trauma are comfortable disclosing their experiences and seeking support presents an opportunity to potentially end a cycle of abuse within individuals' lives. Furthermore, it is possible that victims may believe that discussing their sexual traumas will only bring themselves embarrassment and shame from their community and thus choose to keep quiet. Zuniga and Davis (2010) argued that it is imperative for faith leaders to communicate to survivors of sexual assault and abuse that their trauma was not their fault and they have a right and a place to speak up about their experiences in order to gain support from their faith leaders and receive referral to professionals who are familiar with addressing issues of sexual trauma.

Ringel and Park (2008), through interviews with clergy residing in South Carolina, examined the intervention and prevention strategies used by evangelical clergy members to intervene in cases of interpersonal violence. Participants described the services they provided for individuals facing issues related to interpersonal violence as including community-based interventions such as obtaining baby-sitting services, safe homes, women's groups, healthy relationships workshops, and premarital counseling for couples. With regard to interventions for survivors of interpersonal violence, participants listed scriptural-based services such as praying together (clergy and survivor) and using scriptural passages to reframe the individual's views on

suffering, love for self, and love for one's partner (Ringel & Park, 2008). Participants also mentioned a multi-level intervention utilized with perpetrators of interpersonal violence that followed these steps: the survivor loving the individual perpetrator, teaming up with another member of the faith community and continuing to love the individual, taking the individual to the larger faith community to be confronted by its leaders, and as a last resort, if the perpetrator does not change, excommunicating the individual (Ringel & Park, 2008).

Furthermore, the role of clergy in the lives of members of racial minority groups has been considered in the literature. Neighbors et al. (1998) noted that African American clergy members often serve as primary sources of mental health support for members of black churches, as well as gatekeepers and referral sources to specialty mental health services for their community members. Given the integral and diverse role filled by African American clergy members, Neighbors and colleagues (1998) sought to understand where clergy fall on a continuum of natural helpers, ranging from informal interactions with supportive family and friends to the role of the professional, trained helper. Using data collected in the 1980 National Survey of Black Americans, a national probability household survey, the authors explored the role of African American clergy in assisting African American individuals seeking support for serious emotional distress. This survey specifically evaluated topics related to help-seeking due to a particularly stressful experience or "nervous breakdown," the nature of the distress for which respondents sought assistance (e.g., physical health concerns, interpersonal concerns, emotional distress, death of a loved one, economic distress), and the use of professional help to address one's stressful experience (Neighbors et al., 1998).

Neighbors and colleagues (1998) also found that clergy provided a wide range of assistance to help-seekers, including praying and reading the Bible with help-seekers, allowing

them to talk about their concerns, giving general advice, giving treatment to help-seekers, providing individuals with comfort and sympathy, taking action on behalf of the help-seeker, providing the individual with monetary assistance, providing specific advice regarding the presenting concern, and referring the individual to another clergy member or church for assistance and support (Neighbors et al., 1998). It was also reported that, due to many cultural forces that oppose pursuit of traditional mental health care, including stigma, cost, help-seeker distrust of mental health professionals, and value of self-reliance, African American clergy play a significant role within the black community as faith leaders and counselors. Whereas African American ministers were found to be highly accessible to members of their faith communities and to provide support, the data indicated that in comparison with other sources of professional care, African American ministers seldom offer referrals to providers of specialty mental health care, more commonly referring help-seekers to other clergy members; the reason for the lack of referral was the potential stigma and cost of mental health treatment, along with a tendency to mistrust mental health professionals (Neighbors et al., 1998). Thus, it appears that with regard to the continuum of natural helpers presented by the researchers, African American ministers tend to function as both supportive caregivers and as mental health caregivers. Given the tendency of these clergy members to fill both roles, they are less likely to make referrals to other professional mental health care workers.

In a unique survey of congregation members' experience of pastoral care, Rudolfsson (2015) conducted a series of focus groups with Swedish survivors of sexual assault. Survivors expressed a desire for their need to be recognized by their faith leaders, in addition to a need to be able to express doubts in their faith and relationship with God following a sexual trauma. Furthermore, participants noted that they did not wish to be rushed into forgiving their abuser

when seeking support from clergy members (Rudolfsson, 2015). Reflecting upon clergy members' familiarity with psychological issues, survivors voiced a desire for pastoral caregivers to increase their awareness of psychological issues related to sexual assault. Interestingly, participants also indicated that they would like for psychotherapists to gain a deeper understanding of the impact of sexual assault on one's faith. Participants commented on the vow of silence taken by clergy members that requires them to keep confidential information obtained during confession or individual pastoral care (Catholic Diocese of Stockholm, 2010). This aspect of a clergy member's role was described as both helpful and limiting; it allowed survivors to disclose their trauma in confidence, but limited the ability of the clergy members to assist individuals in escaping abusive situations and relationships (Rudolfsson, 2015). Thus, it appears that Swedish help-seekers benefit from receiving support from clergy following a sexual trauma, but believe that the care they receive could improve.

Very little information is available regarding the specific types of support clergy offer and provide to trauma survivors. However, a few researchers have considered this issue and how intervention may differ depending on how soon after the trauma clergy are responding. Everly (2000) proposed that clergy can provide a value-added role to crisis intervention and response. He noted that traditional mechanisms of crisis intervention included cathartic ventilation (e.g., discussing one's concerns and stressors stemming from an event), social support, problem solving, and cognitive reinterpretation strategies. He argued that through the integration of religious, spiritual, and pastoral resources into the traditional crisis intervention process, clergy could offer many additional mechanisms of pastoral crisis intervention, including the use of scripture to educate, provide insight, and reframe; engage in individual and conjoint prayer; enhance belief in intercessory prayer (e.g., prayer that is said on behalf of someone else; Masters

& Spielman, 2007); facilitate unified and explanatory worldviews; engage survivors in ventilative confession; capitalize on faith-based social support systems; and reflect on divine intervention and forgiveness, as well as the belief in life after death (Everly, 2000). Furthermore, the author noted that clergy engaged in a pastoral crisis intervention may be able to offer a unique, confidential opportunity to communicate one's concerns following a crisis. He noted that this type of intervention can prove beneficial for survivors, their family members, emergency response professionals, and bystanders or witnesses (Everly, 2000).

Mahedy (1986) discussed the spiritual distress that often stemmed from the traumatic experiences soldiers endured during deployment to Vietnam. Mahedy served as a military chaplain and was stationed in Vietnam during active conflict. Drawing upon these two life experiences, Mahedy developed a program called "The Spiritual Boot Camp for Combat Veterans" (n.d.). This program combined principles of Alcoholics Anonymous with treatment for PTSD to focus on individuals' lack of control over circumstances surrounding their traumatic experiences, recognition of a higher power, and consideration of one's personal responsibility for managing one's thoughts, feelings, and actions. This early perspective on intervention with survivors of trauma has since created initiatives within the Veterans' Administration infrastructure to develop and provide spiritually oriented programs targeting symptoms of PTSD (Sigmund, 2003).

More recently, Sigmund (2003) shared that involvement of chaplains at the Dayton Veterans' Administration facility benefitted both patient and treatment team outcomes through assessment of spiritual issues and increased holistic care. Chaplains were involved in facilitating a spirituality group and were also active members of the treatment team at this location. This arrangement created opportunity for clergy members to educate members of the treatment team

regarding issues of spirituality, while members of the treatment team shared information regarding the treatment of PTSD and other mental illnesses with clergy members (Sigmund, 2003). Furthermore, the direct involvement of clergy in this setting allowed patients to address spiritual issues that emerged within the group, including forgiveness, letting-go, and anger at God. Based on the outcomes of this integrated team approach for PTSD treatment in a veteran population, it appears that including a spirituality component in treatment planning can help to overcome obstacles in recovery (Sigmund, 2003).

A program developed by the Office of Rural Health has given special consideration to assisting rural clergy members in supporting rural veterans in need of mental health care. The Office of Rural Health, noting that rural clergy members play a vital role in assisting veterans in rural communities, created the Rural Training Project in 2009. This program provided one-day workshops to clergy in many states, including Alabama, Kentucky, Tennessee, Texas, Minnesota, and Oklahoma, to enhance clergy understanding of veteran and military culture, as well as knowledge of how to make referrals to mental health professionals (Rural Health Information Hub, 2013). Additionally, this program educated clergy about ways to use their position within a community to impact public opinion about mental illness, lessen stigma, and promote acceptance of individuals facing a mental illness. At a one-year follow-up, more than 83% of clergy reported using the materials and skills they were provided through the trainings to continue learning about veterans needs and assisting veterans. Furthermore, a 242% increase in referrals to mental health professionals was noted during the year following trainings (Rural Health Information Hub, 2013).

**Clergy Self-Care Practices**

Given the multiple and diverse demands placed upon clergy, it is important that faith leaders engage in coping and self-care practices to maintain psychological and physical health. Holaday et al.(2001) assessed the impact of providing counseling services to members of their congregation and the ways in which clergy members managed this stress. Participants reported using a variety of coping strategies, including "giving it all to God" through prayer; setting boundaries around one's family time in order to prevent interruptions, including taking only emergency calls after working hours, using caller identification on one's personal telephone, and living away from the church's location; socializing with one's family and friends outside of the church community; and engaging in emotional distancing or compartmentalizing practices.

Kaldor and Bullpitt (2001) asked Australian clergy to reflect on ways they manage the stresses that result from the demands of their responsibilities. Over half of the participants reported that talking with someone or spending time with their family is their preferred way of coping. Other methods of coping that were reported included prayer (45% of sample endorsed), "getting away" or taking time off (41% of the sample endorsed), delegating work to others (18% of the sample endorsed), reorganizing one's time and priorities (17% of the sample endorsed), and seeking additional training to fulfill one's duties and the needs of congregation members (7% of sample endorsed). The researchers noted that coping strategies can either address symptoms of burnout or can focus on relaxation. Their findings showed that participants who employed strategies directly targeting burnout symptoms such as delegating work to others, reorganizing one's time and priorities, and seeking additional training, reported lower burnout rates than did participants who endorsed relaxation strategies alone (Kaldor & Bullpitt, 2001).

Similarly, Meek et al. (2003) reported that clergy members cite the importance of engaging in intentional activities and maintaining a sense of self-awareness. More specifically, participants noted that pursuing intentional balance between their work and personal activities, as well as intentional pursuit of connection with their loved ones and friends allowed them to maintain a sense of closeness and support as they tend to the needs of their congregation. Additionally, maintaining self-awareness was reported to take the form of remembering the sense of being called to the ministry, as well as remaining in spiritual disciplines such as reading scriptures, journaling, fasting, and praying. Self-awareness was also described as a self-appraisal that was paired with an understanding of God's grace and forgiveness, as well as a reliance on the power and presence of God to fulfill their responsibilities (Meek et al., 2003). In light of these findings, Meek and colleagues noted that it appears clergy may often be aware of their limitations; they added that in spite of expectations of others, clergy use this form of self-awareness to maintain a realistic evaluation of themselves in their work and functioning.

In an investigation of outcomes related to clergy coping, Chandler (2009) utilized the concept of burnout to examine the relationship between clergy self-care practices and work-related psychological health. A total of 270 clergy members completed an online survey, including the Maslach Burnout Inventory-Human Services Survey (Maslach & Jackson, 1986), as well as questions regarding the weekly amount of time engaged in spiritual renewal practices (e.g., prayer, worship, devotional Bible reading, meditation, journaling, or fasting) and rest-taking practices (e.g., physical exercise, outdoor activities, television viewing, and hobbies), as well as how frequently an individual contacted potential sources of social support, ranging from never to every day (Chandler, 2009).

Findings indicated that spiritual dryness, or limited engagement in spiritually renewing activities (e.g., prayer, worship, devotional reading or study, meditation, journaling, or fasting), was predictive of the emotional exhaustion component of burnout. Chandler found that more frequent feelings of being rested and renewed was negatively predictive of depersonalization and positively predictive of one's sense of personal accomplishment (Chandler, 2009). Furthermore, the researcher reported that ministry involvement, or obligations that made it difficult to engage in rest and renewal, was also predictive of increased emotional exhaustion and depersonalization. Family support was the only form of social support found to be predictive of an individual's sense of personal accomplishment, suggesting that family may play a critical role in the overall well-being of a clergy member (Chandler, 2009). In light of these results, Chandler (2009) argued that clergy members should attend to the balance between their pastoral activities and their rest and renewal practices in order to stave off the development of burnout.

Doolittle (2007) explored the relationship between burnout, coping strategies, and spiritual attitudes of members of the New York United Methodist clergy community. A sample of 222 United Methodist clergy members completed a written questionnaire measuring burnout using the Maslach Burnout Inventory (Maslach & Leiter, 1996), coping strategies in response to stress as assessed by the COPE axes (Carver, Scheier, & Weintraub, 1989), and their spiritual attitudes as examined by the Hatch Spiritual Involvement and Beliefs Scale (Hatch, Burg, Naberhaus, & Hellmich, 1998). Results indicated that maladaptive coping strategies, such as venting, disengaging, or self-blame, were associated with higher levels of emotional exhaustion and depersonalization. In comparison, adaptive coping strategies, such as acceptance of stressful situations, active coping, planning, and reframing, were associated with higher levels of personal accomplishment and lower levels of emotional exhaustion and depersonalization (Doolittle,

2007). Thus, it appears that some coping strategies are more protective against burnout than others.

A strong correlation between spiritual attitudes and emotional exhaustion emerged, suggesting that a pastor must use all of his/her coping strategies to manage the stress of the job. Doolittle (2007) noted that the data may indicate that it is possible for a clergy member to be fully engaged with his/her work, with a rich spiritual life, and high levels of personal accomplishment, and yet still experience emotional exhaustion. This potential relationship suggests that reports of emotional exhaustion may not necessarily indicate burnout or dissatisfaction with one's job, but may instead reflect one's level of engagement or investment in pastoral work (Doolittle, 2007). Furthermore, results also indicated that higher levels of depersonalization were correlated with lower levels of emotional exhaustion, which is believed to be indicative of the practice of setting and maintaining healthy boundaries between one's professional and personal lives. Also, of note, a strong correlation was reported between spiritual attitudes and levels of depersonalization. Given the methodology of this study, the relationship between these two variables is unclear; however, the author suggested that this finding may represent a tendency of those with a closer relationship with God to have less attachment to the physical world, including members of his/her faith community (Doolittle, 2007).

Interestingly, researchers have found that one's age may provide benefit in coping with the demands of a clergy role. Randall (2007) reported a correlation between the age of English clergy members and facets of burnout as measured by the Maslach Burnout Inventory (Maslach & Jackson, 1986). A negative correlation between one's chronological age and levels of emotional exhaustion and depersonalization was reported (Randall, 2007). The author suggested that these findings may reflect a trend of older clergy members having more time in their

position to develop a larger repertoire of coping strategies to manage the stressors that arise in ministerial work. Additionally, it was suggested that these findings may also indicate the process of maturation into one's occupational role, in that as time passes, clergy members most likely will come to terms with who they are as faith leaders and develop more realistic expectations for themselves and reactions to their work, as well as what they will actually be able to accomplish in their role as a clergy member (Randall, 2007). Thus, it appears that as clergy members remain in their caregiving role over time, they most likely will learn which coping strategies are most beneficial for their psychological well-being and will be able to better manage the stresses of their work.

The literature indicates that coping strategies are essential for clergy, regardless of the populations they serve. Given the additional pressures rural clergy members may face while providing support to trauma survivors, explorations of coping strategies they utilize may prove helpful in increasing resiliency and longevity in their careers.

## The Present Study

Given the information outlined in the literature review, the present study seeks to answer six questions to gain insight into the role rural clergy play in providing support to trauma survivors, as well as the impact this type of work has on these professionals. This study also aims to understand the willingness of rural clergy members to collaborate with mental health professionals in providing care for trauma survivors.

1. What preparation do rural clergy members receive to provide care specifically to trauma survivors?
2. How do rural clergy members approach the process of intervention with rural help-seekers who have experienced trauma?

3. Are rural clergy members able to engage in consultation within their religious organization regarding work with trauma survivors?
4. What is the experience of rural clergy members as they interface with mental health professionals?
5. How does intervening with rural help-seekers who have experienced trauma affect the health and well-being of rural clergy members?
6. How do rural clergy members cope with the stress of intervening with rural help-seekers who have experienced trauma?

The information gathered through these questions will provide mental health professionals, particularly psychologists practicing in rural areas, with greater knowledge of what rural clergy members have to offer trauma survivors. This information will benefit holistic practice (Gelso et al., 2014) with trauma survivors by potentially enhancing collaboration between mental health professionals and members of the clergy serving rural areas through increased awareness of the cultural and spiritual values held by rural help-seekers and rural clergy members. It has been argued that to neglect the spiritual or religious identity of one's clients within mental health practice "deprives the client of a full spectrum of discovery, growth, and healing" (Gotterer, 2001, p. 187). Thus, it is essential that mental health professionals be aware of and honor their clients' religious views and assumptions that may be contributing to their behavior and clinical presentation (Gotterer, 2001).

Additionally, the information gathered through this study will also allow for preventive interventions and outreach to clergy members (Gelso et al., 2014) to enhance the self-care and referral practices rural clergy members employ, in order to reduce the vulnerability to burnout

that is likely among members of this population, as it has previously been reported that there is a 50% burnout rate among pastors (Merritt, 2010).

# Chapter 3

## Method

As noted in Chapter 2, there exists a significant void within the literature regarding the way in which rural clergy provide intervention with help-seekers who have experienced trauma. Furthermore, Chapter 2 outlined the lack of information regarding clergy's self-care practices, as well as barriers to engaging in this type of activity. In this chapter, the rationale for the research design will be provided, as well as a discussion of inclusion criteria for participation, instruments that were used for data collection, and an overview of how interview data was analyzed.

### Design Rationale

In comparison to quantitative approaches, qualitative methods applied to the exploration of phenomena in social sciences offer a unique perspective (Hill et al., 1997). More specifically, qualitative data provide a rich, full description of a phenomenon of interest, in the natural language of those who experience its effects (Eisner, 1991; Miles & Huberman, 1994; Polkinghorne, 1994). Unlike quantitative investigations, qualitative methods allow researchers to apply judgment and wisdom to data, without the constraint of fitting one's findings into pre-existing categories or forcing agreement between a group of judges (Hill et al., 1997). Qualitative research does not begin with preformed or selected hypotheses, but rather pursues predictions and expectations as knowledge and understanding of a topic of interest unfold through data collection and analysis. Thus, categories of information are able to emerge phenomenologically from data during analysis, while leaving flexibility within its interpretation and organization of its themes to permit evolution and adaptations representative of new understandings that can be reached from the data (Hill et al., 1997). This inductive approach to research allows examiners to remain open to discovering relationships, constructs, and ideas

about the event of interest that may have been previously unexamined or not considered (Heppner, Kivlighan, & Wampold, 1992).

Qualitative research is most appropriate when a detailed and in-depth depiction of a phenomenon is needed in order to gain greater understanding of complex situations and processes. The information collected through qualitative methods allows for a vivid illustration of the diverse and multifaceted nature of the human experience (Morrow, 2007). This particular research methodology is adept at answering questions of "How?" or "What?" as opposed to questions of "Why?" (Creswell, 1998). Conveniently, qualitative methods offer flexibility in their design in that they can be applied to data collected from individual participants and may also be used in analysis of data provided by group meetings with participants (Hill et al., 1997).

Qualitative methodologies complement the aspirations and values of counseling psychology (e.g., holistic conceptualization, social justice, prevention, developmental perspective; Gelso et al., 2014); research utilizing these methods provides investigation into phenomena that are congruent with the schools of thought and methods implemented in clinical practice. Moreover, qualitative approaches provide a unique window into issues that could inform multicultural theory and practice. Finally, it has been argued that qualitative methodologies offer a unique opportunity to diversify and expand the field of psychology with detailed and intimate accounts of relevant issues and phenomena (Ponterrotto, 2005). Of particular relevance to counseling psychology, information collected via qualitative explorations can guide the formulations of interventions (Hoshmand, 1999).

The current study utilized consensual qualitative research (CQR) methodology. CQR shares similarities with other qualitative methods; however, Hill et al. (1997) noted that its components are combined in a unique manner to offer a novel approach to interpreting

qualitative data. For instance, CQR prescribes the use of multiple researchers, the process of reaching consensus in data analysis, and utilizing a systematic approach to analyzing data across cases. In consideration of CQR's classification as a qualitative methodology, Hill et al. (1997) argued that this approach meets several characteristics that have been described as typical of qualitative research, including seeking data from natural settings, use of the researcher(s) as the main instrument for interpreting the data, attempting to describe phenomena rather than manipulate them, examining the process as well as the outcome of an experience, relying upon inductive reasoning to build and expand theories, and seeking to understand a phenomenon and its meaning from the perspective of informants (Bogdan & Biklen, 1992). Furthermore, CQR also approaches research with the intent of generating working hypotheses through the emergence of concepts from the data rather than attempting to fit findings into existing theory (Henwood & Pigeon, 1992). Finally, CQR carries on qualitative tradition by expressing results through verbal descriptions rather than numerical summaries, by seeking empowerment for one's informants through the research, and by viewing scientific knowledge tentatively (Stiles, 1993).

CQR was predominantly influenced by grounded theory qualitative methods (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Grounded theory methods involve creating a conceptual network of related concepts about a phenomenon to construct new knowledge from a specific set of data, rather than forming a theory speculating on a phenomenon of interest and then testing it, as one would when using a deductive reasoning approach (Chenitz & Swanson, 1986). Given the seminal influence from grounded theory, CQR shares with it a constant comparative approach through which researchers code data by cycling through consideration of raw data and categories that are developed or drawn from it until they are verified (Strauss & Corbin, 1990).

However, in spite of its origins in grounded theory, CQR differs from grounded theory in many ways (Hill et al., 1997). For example, researchers using CQR methods define the sample and then collect all the data using the same protocol to ensure consistency of responses within the sample, rather than alternating between data collection and data analysis as with grounded theory (Hill et al., 1997). Secondly, CQR researchers use a team to arrive at consensus judgments regarding data analysis and interpretation, while also using auditors to check all work completed. This practice differs from grounded theory's approach in which one judge is used along with systematic checks by the researcher and others (Hill et al., 1997).

The developers of this methodology note that the consensual process of analysis is the most fundamental aspect of CQR; however, the use of a team to analyze data and arrive at conclusions requires researchers to give close attention to the dynamics among members of the team in order to address possible power differentials, as well as reactions to disagreements during the consensual process. During the consensual process of the present study, care was taken to minimize the impact of power differentials on the process by alternating which team member began the discussion. Members of the research team were either graduate students or a psychology faculty member. The graduate student members were from varying cohorts of graduate study, with some being more advanced than others in the program. Thus, it was important to counteract the potential for one member to dominate the discussion. When disagreements arose during the consensual process, team members were encouraged to present their perspectives and clarify their understanding of a given interview. Collaborative discussion ensued until a consensus was reached.

Hill and colleagues (1997) noted that it is imperative that members of a CQR research team are able to get along, be respectful, address inherent power differentials as they arise, are

comfortable challenging one another, and are able to negotiate and resolve differences. With regard to the composition of a CQR research team, these researchers highlighted that their experience has been that when faculty and students are working together, the team is able to function well, so long as faculty do not assume the expert role and are mindful of and manage any needs they may have to dominate or control the consensual process. Furthermore, Hill and colleagues (1997) noted that it is equally important that students have self-confidence and are willing to speak up during discussions, especially if they disagree with a perspective, as this adds richness to the understanding of the data. It is also important to think about the cultural backgrounds of team members and how this may influence the willingness to engage in a lively debate or to disagree with someone who is seen as a superior. Researchers utilizing CQR outside of the United States have noted that using teams composed of individuals with a range of experiences and progress in their academic career have been quite challenging because members seem to feel the need to defer to the opinion of the most superior or advanced team member (Hill et al., 2005).

CQR seeks to create a team dynamic that allows all members to feel equal and to have an equal investment in the process, without dominating or deferring too much. Strategies that can be effective in creating this type of environment include asking someone who has been unusually quiet about his/her experience of the team process and how he/she might be able to feel more comfortable or involved; working through issues (e.g., power struggles, reactions to disagreement) as they arise rather than allowing them to create and foster tension; and rotating who speaks first to avoid one person dominating and allowing everyone the opportunity to initiate discussion (Hill et al., 1997).

A third unique aspect of CQR is that researchers initially code data into logically derived domains or topic areas used to group information about related topics (Hill et al., 1997), and then core ideas are used to summarize the content of each domain for a given case (Ladany et al., 1997). In comparison, researchers using a grounded theory design code the meanings or themes directly into the transcript and then organize the themes or core ideas into a hierarchical structure. Unlike those using grounded theory, which guides researchers to state general findings across an unknown number of participants, CQR methods guide investigators to compare data systematically across cases and calculate the number of cases that fit within each category across domains (Hill et al., 1997). Finally, CQR describes findings across multiple domains rather than presenting them as a hierarchical theory of one single core category with several related subcategories as one would when using a grounded theory method (Hill et al., 1997).

**Participants**

Given the prevalence of Christian churches and faith communities throughout rural areas of the United States (Vaaler, 2008), Christian clergy members were recruited for the purpose of this study. Selection criteria for participants included completion of Christian seminary training, current active leadership role within a church, and current service in rural churches and communities. Participants were excluded if they had not intervened or were not currently intervening with a trauma survivor and if they were serving in the role of a pastoral counselor, rather than in an active clergy position within a church. Participants were obtained using a convenience sampling method to entail contacts within the researcher's professional and personal contacts. Potential participants were contacted via email and, if interest was expressed, a follow-up phone call was made detailing general information about the study in order to allow

each potential participant to make an informed decision as to whether or not he/she would like to participate.

The current study interviewed 8 participants of various Christian denominations. The final sample was predominantly male (62.5%), with an average age of 48.6 years. Overall, 75% of participants identified as White, with 12.5% African American and 12.5% as Sri Lankan. Fifty percent of participants had obtained a Master of Divinity, whereas 25% of the sample was currently in seminary and the remainder of the sample had completed training in less formal venues (e.g., online coursework and denominational trainings). One participant had completed zero courses pertaining to counseling, four had completed between one and three classes; one completed six, and two completed more than 15 courses. Half of the sample rarely discussed issues related to trauma during their coursework, whereas the remainder reported frequent discussions of this topic during training. One third of the sample had sought additional training related to trauma separate from their seminary training. Notably, all participants endorsed some type of personal traumatic life experience (see Table 1).

CQR conceptualizes the qualitative concept of saturation (Strauss & Corbin, 1990) as "stability of findings" (Hill et al., 1997). "Stability of findings" refers to whether or not the results obtained with a specific sample size appear to explain the phenomenon for a defined group of interest. This characteristic of the data is determined by collecting data from 8-15 individuals and then completing the preliminary analyses (domains, core ideas, cross analysis, charting findings) on 8-12 of the cases. The remaining cases can then be examined to see if there are new domains, categories, or relationships that emerge from the data. However, if the remaining cases are not found to change the results dramatically, the findings can be considered

to have stability and to be representative of the experience of the group of interest (Hill et al., 1997).

**Instruments**

**Screening questionnaire** (see Appendix A)**.** Basic information was gathered during the follow-up phone conversation process to ascertain whether or not a participant met inclusion criteria for the present study prior to scheduling an interview meeting.

**Demographic information form** (see Appendix B)**.** Demographic information included religious denomination, years in the ministry, size of current congregation serving, size of the community in which assigned church is located, locale in which majority of service has been completed, age, sex, ethnicity, type of training received to become a minister, seminary classes offered related to counseling skills, seminary exposure to counseling trauma survivors, trainings related to trauma completed since seminary, and personal history of trauma. This information was analyzed using descriptive statistics in order to better characterize the sample (see Table 1). Additionally, this information was used to understand the perspective each participant brought to the interview and the information he/she shared in response the semi-structured interview questions and prompts.

**Semi-structured interview** (see Appendix C)**.** The questions for a semi-structured interview were developed based on a review of the extant literature regarding clergy intervention with trauma survivors, experiences of clergy burnout and secondary traumatization, in consideration of issues faced by helping professionals within rural areas, and through reflection on data collected through a pilot study approved by the Radford University Institutional Review Board.

**Researcher as an instrument.** In qualitative research, the researcher is viewed as a tool for gathering data (Bogdan & Biklen, 1992; Morrow, 2007). Because of the semi-structured interview protocol that was used, the researcher asked a series of prompts in order to encourage in-depth exploration of participants' responses (Fassinger, 2005). Due to the nature of the interaction between the interviewer and the interviewee, it is possible that the researcher had some influence on the research process and the data collected. Furthermore, the principal investigator was involved with the data analysis process following collection of interview data; thus, interviewer bias may have influenced the process of analysis and interpretation at this stage as well (Patton, 2002). These potentials for bias to enter the data collection and analysis process are not to be taken lightly. Morrow (2005) offers multiple ways to manage these types of influence, through exploring one's personal assumptions from lived experiences, as well as those found within the literature, being honest with regard to any emotional involvement related to the research topic, and monitoring the ongoing impact that may develop through interactions with each of the research participants. Patton (2002) described this process as being reflexive, or remaining aware of, and attuned to, the cultural, political, social, linguistic, and ideological backgrounds of one's perspective as a researcher, as well as the perspective of the individuals who participate in research studies, and those to whom research findings are reported. As it pertains to the present study, the recommendations provided by Patton (2002) and Morrow (2005) were implemented in the form of a field journal; as the researcher conducted interviews, she documented any interpersonal dynamics that could be at play during the interview process (e.g., frustration with a participant who had been particularly difficult to schedule with; concern about the receptiveness of a participant to the topic). The information that was recorded in the field journal was shared with the research team prior to the analysis of each transcript.

Additionally, members of the research team also shared the initial reactions they had as they reviewed transcripts in preparation for coding meetings. These reactions included disagreement with the methods utilized by some participants to encourage help-seekers to address their posttraumatic responses, feelings of inspiration at the support provided by some participants to rural help-seekers, and confusion about aspects of participants' interventions with help-seekers. The research team discussed these reactions prior to initiating the coding process for each transcript. Those reactions that were particularly strong (e.g., disagreement with participants) were highlighted and team members challenged one another to ensure that their own biases were not unduly influencing the consensual process. For reactions related to confusion about the interventions provided, team members discussed their own understanding of the information in context of the participant's demographic information in order to enhance the coding process.

In conjunction with the cautions and suggestions outlined previously, CQR provides additional safeguards against the influence of bias in data collection and analysis. The use of a team approach to reach consensual agreement about the final analysis of each interview's transcript, as well as cross analysis of multiple interview transcripts to create overarching categories, provides multiple levels of checks for bias in data analysis (Hill et al., 1997). Furthermore, the use of auditors who are involved in the study itself, but who abstain from the consensual analysis process, allows for a check for the team's conclusions and interpretations. Hill and colleagues (1997) also noted that it is helpful for each member of the research team to record his/her biases, or personal experiences that may limit objectivity during data analysis, prior to beginning data collection. Hill et al. (1997) also stated that it may be helpful for each team member to record his/her impressions or reactions to each interview transcript in order to separate reactions that are based on personal issues rather than the specific data set currently

under consideration. Using these guidelines, other qualitative researchers have since noted their biases prior to collecting interview data and have highlighted the prevalence of the biases among the team (Castro-Convers, Gray, Ladany, & Metzler, 2005; Constantine et al., 2005; Ladany et al., 1997). In the current study, three team members believed that clergy are not competent to intervene with trauma survivors. Additionally, members of the research team also shared their initial reactions to transcripts, including disagreement with the approaches used by some clergy to encourage help-seekers seek treatment for their posttraumatic responses, appreciation of and awe at the support provided by some participants to rural help-seekers, and uncertainty about aspects of participants' interventions with help-seekers.

In accordance with the CQR method, each member of the research team who was involved with data analysis was educated about the importance of noting his/her impressions or reactions to the material in order to enhance the ability of the team to proceed with as little bias as possible. Prior to engaging in data analysis, the research team discussed potential biases that it needed to be aware of during the analysis process. Finally, this design utilized an auditor to check the work of the team and ensure the highest quality analysis possible at the conclusion of the individual analyses of transcripts and following the cross-analysis process.

**Procedure**

Following approval from the Radford University Institutional Review Board, a recruitment letter (see Appendix D) was disseminated through a local Christian clergy email listserv. Nine individuals expressed interested in participation, with one individual being excluded due to limited experience with rural residents and trauma survivors. In-person interviews were coordinated via email or telephone. As part of the scheduling procedure, participants were given a brief summary of the purpose of the study and completed a brief

screening questionnaire to verify their fit with the study's inclusion criteria. During the interview meeting, participants were oriented to the informed consent document (see Appendix E) and completed a brief demographic questionnaire (see Appendix B). All interviews were audio recorded with the written permission of participants (included in the informed consent document) for transcription purposes. Following the demographic questionnaire, participants were asked questions contained in a semi-structured interview protocol, regarding his/her respective knowledge of trauma and experience in working with survivors of trauma, consultation with other clergy members and/or with community mental health professionals, the impact of working with trauma survivors on one's relationships and health, and coping strategies employed to manage these reactions (see Appendix B). Interviews lasted an average of 45 minutes.

Recordings were transcribed by members of the CQR team prior to data analysis. To ensure confidentiality, any identifying information mentioned in the interviews was omitted from the transcripts. Once transcription was completed, participants were offered the opportunity to review and edit the transcript of their interview once it had been completed; no major edits were provided by any participant. Many participants shared aspects of their personal trauma histories during the course of interviews. When these transcripts were analyzed, quotes related to personal trauma were bracketed and denoted as such. The trust and authenticity of these participants is highly valued and speaks to their interest in the current topic. However, the interviewer also highly regards the sensitive nature of these disclosures and has taken every measure to preserve the anonymity of these participants. No quotes from these disclosures were utilized in the interest of preserving the privacy and confidentiality of these participants.

In accordance with recommended guidelines using CQR, one interviewer completed the data collection process in order to ensure consistency across interviews and to provide relatively

constant stimuli for each participant (Hill et al., 1997). In the interest of trustworthiness, the researcher kept a record of the length of each interview session, the atmosphere of the interview itself, and interviewer impressions of, or reactions to, interviewees. These notes were utilized during the analysis portion of the study to help maintain an awareness of biases on the part of the researcher that could influence interactions with participants, as well as the conceptualizations of data that are presented (Hill et al., 1997).

**Analysis**

Data collected from the demographic questionnaire was analyzed using descriptive statistics in order to describe the characteristics of the sample in terms of religious denomination, years in the ministry, size of current congregation, size of the community in which the assigned church is located, locale in which the majority of service has been completed, age, sex, ethnicity, type of training received to become a minister, seminary classes offered related to counseling skills, seminary exposure to counseling trauma survivors, trainings related to trauma completed since seminary, and personal history of trauma (see Table 1). Given the small sample size and the potential for aspects of the demographic information to allow for the identification of an individual, descriptions of the sample were approached by providing descriptions of the sample as a whole (i.e., on average participants had 20 years of experience) rather than describing each participant in terms of his/her individual demographic characteristics.

Interview data was analyzed using the process of CQR (Hill et al., 1997), which utilizes a research team to organize individual participant responses from open-ended interview questions and questionnaire items into domains or topic areas. The domains generated through the consensual analysis process are used to group information about similar topics and may change as the team works in order to be more precise, capture unexpected data, or may be deleted if they

prove to be irrelevant or redundant (Hill, Knox, Thompson, Williams, & Hess, 2005; Ladany et al., 1997). Using the domains identified for each participant's responses, core ideas or brief summaries are constructed for all the material in each domain. The purpose of core ideas is to summarize the content of each domain for a given case or transcript in order to capture what was said concisely and with clarity (Hill et al., 2005). Finally, a cross analysis is conducted, in which categories are developed to describe consistency in core ideas within domains found across participants. The use of categories during the cross-analysis process is intended to represent similarities between cases that are discovered through review of all interview transcripts to identify how core ideas cluster and can be summarized across cases (Hill et al., 1997; Ladany, et al., 1997).

CQR utilizes a research team of three to five people to complete the analysis of each participant's responses, as well as one or two auditors, who serve to review analyses and provide feedback. As CQR analysis is conducted, each member of the research team independently analyzes each participant's data and then the entire team discusses its respective conceptualizations and conclusions until a consensus regarding conceptualization of the data is reached. The auditor plays an active role both in checking the individual consensual agreements for each interview, as well as the consensual agreements obtained through cross analysis by reading through all of the material that has been placed in a given domain by the research team to determine if the material is in the correct domain, if all of the important material has been represented within each domain, and if the wording of core ideas within each domain is concise and reflects the content of the raw data (Hill et al., 1997). Once the auditor has reviewed this material, he/she provides feedback to the research team, which then meets to consider each

comment. The team may accept or reject each comment, but should be able to provide a rationale for each decision it makes.

In addition to creating categories based on qualitative data, CQR also allows researchers to describe how representative of the sample each category is. Hill and colleagues (1997) noted that categories that are found to apply to all interview cases can be considered *general*. Those categories that are found to apply to half or more of the interview cases can be considered *typical*. Categories that apply to either two or three or less than half of all interview cases can be labeled *variant*. Finally, those categories that are found to apply to only one or two cases are dropped from the analysis as independent categories because they are not considered to be descriptive of the sample. Hill and colleagues (1997) stated that in this situation, researchers should try to see if the core ideas of the infrequent categories can be subsumed by a more frequent category by broadening its content.

As outlined, the current sample generated qualitative findings, presented in overarching categories drawn from the raw data using the CQR methodology. Additionally, the qualitative data was described in terms of its frequency within the sample.

**Trustworthiness.** Validity in qualitative research considers whether or not findings are trustworthy based on the research design and data interpretation. From this perspective, the validity of a qualitative study rests with the truthfulness of findings and conclusions reached through hearing the insights of participants regarding a particular situation or phenomenon (Hays & Singh, 2012). Hill and colleagues (1997) described trustworthiness as the degree to which the results of a study can be trusted, demonstrated by the use of rigorous procedures and inclusion of details in the summary that allow others to evaluate what happened in the research process. Trustworthiness can be determined by evaluating multiple components of the research process,

including adequacy of the research questions, composition of the sample, consensual process, functioning of the research team, auditing process, and the use of consistent rules across cases. Consideration of the adequacy of questions used in a CQR design involves determining whether or not the questions utilized are adequate for addressing the topic, whether or not the questions are open ended to allow for participants' experiences to be assessed completely, and if interviews were conducted consistently across participants with the use of probing to obtain deep understanding of information (Hill et al., 1997).

Examining the composition of the sample allows reviewers of a CQR design to determine if the researcher adequately defined the population. Additionally, this consideration seeks to ascertain whether or not the sample has been randomly selected where possible and if the participants have experienced the phenomenon of interest (Hill et al., 1997). Consideration of the consensual process completed by CQR researchers seeks to determine whether or not the researchers have followed the procedure of individual analysis of each case followed by a consensual discussion that leads to a shared interpretation of the raw data. Given the collaborative effort that is characteristic of CQR data analysis, reviewers of a study's trustworthiness should also attend to the functioning of the research team in order to determine whether or not there is a healthy level of disagreement among members that leads to good discussion and consideration of the data (Hill et al., 1997).

In the process of evaluating the validity or trustworthiness of a CQR study, attention should also be given to the auditing process to determine whether or not the auditor has identified discrepancies or alternative interpretations separate from those reached by the research team. Reviewers should give careful consideration to studies in which there is no disagreement between the research team and auditors, as this could indicate a situation in which one party or

both is attempting to avoid possible friction or tension in the process of analyzing the data (Hill et al., 1997). Finally, consideration should also be given to whether or not the researchers applied the same rules to data analysis across cases in the assignment of data to domains, construction of core ideas within each domain, and creation of categories. As decision rules change, it should be made clear in the summary of a study that early cases were revised based on the evolving decision rules applied to the analysis (Hill et al., 1997).

In consideration of the guidance provided by Hill and colleagues (1997) regarding components of validity within a CQR methodology, the present study attempted to fulfill each of these requirements in order for the findings to be considered applicable to the population and phenomenon of interest, as well as generalizable to similar populations and phenomenon.

**Conclusion**

The current study explored the method of intervention rural clergy utilize when working with rural trauma survivors. There is some evidence in the literature to suggest that trauma survivors seek the support of clergy members; however, no study to date has examined the role that rural clergy play in the recovery of this particular type of help-seeker. Additionally, this study sought to understand the impact of working with trauma survivors on rural clergy members in terms of burnout, as well as the ways in which clergy members address and manage the stress of this particular type of work.

This chapter has outlined the procedure that was followed during the recruitment of participants, during data collection, and during data analysis. Additionally, the measures that were utilized were also introduced and described. Finally, the measures taken by the research team to promote collaborative exchanges and active management of biases and disagreements were reviewed.

# Chapter 4

## Results

In this chapter, the findings of the present study will be discussed. Information regarding participants' training prior to joining the ministry, as well as ongoing continuing education, was collected via the demographic form. This information was analyzed using descriptive statistics. Half of the sample reported obtaining a Master of Divinity as part of their preparation for their current role as a head or associate pastor of a congregation. One fourth of the sample described themselves as in the process of completing seminary training, while the remaining quarter described less traditional manners of training, including completion of some online coursework, and training through one's denominational organization. One participant had completed zero courses pertaining to counseling, four had completed between one and three classes; one completed six, and two completed more than 15 courses. Half of the sample described rarely discussing trauma and its sequelae during coursework, while the remaining half described frequent discussions of trauma in their coursework. More than 50% of participants denied additional training in trauma-related issues after completion of seminary. Of note, all participants endorsed some type of experience in their own life that they characterized as traumatic.

The analysis of interview data using consensual qualitative research (CQR) methods (Hill et al., 1997) revealed eight domains that were consistent with the research questions. Each domain contains multiple categories that represent more detailed aspects of a domain. CQR methodology offers a classification system to indicate how frequently categories were observed across interviews. Categories that are found to apply to all interview cases can be considered *general*. Those categories that are found to apply to half or more of the interview cases can be considered *typical*. Categories that apply to less than half of all interview cases can be labeled

*variant*. Finally, those categories that are found to apply to only one or two cases are usually dropped from the analysis as independent categories because they are not considered to be descriptive of the sample. Hill and colleagues (1997) suggest that any responses that are infrequently observed be excluded from the final summary. However, the researcher did not want to silence the voice of any participant when reporting findings. Thus, the researcher will report *infrequent* responses in this chapter and will highlight its infrequency within the narrative. The classification of *infrequent* will be reserved for categories capturing the responses of one individual only.

Quotations were provided to give a more detailed description of a participant's experience with a specific domain and/category (e.g., P1 represents participant 1; Bradley, 2011). Throughout this chapter, the section headers used are based on the domains generated through the consensual process of CQR. Within each section to follow, the domains are further expanded through discussion of the respective categories that emerged within a given domain. Table 2 provides a summary of the domains and categories that emerged using CQR methodology.

**Definition of Trauma**

When asked to describe what the word "trauma" meant to them, participants' responses captured the following aspects of traumatic life events: negative experience, physical and/or psychological injury, lasting impact, can lead to growth, and individual responses to trauma vary. Each participant was able to describe at least one characteristic of what he/she considered trauma. Most participants were able to speak to the impact that a traumatic experience may have on an individual's life. The following sections provide a more detailed discussion of each

category within this domain, using participant quotations to illustrate content captured during the interviews.

**Negative experience.** The most commonly used description of trauma was conceptualizing it as a negative experience an individual had endured. This category was observed in five of the eight transcripts analyzed, suggesting that it is a *typical* category within the descriptions of trauma used by participants. One participant characterized trauma as "an intense, negative physical, emotional, or spiritual experience" (P1). Another clergy member characterized trauma as "an acute moment when there is either physical or emotional… intense pain or anxiety… that rises above everyday highs and lows" (P5). One pastor observed that trauma can be "any kind of pain or violence experienced by someone" (P6). Another referred to the impact of unanticipated events, "anything that throws you for a loop… an unexpected change for the worse" (P8). Others spoke to the overwhelming nature of trauma (P9) and reflected on the feeling that "the whole world is going on, while you're in this shell wondering why your whole world has just collapsed" (P8).

**Lasting impact.** Four of the 8 participants provided discussion around the many ways traumas can change the manner an individual functions post-trauma. This category is considered *typical*. One clergy member discussed the influence of early childhood neglect on a help-seeker's worldview: "a lot of students are living with an aunt or uncle and have free range… when we talk about 'do you feel cared for' or 'there's a God who loves you,' it can be hard to wrap [their] minds around that" (P1). Another reflected on the impact of traumatic experiences on one's emotions: "I had a lady who had something [traumatic] happen to her; what I saw a lot out of her was fear, she was very, very fearful" (P2). One participant discussed the struggle some people

may experience to recover from a traumatic event: “being so immersed in it that you can’t see how much of a difference has been made over time” (P6).

**Physical and/or psychological injury.** Several participants offered perspective on traumas including some type of injury that is experienced and necessitates a recovery process post-trauma. This category was derived from 3 of the 8 interviews, suggesting that it is a *variant* in its occurrence within this sample. One individual described trauma as a “deep wound” (P4). Another characterized it as “anything that physically, emotionally, or mentally makes you bleed. It’s the wounds that never completely heal” (P7).

**Individual responses vary.** Three out of 8 participants observed that two people may not have the same response to a shared traumatic experience, indicating another *variant* category within the domain of definition of trauma. One clergy member commented, “for some people it [traumatic experience] is the end of their world, others can move on” (P4). Others referred to the role that perceptions play in responding to traumatic events: “What is traumatic for one person may not be for somebody else” (P5, P6).

**Can lead to growth.** One individual described the possibility that traumatic experiences may lead to personal growth as an individual recovers from his/her trauma. While this category is considered *infrequent* and often would not be included as a finding, it is important to draw attention to this insight and contemplate ways to increase consideration of ways to expand this understanding of trauma and its aftermath. This participant observed “through people sharing their scars, we can recognize gifts in each other. Trauma is wounding but can also lead to growth” (P7).

**How Pastors Get Involved with Help-Seekers**

Participants were asked to describe how they become aware of a person's traumatic experiences and need for support. Their responses were organized into the following categories: word of mouth, phone calls, with person at the time of the event, and concerns voiced during service or meeting. Most participants described at least one of the categories within this domain. A detailed description of each category, including participant quotations, follows.

**Word of mouth.** Five participants described learning of a person's need for support following a traumatic experience through a network of family and/or community members who share information with them on another's behalf. Within this sample, this response is considered *typical*. One participant who works with primarily adolescents shared that he tries to cultivate "working relationships" with school administrations, parents, and other local pastors. He observed "[our] relational connections and investments in the community … lead students to gravitate toward us or … some of their friends will introduce us" (P1). Another clergy member shared it is common for a friend or family member to notify him about an incident that someone has experienced, rather than the survivor themselves reaching out for support (P6). One pastor commented, "I'll tell people, 'if you hear of somebody or if you hear of a situation you think I could assist in … tell me so I can check it out, because I'm not always aware of everything'" (P8). Another individual described hearing about the needs of her congregation through conversation and "pastoral care connections" with the community (P4).

**Phone calls.** Two of the 8 participants mentioned becoming aware of help-seekers' needs by phone calls. This category is considered *variant*. One individual noted "about ½ [of help-seekers] will call themselves" (P6). Another participant mentioned, "I'm usually contacted fairly

soon after [something traumatic] by phone with someone asking, ‘can you come be with us’ or, ‘can you just pray with us over the phone?’” (P5).

**Innate sense.** Two participants discussed having the ability to sense that something was troubling an individual that led them to start a dialogue with potential help-seekers. One clergy member noted:

> If you just sit and pay attention to body language, what they say, how they say it, and you can offer “you know, I’m here” … I’ve always found the people I need to find when I need to find them. (P7)

Another participant described this as “I can look at people and tell that something is wrong” (P2). This category is considered *variant* for this sample.

**With person at the time of the event.** One participant described being with help-seekers at the time of a traumatic event. This category is considered *infrequent* and typically would be excluded from analysis. However, it appears to capture a unique role that clergy members may play when serving help-seekers, particularly in rural communities. The participant shared experiences that characterize this category: “I was in the emergency room with a couple who lost their son… I was with a woman whose mother had to come off life-support… I was with another couple whose adult son died on the operating table” (P4).

**Concerns voiced during service or meeting.** One of the 8 participants described aspects of the way weekly meetings are structured that allow her to become aware of the needs of her community: “Sunday mornings we always have our joys and concerns moment at church… If I hear something I think I need to follow up on, I’ll make a note of it and try to follow up on it later” (P8). This category is considered *infrequent* and typically would not be included in the final summary given its limited representation among the data. However, it captures an aspect of

intentional practices that allow the needs of a community to be regularly shared that was not otherwise mentioned. It is possible that this practice is common within the work of rural clergy members, but was not mentioned specifically by other participants.

**How Pastors Assist Help-Seekers**

Participants reflected on the process they use to intervene with help-seekers who have experienced a trauma. The following categories were found among their description of the way they intervene: being physically present, listening to help-seeker, authenticity, helping individuals develop ways to cope, incorporating the help-seeker's faith, using the "movement of the Spirit" as a guide, using own life as a testimony, and connecting help-seekers to crisis resources. All participants described at least two of the categories within this domain. The following includes a description of each category within the domain of how pastors assist help-seekers, as well as direct quotes from participants to better characterize interview content that contributed to this domain.

**Being physically present.** All participants described efforts to be available for face-to-face meetings and expressed valuing this type of contact with help-seekers. This category is considered *general* for the current sample. One participant stated, "I try to be attentive and available to talk… A lot of times what people need is for others to care and walk with them and be available" (P4). Another said, "I bring my presence, to remind you that you are not alone" (P5). Similarly, Participant 9 said, "As soon as I find out [about someone's need], I'm in the car and gone… to show them I'm there [for them]." One clergy member noted that being these types of encounters allows for an "assessment of perceived need" following a traumatic experience (P6). Some participants work with younger age groups and described the benefit of "just being around" (P7) so that their community members could utilize them when needed. Another

individual observed that being accessible allowed her to serve as "a grounding, stabilizing force" for those recovering from trauma (P8).

**Listening to help-seeker.** All participants reported using listening skills when assisting help-seekers who have experienced some type of trauma. This category is *general* within the current sample. One participant stated, "A lot of times it's just listening and letting them talk it out" (P2). Another noted, "I encourage people to talk because it often seems cathartic for people to share their experiences" (P5). Similarly, Participant 9 said, "You have to listen compassionately." One clergy member commented, "The biggest thing is just trying to shut up and listen… sometimes listening is the hardest thing to do because we want to fix… That's a process you learn" (P7).

**Authenticity.** Multiple clergy members emphasized the value of being authentic when engaged in conversations with help-seekers. In this sample, this category is considered *variant*. One participant noted the impact this can have on people struggling with reactions to trauma:

> Building a relational bond of trust so people will feel comfortable sharing and opening up… No one really wants to be honest and transparent, if they are, they're selective. Around trauma, it's a really unique time… the barriers to emotions come tumbling down and we get a glimpse of the raw emotion they're feeling… if we're gentle and responsible with it, we can trace those things to a lot of different places. (P1)

Another clergy member shared, "I try to preface with 'it doesn't matter what you say, I'm not going to be surprised, I'm not going to judge you" (P2). One participant acknowledged how this factors into having difficult conversations with help-seekers: "You can tell them a fairy tale and tell them they'll live happily ever after… But if you lie to them, they know it… Sooner or later a lie is just a lie, it doesn't help anybody" (P7).

**Help individuals develop ways to cope.** Three of the 8 participants mentioned their role in helping members of their communities explore ways to cope and manage stress following traumatic experiences. This category is *variant* for the current sample. One participant said, "I try to give permission for people to figure out what works for them and support people as they move out of the dark place" (P8). Another characterized this process as "I facilitate conversations around finding and developing a new normal" (P6).

**Incorporating the help-seeker's faith.** Several participants mentioned examining and including help-seekers' faith and spirituality in the process of recovering from a traumatic event. This category is considered *variant*. One clergy member recalled a gathering he facilitated among a group of students following a student's death in a motor vehicle accident:

> We talked about the dead student's faith and said, "This is what he believed and because of that, this is where we think he is; he's spending eternity with God in heaven." We addressed the questions of how, why, and what happens. (P1)

For another participant, spirituality is a priority in the process of healing from a traumatic experience. She noted, "I pray with them, even before they open up to me… After that we go straight to the scriptures" (P2).

**Using "movement of Spirit" as a guide.** Two participants described tapping into a personal connection with the Holy Spirit while working with help-seekers to more effectively intervene; this is a *variant* category. One clergy member stated,

> I listen to them and what God is saying to tell them… I will say to them "this is what the Lord just said to me" and nine times out of 10 they'll open up and be like "I don't know how you knew that." (P2)

Another described a shift in his way of engaging with help-seekers as he gained more experience in ministry:

> There's this certain point when you're actively listening… you're hearing everything, but you're able to also have other things happening in your mind and spirit to [better understand]. Some people would call that the movement of the Spirit, others call it experience. (P5)

**Using own life as a testimony.** A couple of individuals mentioned using their own lives and faith journeys to assist and comfort help-seekers who are struggling with a traumatic event. In the present study, this category is considered *variant*. One clergy member said she will share with help-seekers: "This is how God helped me… This is how the scriptures helped me… This is how prayer has helped me" (P2). Another said, "I try to accumulate my own and others' success stories to tell of how God's shown up, to say 'I trust that He's going to pull you through and be there'" (P4).

**Connect help-seeker to crisis resources.** Two clergy members discussed their knowledge of crisis resources within the community, as well as ways in which they address these types of situations when they occur. This category is classified as *variant* within the current sample. One observed, "The greatest responsibility I have is to watch whether or not they may harm themselves or someone else… If their trauma is so insufferable for them, I'll refer them to ACCESS or the local community service board" (P4). Another participant stated, "I give away a lot of responsibility to our congregational care team, but I'm very much the point person for crises" (P5).

### Reaching Out to Other Clergy

Participants were asked to describe how often they found themselves consulting with other clergy members within their community and/or professional network to better assist with difficult cases. Responses captured the following ways that participants sought consultation from their peers: informal conversation as needed, monthly clergy groups, individual mentoring, and infrequently. Most participants discussed at least one way that they utilized consultation as it related to providing care to trauma survivors. However, one participant shared that she rarely consults with her colleagues, representing an *infrequent* finding for this sample. A more detailed discussion of each category within this domain follows, as well as participant quotations that illustrate core ideas of each category.

**Informal conversations as needed.** Half of the participants reported using informal conversations with other church leaders when they needed assistance working with challenging situations. This category is considered *typical* for this sample. One participant stated, “I get together with other church leaders and … process how to approach situations” (P1). Another commented, “I have ministers whom I’m very close with; I seek their advice” (P2). Two participants (P7, P8) had spouses who were also clergy members and served as sources of consultation when needed. One of these individuals (P8) noted, “I bounce a lot of stuff off my husband… we respect confidentiality that comes with being pastors of separate churches.” She added, “It’s a scary thought, me trying to pastor without some conversation partners” (P8).

**Monthly clergy groups.** Three participants described their ability to use monthly clergy group meetings as a resource for support and consultation related to work with trauma survivors. In this sample, this category is considered *variant*. One participant said, “I meet with a group of clergy once a month and we discuss counseling issues” (P7). Another commented, “Pastors get

together monthly… I can ask them 'do you have any suggestions on how to intervene and be a helpful presence?'" (P6). One clergy member characterized her monthly meetings as "we present case studies and check in about any situation where we need help or advice" (P8).

**Individual mentoring.** As it pertains to seeking consultation and support in working with trauma survivors, two participants reported having the opportunity to utilize individual mentoring. This is a *variant* category within the domain of reaching out to other clergy. One individual characterized her mentor as her "spiritual mother," with whom she could discuss ministerial needs, as well as ways to better manage the demands of her work, (e.g., "you need to learn how to rest"; P2). Another participant described being placed with a mentor as part of his ordination process: "We talk a couple times a week and get together monthly… we're always consulting with one another about something" (P6).

**Barriers to mental health care.** Participants were asked to reflect on barriers they had experienced in collaborating with mental health professionals. Their comments outlined the following difficulties in collaborating with mental health professionals: stigma of mental illness, help-seekers' concern that therapy does not complement their faith, help-seekers' readiness to address trauma, lack of compatibility between therapist and clergy worldview, too few mental health providers, and help-seekers' concern about confidentiality. Most participants discussed at least one way in which they utilized consultation as it relates to providing care to trauma survivors. A more detailed discussion of each category within this domain follows, as well as participant quotations that illustrate core ideas of each category.

**Stigma of mental illness.** More than half of the participants identified stigma as a barrier to help-seekers pursing mental health care; this is a *typical* category within this sample. Participant 4 characterized stigma as "the greatest barrier" to help-seekers engaging in mental

health care. Another described the general attitude of his church community toward mental health services as, “I’m a little crazy, but I don’t need to seek a counselor” (P6). Similarly, another clergy member commented, “Nobody wants to be crazy” (P7).

**Help-seekers’ concern that therapy does not complement their faith.** Several participants mentioned concern that therapy is not complementary to their faith and identified this as an obstacle to help-seekers utilizing mental health services. In this study, this category is considered *variant*. One participant observed,

> Secular therapists who have an agenda and try to steer clients in a direction that is not complementary to their faith; that is a really hard place for people who experienced trauma and are in need of mental health to sort through. (P1)

Another clergy member discussed an experience in which a member of her community saw a therapist who recommended an intervention that did not align with the help-seeker’s faith. She said, “I [tell people] make sure you talk to a Christian counselor, because sometimes what I’m saying contradicts the secular world and the two don’t mesh… It just doesn’t line up with what the Bible says” (P2). Participant 6 described the intersection between faith and seeking psychotherapy as, “There is this theological sense that counseling isn’t Christian. There’s a fear that somehow [psychotherapy] isn’t faithful.”

Two clergy members discussed the importance of a psychotherapist’s ability to integrate faith into the therapeutic process; the absence of this integration was perceived as a barrier to mental health care. In the current sample, this category is considered *variant*. One clergy member described positive encounters with “secular counselors who are complementary to the Christian faith and are willing to positively integrate that into therapy” (P1).

**Help-seekers' readiness to address trauma.** With regard to addressing trauma through psychotherapy, three participants highlighted the lack of readiness of help-seekers to discuss their trauma as a potential barrier to seeking care. This is a *variant* category. As Participant 5 observed, "Not everyone is ready to talk about trauma. The young and the old are. The middle-aged adults have compartmentalized it and won't talk about it." Another said, "It depends on how desperate they [help-seekers] are" (P7). One clergy member commented, "People just don't want to admit [psychotherapy] is something they need" (P8).

**Financial limitations.** The role of limited income and/or lack of health insurance coverage was identified by two participants as a barrier to accessing mental health care. This category reflects a *variant* frequency for the current sample. One participant talked about difficulty negotiating the "financial aid piece" for those with limited income and basic insurance (e.g., Medicare; P4). Another clergy member commented about an instance in which a help-seeker "couldn't get the insurance worked out," limiting access to mental health care (P8).

**Too few mental health providers.** Two participants discussed mental health provider shortages within rural areas and the difficulty this creates for help-seekers interested in psychotherapy. Within the current sample, this category is considered *variant*. Participant 8 observed, "It can be frustrating, 'cause often times there aren't many places, especially in a rural setting, to send people [for mental health services]." Another clergy member stated, "The whole service capacity is inadequate, there are way too few counselors to meet the need" (P4).

**Help-seeker concerns about confidentiality.** A few participants commented on the interaction between small community dynamics and their ability to have confidentiality while receiving mental health care. This category is considered *variant*. Both participants reflected on ways in which confidentiality is limited within small communities, specifically related to the

daily routines and travels of people. One commented, “People know what your car looks like and will see you parked at an office” (P6). The other reflected, “People won’t go to a counseling center because the community is small, and they don’t want their car to be seen” (P5).

**Referrals to Mental Health Professionals**

When asked to discuss their experiences with referring help-seekers to community mental health providers, participants described the following aspects of this domain: therapists are used when issue is beyond clergy’s comfort level or scope, clergy’s limited knowledge of trusted providers, desire for help-seekers to trust in counseling, comfort level in making mental health referral, use of crisis resources, and appreciation of learning when a referral has been used. Most participants described at least one category related to making referrals to mental health professionals. The following sections provide a more detailed discussion of each category within this domain, using participant quotations to illustrate content captured during the interviews.

**Used when issue is beyond clergy’s comfort level or scope.** Four participants mentioned using mental health referrals to address problems outside their comfort level or scope. This is a *typical* category within the current sample. One participant explained, “There’s a scope that we as youth ministers are able to operate in; we’re not fully equipped to deal with major trauma or depression” (P1). Another clergy member said, “I stay in my lane… I’ll go as far as I can and then I’ll refer to somebody else” (P2). Similarly, Participant 8 said, “If at some point it feels like it’s more than I can handle, I refer them.”

**Clergy’s limited knowledge of trusted providers.** Some clergy members discussed difficulty making referrals because they were unsure of who would be receptive to the concerns a help-seeker had. Within the current sample, this category is considered *variant*. One said, “I don’t have a good referral base to pull from. A lot of times, general practitioners are the source

of referral. Other times, people have found their own way to a counselor and I breathe a sigh of relief" (P4). Another participant reflected on the impact of changing church assignment on his ability to refer to area mental health providers: "I'm fairly new to this congregation, I'm still trying to figure out the mental health resources in this area" (P5).

**Desire for help-seekers to trust in counseling.** Three participants expressed a desire for their community members to believe in the benefit of counseling prior to making a referral for psychotherapy. For the current sample, this is considered a *variant* category. Participant 5 described his process of referring help-seekers as, "I learned a responsible model of referral that parishioners might build trust in the concept of counseling through me and then I refer them out to someone else." Another clergy member said, "I build enough trust with my congregation to say, 'I think the best thing would be for you to have someone who's trained in helping these very specific things' and I'll be there alongside that" (P6). One pastor described establishing a relationship with a college counseling center to facilitate referrals when needed. He said, "We have them [college counselors] over here at different times to have dinner with us and get to know each other" (P7).

**Comfortable making mental health referral.** A few participants expressed comfort with referring help-seekers for mental health services. This category occurred at a *variant* frequency in the current sample. One clergy member said, "I'm not afraid to refer" (P6). Another individual stated, "I'm really keen to refer people to a mental health professional for a few sessions" (P1).

**Appreciation of learning when a referral has been used.** Two participants mentioned the benefit of being notified when a referral was utilized. Although this category is considered *infrequent* and typically would not be included as a finding, it highlights a unique rural clergy

member's perspective that was not otherwise discussed by the current sample. Participant 6 commented that hearing from a therapist, "This person said you'd referred them to me," was very helpful and allowed him to know that "the connection has been made." This kind of communication helped him to combat feelings of "screaming into the darkness" without feedback or observable outcome. Another pastor expressed a desire to know if help-seekers are "participating" or utilizing referrals he has made to mental health professionals (P9).

**Clergy's use of crisis resources.** One clergy member discussed her use of crisis resources when necessary; this is an *infrequent* category. Typically, this finding would not be included in the final summary given its limited representation among the data. However, it captures an aspect of clergy assistance provided to trauma survivors when a need for a higher level of care was identified that was not otherwise mentioned by the current sample. Participant 4 said, "The greatest responsibility I have to somebody is to watch whether they may harm themselves or someone else. If their trauma is so insufferable, I'll refer them to ACCESS [local crisis hotline] or the local Community Resource Board."

**Impact of Trauma-Work on Pastor**

Participants were asked to reflect on the impact working with trauma survivors has had on their life, including personal relationships, their faith, and physical and mental health. Their responses were organized into the following categories: transition from overwhelmed to greater confidence, greater self-awareness and perspective, faith enhanced, and stressful. All participants discussed at least one of the categories that emerged from the data. Detailed discussion of each category, as well as participant quotes that give an example of category content follow.

**Transition from overwhelmed to greater confidence.** Six of the 8 participants described a feeling of increased confidence as they gained experience intervening with trauma

survivors. Within this sample, this category is considered *typical*. Clergy members described a shift in their response to trauma stories over their careers:

> [Initially] it was unfamiliar, there was a welling up of anxiety, fear, and sadness… [now] I have an internal peace of mind and ability to accept that it's part of life instead of trying to fight against it, to experience the range of emotions that come with it, sadness, fear, anxiety, instead of blocking them out. (P1)

Another recalled, "In the beginning I really feared the power of other people grieving and how it would affect me… But if you do enough of something, you get used to it and become more comfortable with it" (P4). Similarly, Participant 5 said, "When I first started, I felt like I always had to have an answer; I've learned not to undervalue just being present." One individual provided the following metaphor to describe his experience with trauma work over time: "The only way I can describe this is an actual callus… It's still heartbreaking, but for me at this point, I've got more [of my reaction] under control. I'm at least able to take a few breaths and center myself (P6)."

**Greater self-awareness and perspective.** Over half of participants mentioned developing an increased awareness of their responses while working with trauma survivors and enhanced perspective of one's life and the world. This category occurred at a *typical* frequency in the current sample. One clergy member discussed becoming aware of the impact of trauma work on her own life:

> I've learned to pull back. I didn't know how to do that earlier in my ministry. It was give, give, give… I asked, "Why am I so tired? Why am I so depleted? Why do I feel so empty? Depressed?" My spiritual mother said, "You need to learn how to rest and say no." I've learned how to do that. (P2)

Another participant reflected on developing an increased insight into his need for additional training: “There have been times that I have felt so over my head that I could do harm, so I sought out more training [e.g., seminary]” (P5). One participant said, “As I’ve seen other people process trauma and as I’ve been part of the solution… I’ve realized my own ability to process through as well” (P6). Another added, “I’ve learned to look at life like a pitcher, when it’s full you can’t add anything to it, it’s important that it gets emptied out” (P7).

**Faith enhanced.** Half of the sample discussed the positive impact upon their own faith of working with trauma survivors. For the current sample, this category is considered *typical*. One participant said, “It solidifies my faith. Faith is essential for processing and filtering emotions because it gives us hope outside ourselves, hope in God” (P1). Another participant reflected on the interaction between one’s personal trauma history and response to the trauma stories of others: “Because I come from trauma, the first time I heard somebody’s stuff it was a familiar story. It was reassuring and comforting… like I’m walking in the calling I know I’m supposed to be in” (P2). Similarly, one participant said, “Watching other people go through hard times and how they cope… strengthens my faith” (P8). Another said, “It just keeps exercising my faith, it doesn’t call it into question. It’s kind of like being called to a workout session, you just exercise” (P4).

**Stressful.** Four clergy members described their work with trauma survivors as “stressful.” This category occurred at a *typical* frequency in the current sample. Participants reported experiencing the following difficulties related to working with trauma survivors: sleep deprivation, feeling emotionally drained, and difficulty being present due to worries about help-seekers (P1). One clergy member commented, “It’s a little draining sometimes, any minister will tell you that ministry is hard emotionally” (P2). Another participant characterized this:

> It's heart wrenching and burdensome. It makes me want to cuss, kick something, spit. It's shocking to the system. I grieve with them, that's how it impacts me… You get some fatigue from being around a lot of trauma and sorrow. (P4)

One participant said, "It's frustrating to know that there are problems and not be able to fix it. I have to accept there ain't a darn thing that I can do about that right now. (P9)

**Coping**

With regard to how participants cope with the impact of working with trauma survivors, five categories emerged from the discussion around this concept, including social support, making time to recharge and rest, specific activities, religious practices, creating boundaries and limits, and reflection on one's sense of calling. All participants discussed at least one of these categories; several discussed two or more. The following sections provide a more detailed discussion of each category within this domain, using participant quotations to illustrate content captured during the interviews.

**Social support.** More than half of the participants described social support as a source of renewal; within the current sample this category is considered *typical*. One clergy member described seeking specific types of social support that allow him to reflect on his own experiences: "I find people I can process my own personal emotions with and acknowledge when I don't feel supported. I need to know I have a safe space to land when I need help" (P1). Others described utilizing members of their faith community, including "spiritual mother[s]" (P2) and an "accountability partner" (P5). Another participant highlighted the reciprocal support she receives from her congregation:

> I am blessed with long-term relationships with them [congregation]. It is very therapeutic because you can survive with their survival and rejoice with their accomplishments and

> victories... Generally, if they can get through, then I come out vicariously stronger, inspired, and empowered. (P4)

**Making time to recharge and rest.** Five clergy members discussed the benefit of designating time for themselves to rest and recover from the stresses of addressing trauma-related issues. This category occurred at a *typical* frequency within the current sample. One individual said, "I make time to replenish my tank- mentally, emotionally, and spiritually" (P1). Another participant described themselves as, "I'm pretty rabid about taking all of my vacation" (P6). Similarly, another commented, "You have to be intentional about taking care of yourself. If you don't, it'll just eat you alive" (P7).

**Specific activities.** Multiple participants identified specific activities they used to care for themselves while serving help-seekers who have experienced trauma. This category is considered *typical*. One individual reported using journaling as a way to cope with the impact of the work with trauma survivors (P5). Another said, "Doing yoga and meditation has helped me to be more elastic with trauma" (P6). This person mentioned previously struggling with feelings of being "devastated" by the vicarious impact trauma can have on one's life. Two participants noted that "staying busy" helps them manage their response to their work with trauma survivors (P7, P9). One explained the benefit of doing so as, "I can empty all the noise out of my head and focus on planting a flower or picking weeds [on my property]" (P9). Another stated, "Exercise is important for me" (P8).

**Religious practices.** More than half of the participants cited the use of religious practices to manage the impact of working with trauma survivors on their own lives. In the current sample, this category is considered *typical*. One individual mentioned seeking out the following: "My own private time of worship with just me and God is when I replenish and let Him fill me back

up" (P2). Another expressed the benefit of prayer in continuing to "stay in love with God" (P5). The benefit of reading scripture was highlighted as well: "I try to start and end my day with scripture and devotion" (P8). Another clergy member said, "There's so many faithful ways to represent God. I think that's the stuff that gets us all through" (P4).

**Creating boundaries and limits.** Three participants mentioned the use of boundary setting and establishing limits to maintain good self-care practices. This category was observed at a *variant* frequency in the current sample. One individual said, "I set personal boundaries because dealing with trauma and its weight is about finding places to be really disconnected from it in a healthy way" (P1). Another stated, "I try to be grounded in my life outside of ministry" (P6). Similarly, Participant 8 said, "I really need my boundaries. I understand that is part of my self-care. I have to know what my own limits are and I need to respect them."

**Reflection on sense of calling.** A few participants highlighted the influence their sense of "being called" to their ministry had on their coping and stress management abilities. In the current sample, this category is considered *variant*. One clergy member, who joined the ministry as a second career, said, "People tell me, 'you waited a long time to hear the call.' I answered the call I had, and I knew I was ready" (P9). Another acknowledged how her work confirms her calling: "I'm walking in the calling I know I'm supposed to be in" (P2).

**Summary**

The data analysis revealed most of the themes arose as a direct result of the questions asked during the interview. The domains and categories presented in this chapter emerged following a consensual process to determine which domains were present within each interview. This information was submitted to an external auditor for review and feedback. After the initial auditing process was completed, the researcher incorporated feedback from the auditor, prior to

examining which domains and categories were present across many interview cases. This process produced a cross-analysis, which was again submitted to an external auditor for review and feedback. The comments provided by the auditor were used to revise and finalize the cross-analysis that is presented in this chapter. In the next chapter, results of the present study will be compared to the extant literature and potential implications and future directions will be discussed.

# Chapter 5

## Discussion

In this chapter, the findings of the present study will be discussed in context of the research questions. Additionally, the domains and categories that emerged through the consensual process utilized by consensual qualitative research (CQR) methodology will be reviewed and juxtaposed with findings documented in the existing literature base. Implications of the findings will be discussed, as well as limitations of the present study, and opportunities for future research.

### Research Questions

It has been acknowledged that clergy members often serve as frontline helping professionals in their community (Weaver et al., 2003; Weaver et al., 1996). Rural residents struggle with access to mental health services as a result of mental health provider shortages (Lutifyya et al., 2012; U.S. Department of Health and Human Services, 2011). Additionally, many rural residents have been characterized as engaging more with religion than inhabitants of more highly populated areas (Wagenfeld, 2003). For rural help-seekers searching for assistance with posttraumatic stress, it is likely that their only available resource is a member of the clergy. This study sought to understand rural clergy members' experiences in intervening with issues related to posttraumatic stress, as well as their own self-care practices related to this area of ministry. The current study was guided by six research questions aimed at an increased understanding of the ways in which rural clergy members navigate responding to issues of posttraumatic stress. The current section will discuss the results summarized in Chapter 4 and will examine connections to the current literature base on clergy intervention with help-seekers who have experienced trauma.

Information gathered via the demographic questionnaire offered insight into the depth and breadth of training clergy members receive related to issues of traumatic stress. The consensual qualitative methodology used to analyze information from the interviews yielded a total of eight domains and 44 categories (CQR, Hill et al., 1997). To avoid silencing the voice of any participant when reporting findings, all categories that were arrived at through CQR analysis were included. However, categories that were derived from the response of only one individual were clearly identified as such through classification as *infrequent* per the Hill and colleagues (1997) guidelines. The themes discovered remained closely linked to the questions asked of each participant and are therefore able to be tied to the original research questions.

**Research Question 1. What preparation do rural clergy members receive to provide care specifically to trauma survivors?** Fifty percent of participants had obtained a Master of Divinity in preparation to serve as a head or associate pastor of a congregation. Twenty-five percent reported current enrollment in seminary training, while the remaining 25% described less traditional paths through training, such as completion of online coursework, and training through one's denominational organization. It has previously been reported (Bruns et al., 2008) that clergy feel poorly equipped to assist survivors of trauma, including those who have experienced sexual abuse or assault. Bruns and colleagues (2008) attributed this finding to the lack of focus on responding to the needs of trauma survivors during seminary or other types of preparation for ministry. One pastor had completed zero courses pertaining to counseling, four had completed between one and three classes; one completed six, one completed 15 courses, and one completed 20 courses. Half of the participants described rarely discussing trauma and its sequelae during completion of coursework, while the remaining half described frequent discussions of trauma in their coursework. The experience of the pastors in our current sample with training in trauma-

specific issues is consistent with other findings related to clergy preparation to address mental health issues. It has previously been noted that faith leaders are often poorly trained in the identification of mental illness and appropriate interventions (Hankerson et al., 2013; Kramer et al., 2007). Most of the sample completed no more than three courses related to counseling skills. Similarly, over 50% of participants denied additional training in trauma-related issues after completion of seminary, while the remainder of the sample endorsed completing at least one continuing education course to enhance their competency with trauma-related issues. This willingness to seek additional training through workshops, seminars, and/or continuing education events to more effectively identify and intervene with mental health issues is consistent with findings reported by Weaver et al. (1996). Of note, all participants in the study endorsed at least one experience in their personal life that they characterized as traumatic.

Participants were also asked to describe their understanding of trauma. Within the domain, *definition of trauma*, six categories emerged representing a range of conceptualization of traumatic experiences. These categories included negative experience, lasting impact, physical and/or psychological injury, individual responses vary, and can lead to growth. At least half of the participants identified trauma as a negative experience that has lasting impact on an individual's functioning, while three participants described trauma as a form of physical or psychological injury. These definitions are partially consistent with the way posttraumatic stress is conceptualized in the mental health profession (e.g., DSM-5; American Psychiatric Association, 2013). When asked to give specific examples of traumatic experiences, participants listed a wide range of events, including bullying, childhood neglect, divorce, sexual abuse and rape, physical abuse, death of loved ones, car accidents, end-of-life decisions, worsening physical health, stillborn children, violent crime, suicide, and chronic stress about one's financial

stability. This broader categorization of trauma may be an artifact of spiritual conceptualizations of trauma, which frequently include a need to reevaluate one's spiritual beliefs and values following a traumatic event (Decker, 1993; Parlotz, 2002). Interestingly, none of the responses provided by participants indicated awareness of other components of posttraumatic stress sequelae, such as intrusive symptomology, avoidance behaviors, or hyperarousal (American Psychiatric Association, 2013). It is possible that considering the impact of traumatic stress on an individual's beliefs and values may lead to less consideration of other sequelae of posttraumatic stress that are crucial for diagnostic purposes within the mental health field. The benefit of collaborative interdisciplinary exchange related to the impact of trauma on multiple domains of an individual's life could enhance the understanding of rural clergy members and mental health professionals alike in efforts to intervene with and support rural trauma survivors.

Three participants highlighted the possibility that not everyone will react in the same way to a given traumatic or stressful event. The mental health literature base acknowledges that numerous factors impact one's ability to cope with traumatic experiences, including previous traumatic experiences, anxiety difficulties, lower intelligence, minority racial and/or ethnic status, and degree of social support available (American Psychiatric Association, 2013). Furthermore, Pargament and colleagues (1998) reported the predictive power of positive religious coping on outcome following a traumatic experience, with those who drew upon their religious coping skills endorsing less psychological stress, more cooperative interactions with others, and greater subjective experience of psychological and spiritual growth post-trauma. In conversation about what constitutes trauma, one participant observed that traumatic experiences can lead to growth. While this was an *infrequent* response in the current sample, it is consistent

with previous research examining the possibility and process of posttraumatic growth (Calhoun & Tedeschi, 1998, Calhoun et al., 2000).

**Research Question 2. How do rural clergy members approach the process of intervention with rural help-seekers who have experienced trauma?** Two domains emerged from the interview data related to how rural clergy members assist individual with a trauma-history: how pastors get involved with help-seekers and how pastors assist help-seekers.

**How pastors get involved with help-seekers**. When asked to describe how help-seekers came to their attention, clergy responses fell within the following categories: word of mouth, phone calls, innate sense, with person at the time of the event, and concerns that are voiced during services or meetings. Clergy members have been described as making themselves available to their congregations during their times of need (Vaaler, 2008). Five participants stated they were made aware of an individual in need of support through word of mouth, typically from a network of family or community members. Some participants described efforts to cultivate a relationship with members of their community to promote this connection for the benefit of the community. Two participants acknowledged receiving phone calls from help-seekers or on the behalf of someone in need. One person mentioned being with members of their congregation at the time of a traumatic event (e.g., in the emergency room). The responses obtained during this study appear consistent with prior reports that clergy members are contacted for support at higher rates than psychiatrists and/or general medical doctors (Wang et al., 2003; Weaver, 1995). Additionally, previous studies examining patterns of help-seeking across various population densities have reported continued reliance of rural help-seekers upon the guidance and support of religious leaders, even when mental health professionals are available in these locations (Wang et al., 2006).

Two participants discussed having an innate ability to notice when something is troubling an individual and respond to this information accordingly. One clergy member attributed this to observations of a person's "body language." Multiple researchers have observed that clergy members often form long-term relationships with their congregants (Oppenheimer et al., 2004; Weaver et al., 1996). It is possible that this ability is reflective of ongoing and emotionally close relationships that clergy members develop with members of their congregations. The degree of trust and openness in these ongoing relationships may also provide pastors with a unique platform from which to introduce help-seekers to the notion of psychotherapy targeting traumatic stress and encourage them to pursue it as indicated. In the context of a working relationship between pastor and mental health professional, such an approach could lead to greater rates of engagement in and completion of treatment for trauma-related disorders among rural residents. The value of finding a faith leader who is willing and able to support help-seekers through the process of pursuing and completing a course of psychotherapy to address posttraumatic stress is imperative.

One participant discussed becoming aware of the needs of her congregation through concerns voiced during weekly services and meetings. Some Christian denominations, such as the United Methodist Church, utilize a structured approach to worship services that creates an opportunity to share one's concerns and offer prayers (United Methodist Publishing House, 1992). This portion of a worship service allows congregants to participate in intercessory prayer on behalf of another congregant. Additionally, pastoral prayer typically concludes this portion of the service and entails a summary of all concerns expressed (United Methodist Publishing House, 1992). The individual who shared this aspect of information gathering in her ministry identified as a United Methodist minister; thus, this finding likely reflects the training

background. It is unclear based on the current study and lack of literature regarding the order of service for other denominations if other pastors use similar structures to learn of hardships within their congregation.

**How pastors assist help-seekers**. Clergy descriptions of their "process of intervention" with trauma survivors fit within these categories: being physically present, listening to the help-seeker, authenticity, helping the individual develop ways to cope, incorporating the help-seeker's faith, using the "movement of the Spirit" as a guide, using one's own life as a testimony, and connecting help-seekers to crisis resources. All participants characterized their approach to supporting trauma survivors as being physically present and listening to help-seekers. Three participants mentioned the importance of authenticity, which was described as allowing clergy to build a trusting relationship with help-seekers to better assist them. These characteristics of intervention are consistent with basic counseling skills that are often the focus of early training in the mental health profession (Kuntze et al., 2009) and may represent the influence of general counseling coursework completed during seminary studies, as reported in the demographic summary. Similarly, Everly (2000) described the added benefit of clergy response to traumatic situations in that they may offer opportunity for cathartic ventilation about an experience and provide social support post-event.

Three participants discussed the value of engaging help-seekers in the development of coping strategies following a traumatic experience. Neighbors and colleagues (1998) documented the role of clergy in helping members of their community address their situations through discussion of specific ways to manage a concern. Other researchers have acknowledged the ability of clergy members to engage trauma survivors in problem-solving around an individual's response and adaptation following a traumatic experience (e.g., Everly, 2000). Three

participants highlighted their use of faith-based principles during interventions with trauma survivors. One individual described addressing existential questions with members of the youth congregation following the death of one of its members in a car accident. Another mentioned utilizing prayer and scripture reading throughout her process of assisting help-seekers. Similarly, two participants mentioned their use of their own lives as examples of how their faith helped them persevere through challenges. Both individuals stated they have used personal examples in such conversations. One mentioned accumulating "success stories" from others' lives in addition to her own to be able to speak to the nature of God and provide hope.

These examples are consistent with previously described strategies for assisting help-seekers (e.g., Everly, 2000; Neighbors et al., 1998; Ringel & Park, 2008). Two participants described their use of the "movement of the Spirit" as a guide when intervening with a trauma survivor. Both individuals described their process as listening to what a help-seeker is saying while simultaneously attending to what God is telling them to do. Previously, this type of intervention has been described in the literature as "spiritual direction" and is intended to develop and enhance the spiritual health and well-being of a help-seeker (Sperry, 2003). This intervention involves a collaborative interaction between a spiritual director (e.g., faith leader or clergy member), a directee (e.g., help-seeker), and God or the Holy Spirit. During intervention, the spiritual director listens to the directee's life story for indications of the movement of God in their daily life. Prayer is often used to enhance one's relationship with God (Sperry, 2003). This practice is similar to that described by one clergy member:

> I listen to them [help-seeker] and what God is saying to tell them… I will say to them, "this is what the Lord just said to me," and nine times out of 10 they'll open up and be like, "I don't know how you knew that."

To a culturally uninformed mental health professional, this type of intervention may be perceived as inappropriate or pathological. However, for rural help-seekers who hold spiritual or religious beliefs, spiritual direction or a similar intervention may offer hope and comfort in resolving posttraumatic stress. Thus, it is important that mental health professionals strive to develop knowledge and awareness of cultural values and practices that are commonplace within the areas they are serving in order to avoid pathologizing culturally normative practices and to engage effectively with their clientele.

Two individuals identified connecting help-seekers to crisis resources, when necessary (e.g., danger to self or others), as part of their role in intervening with trauma survivors. One stated her greatest responsibility was to monitor her community members for indications of potential for danger to self or others. The other stated he allows himself to delegate many intervention and support activities to other, capable members of his congregation, but he is the "point person" for crises. Clergy members are known to be sought out by 25% of people struggling with a mental illness (Ellison et al., 2006; Wang et al., 2003). The likelihood that a clergy member will be approached by a member of a rural community is even greater, due to the current shortage of mental health professionals in these locales (Lutifyya et al., 2012; U.S. Department of Health and Human Services, 2011). Thus, these responses represent the magnitude of the responsibility assumed by rural faith leaders when they intervene with a trauma survivor and further emphasize the gatekeeping role clergy often assume when interacting with the mental health field (Gorsuch & Meylink, 1988). Given the increased probability that pastors will be approached by someone in crisis for assistance and support, it is crucial that clergy are aware of local resources and are able to utilize them to direct help-seekers to them when they are imminent risks to themselves or others.

Through the process of analyzing data, team members challenged their initial beliefs that clergy are not competent to intervene with trauma survivors. Discussion of the support and intervention participants utilized with help-seekers gave way to a greater understanding and appreciation for the ability of these clergy members to deploy basic counseling skills and determine their own limitations in addressing the depths of trauma-related distress. Team members expressed feelings of inspiration and surprise at the ability of some participants to navigate difficult circumstances that led help-seekers to pursue assistance. The team discussions during analysis also led to an increased awareness of the nuance with which rural Christianity can present and areas for potential intervention to enhance interdisciplinary collaboration.

**Research Question 3. Are rural clergy members able to engage in consultation within their religious organization regarding work with trauma survivors?**

**Reaching out to other clergy**. Participants' comments about this topic fell within three categories: informal conversation as needed, monthly clergy groups, and individual mentoring. Half of the current sample described utilizing their professional network for informal conversations about how to address challenging situations. Some participants were married to an individual who also served as a faith leader and described utilizing their partner as a source of consultation, in addition to other members of their professional network.

Three participants mentioned involvement in monthly clergy groups that allowed them to gain support and consultation from their peers, as it pertained to working with trauma survivors. These monthly meetings ranged from opportunities to "discuss counseling issues" to "present case studies and check in about any situation where we need help or advice." A previous survey of approximately 400 senior Christian pastors found the use of accountability groups that met regularly provided an opportunity to engage in consultation with one's peers about ministerial

duties (Meek et al., 2003). However, McMinn and colleagues (2005) described the complexity of relying on one's peers for consultation, stemming from the potential for competition and/or vulnerability within these relationships. It is also possible that the low population density characteristic of rural areas (Slama, 2004; Wagenfeld, 2003) complicates the use of peer consultation among clergy members, particularly if one is vulnerable with a clergy peer and does not receive the support needed.

A third category that was found within this domain describes individual mentoring relationships that offer clergy members the opportunity for ongoing consultation and discussion about current professional needs and activities, including counseling of help-seekers. Two participants reflected on the role this type of professional support had played in their work with trauma survivors. This is consistent with findings reported by Meek and colleagues (2003), who interviewed 26 exemplar Christian clergy members about their coping strategies. Of this sample, 30% mentioned the benefit of obtaining perspective and feedback from a peer mentor.

**Research Question 4. What is the experience of rural clergy members as they interface with mental health professionals?**

**Referrals to mental health**. While describing their experience with referring help-seekers to mental health professionals, participants identified issues within the following categories: issues beyond one's comfort level or scope, limited knowledge of trusted providers, desire for help-seekers to trust in counseling, comfort making referral to mental health, use of crisis resources, and appreciation of learning when referral has been used. Three participants mentioned their use of referrals to mental health professionals when a help-seeker's needs were beyond their comfort level or scope of practice. Openshaw and Harr (2009) have previously discussed limitations clergy face when balancing the multiple responsibilities that accompany

their position. These include limited time to provide support to help-seekers, insufficient training, and lack of expertise with mental health concerns. Clergy members frequently balance multiple responsibilities, including administrative duties, preparation and delivery of weekly sermons, and providing leadership to their congregation. It can be very challenging to designate additional time to intervene with help-seekers who may be in crisis. Some pastors have completed trainings related to intervening with mental health concerns, while others serving as lay pastors or who are new to the role do not always feel comfortable addressing these concerns. Despite these limitations, clergy often are the first professional approached by someone struggling with a diagnosable mental health condition (Hohmmann & Larson, 1993).

Two participants discussed limitations in their ability to make referrals to mental health professionals because they did not know providers in the area who would be receptive to the intersection of help-seekers' faith and their mental health concerns. McMinn and colleagues (1998) described the importance of shared beliefs and values between clergy members and psychologists engaged in collaborative relationships. Faith leaders with conservative theological backgrounds and small congregations may view referring help-seekers to secular providers as especially risky (McMinn et al., 1998). Furthermore, the recommendations made by mental health providers may be in conflict with a help-seeker's religious beliefs, creating a need to choose between the two (Sullivan et al., 2013). Based on the consistency of the current findings with the literature base, it is important for both professions to consider ways to enhance trust and transparent communication to promote the health and well-being of help-seekers.

A fourth of the sample described their efforts to instill a help-seeker's trust in the psychotherapy process prior to making a referral to a mental health professional. Previous findings from a survey of Southern California pastors indicated a sentiment of, "Each referral is a

lesser or greater risk of trusting our congregants' emotional, relational needs to outside mental health professionals" (Bledsoe et al., 2013). Similarly, participants in the current study described a desire to ensure that a help-seeker felt comfortable and willing to pursue a referral to a mental health professional when provided. This need to bolster a help-seeker's buy-in and confidence in the benefit of psychotherapy may be heightened by the contributions of rural culture characteristics, such as self-reliance, reduced anonymity and confidentiality, and heightened stigma of mental illness to help-seeking behavior (Jones et al., 2012; Slama, 2004; Wagenfeld et al., 2003). Although an atypical response among the current study participants, one individual highlighted her appreciation of learning from a mental health professional that a referral had been used. When possible (e.g., as permitted by clients), communication of this information with clergy members could further enhance interdisciplinary collaboration of rural helping professionals. Practitioners could explore with clients the benefit of completing a release of information to allow communication with his/her pastor, if the pastor was the referral source, which could promote interdisciplinary collaboration. Furthermore, discussing with clients their preference in utilizing their relationship with their pastor for existential and religious guidance as it relates to posttraumatic stress could enhance culturally competent practice.

Two participants expressed comfort in making a referral for mental health services. Bledsoe and colleagues (2013) found most Southern California pastors were comfortable in making a referral to secular mental health professionals. In a similar study, conducted with clergy residing in Kent, Michigan, VanderWaal et al. (2012) reported a majority (82%) of Christian clergy members were willing to refer congregants to a mental health professional when a situation was beyond their scope of practice. However, participants provided an important caveat to their considerations when making a mental health referral, with more than 85% of

clergy expressing a desire to make referrals to Christian counselors (VanderWaal et al., 2012). Approximately 25% of the current sample expressed comfort in making a referral to mental health professionals when needed, which is a smaller proportion than has been previously documented. It is unclear what factors may be limiting the comfort of rural clergy members in making referrals to mental health professionals. However, based on the findings of the current study, it appears that rural pastors are unsure of to whom they could refer help-seekers. Thus, it is important for clinicians to consider ways in which to establish professional connections with members of the religious communities within their service area, in order to promote interdisciplinary collaboration. Participants in the current study identified the use of referrals for mental health counseling by primary care providers, personal knowledge of mental health professionals, creating working relationships with university resources for those who serve undergraduate populations, and consulting with one's denominational leaders for guidance and recommendations for mental health providers in the immediate area.

Although uncommon for the pastors in our current sample, one participant, who had completed six counseling courses, discussed utilizing crisis intervention resources within her community as needed. This finding is surprising and encouraging, as previous literature has described limitations in the ability of clergy members to identify emotional distress and suicidality among help-seekers (Domino, 1990). Given that this individual had completed six counseling courses, it is possible that completion of multiple courses can facilitate increased awareness of emotional crises and effective response to such presentations. Furthermore, mental health professionals who are interested in developing collaborative relationships with rural clergy members may consider providing trainings within the community to increase knowledge of available mental health crisis resources and ways to utilize them.

**Barriers to mental health**. Clergy members identified several difficulties rural trauma survivors encounter when they pursue mental health treatment, including issues within the following categories: stigma surrounding mental illness, concern that therapy does not complement one's faith, readiness to address trauma, lack of compatibility between therapist and clergy worldviews, financial limitations, too few mental health providers, and concerns about confidentiality. Five of the participants discussed the impact of the stigma associated with mental illness on help-seekers' willingness to pursue psychotherapy. One aptly commented, "Nobody wants to be crazy." Generally, it is known that mental illness is associated with stigmatization (Rusch et al., 2005); however, Robinson (2012) and others (Hauenstein et al., 2007) remind us that when mental illness intersects with rural cultural values, additional feelings of shame related to the perception of being unable to solve one's problems independently emerge.

Three participants mentioned difficulty connecting help-seekers with mental health services due to concern that psychotherapy is not complementary to their religious beliefs and values. Additionally, two participants mentioned difficulty interfacing with mental health professionals who do not acknowledge the role faith plays in the life of a help-seeker or who are adversarial in their approach to working with religious help-seekers. These concerns have consistently been documented within the literature (Pattison, 1969; Ringel & Park, 2008) and represent an ongoing need for cultural awareness and competence on the part of mental health professionals (American Psychological Association, 2010). Previous report of clergy frustration at poor communication with mental health providers, as well as limited clergy knowledge of available mental health resources (Bruns et al., 2008), offers a potential inroad to address this ongoing challenge. Through transparent communication and efforts to create a professional collaboration between religious leaders and mental health professionals serving rural

communities, there is the opportunity to enhance service provision and reach a greater number of help-seekers.

The importance of considering whether a help-seeker is ready to address a trauma when making referrals to mental health professionals was addressed by three participants. In the psychological research base, the benefit of examining an individual's level of motivation and interest in change is well documented (e.g., Rollnick & Allison, 2004; Ruback et al., 2005). In fact, researchers and therapists alike recognize that ambivalence is a natural part of the change process and should be treated as such rather than resistance or refusal to change (Rollnick & Allison, 2004). Additionally, it is expected that psychologists providing mental health care abide by their ethical code, to respect client autonomy, promote beneficence, and avoid maleficence (American Psychological Association, 2010). Whereas the current sample was comprised of clergy members, their responses evidence attitudes that are consistent with mental health professionals about assisting help-seekers address posttraumatic stress.

Two participants mentioned help-seekers' difficulties pursuing psychotherapy due to financial limitations, shortages of mental health professionals within rural areas, and concerns about confidentiality unique to rural settings. Rural residents often have lower yearly incomes and higher rates of being uninsured than urban residents (Barker et al., 2013). Robinson and colleagues (2012) mentioned ongoing challenges rural patients face in paying for their health services, despite insurance coverage. This is likely reflective of additional expenses incurred by traveling to health appointments, including the cost of fuel to travel to and from an appointment, taking time off from work, and finding childcare when needed (Mojtabai et al., 2014; Robinson, et al., 2012). The expense associated with seeking mental health care often leads rural residents to rely on informal sources of support, including faith leaders and family members (Blank et al.,

2002; Fox et al., 1995); these conclusions were further supported by the findings of the present study.

The shortage of mental health professionals in rural settings is well documented in the literature and continues to present challenges for rural residents in need of mental health care (Gamm et al., 2003; Goldsmith et al., 1997; Holzer et al., 1998; Lutifyya et al., 2012; U.S. Department of Health and Human Services, 2011). One participant commented, "The whole service capacity is inadequate, there are way too few counselors to meet the need." However, with regard to the unique interaction between population density and confidentiality of one's mental health treatment, Slama (2004) has previously documented that rural residents experience high rates of visibility within their communities that often leads to a "goldfish bowl effect" and reduced privacy and confidentiality. Indeed, participants in the current study discussed examples of one's car being recognized at a mental health clinic, thus limiting the willingness of trauma survivors to pursue psychotherapy within their community.

**Research Question 5. How does intervening with rural help-seekers who have experienced trauma affect the health and well-being of rural clergy members?**

**Impact of work on pastor.** Clergy members' responses to this portion of the interview fell within four categories: transition from overwhelmed to greater confidence, greater self-awareness and perspective, faith enhanced, and stressful. Six participants observed a transition in their response to working with trauma survivors over the course of their ministry. Each of these individuals described initial feelings of being overwhelmed by the needs of trauma survivors, but had gained increased comfort and confidence in their work with this population over time. This trend reiterates findings reported by Randall (2007), who found that as clergy members matured in their work, they reported less emotional exhaustion and depersonalization from their work.

The researcher speculated that this may be the result of older clergy members having more opportunities to develop a greater range of coping strategies and a more realistic expectation for their work (Randall, 2007). It is possible the findings of the current study reflect similar processes at work in the participants' lives.

Five participants described arriving at a greater self-awareness and perspective on life through their work with trauma survivors. One individual remarked, "I've learned to pull back. I didn't know how to do that earlier in my ministry." Another discussed insights realized about his own ability to persevere through the challenges of life by witnessing resilience within help-seekers he assisted. Half of the participants reflected on ways in which their work with trauma survivors had enhanced their faith. These experiences highlight the potential for work with trauma survivors to positively impact helping professionals. Previously, researchers have introduced concepts of vicarious resilience (Engstrom et al., 2008) and vicarious posttraumatic growth (Arnold et al., 2015) to describe this outcome. Vicarious resilience is defined as experiencing positive influence related to clients' growth, alterations in one's personal perspectives, and valuing the work performed (Engstrom et al., 2008). Vicarious posttraumatic growth is described as psychological growth that occurs because of vicarious exposure to trauma (Arnold et al., 2015). While not included in the definition of vicarious posttraumatic growth, the role that religion and spirituality play in making meaning of a traumatic experience (Calhoun et al., 2000) appears to contribute to vicarious posttraumatic growth and lead to enhanced personal faith, as described by the participants in the current study.

Interestingly, the literature suggests that vicarious resilience can be promoted through several external factors, including social and organizational support (Linley & Joseph, 2007; Tedeschi & Calhoun, 2004), personal relationships and a collaborative work environment (Pack

2014), and organizational qualities such as training, provision of supervision, and positive professional relationships (Hernandez-Wolfe et al., 2015). Furthermore, a personal trauma history has been postulated to create an opportunity for personal growth in the lives of helping professionals (e.g., Linley & Joseph, 2007; Tedeschi & Calhoun, 2004). In the current sample, all participants reported some type of previous traumatic experience in their personal life. Thus, it is possible that the findings of positive outcomes of working with trauma survivors disclosed by the current participants is an interaction between personal and professional histories of trauma exposure.

Despite the growth in their own faith related to working with trauma survivors, half of the sample also described their work with this population as stressful. Participants mentioned the following difficulties related to the stress of their work with trauma survivors: sleep deprivation, feeling emotionally drained, difficulty being present due to worries about help-seekers, struggles with being shocked at the experiences of help-seekers, and frustration with problems that cannot be resolved immediately. Previous literature has documented the potential for helping professionals involved with those who have experienced trauma to develop compassion fatigue, vicarious trauma, or secondary traumatic stress (Cerney, 1995; Stamm, 2002). Thus, it is possible that rural clergy members who are not active in self-care or those who are limited in their coping strategies and abilities, may be vulnerable to compassion fatigue and/or secondary traumatic stress. The next section focuses on ways in which clergy members in the current study managed their feelings of stress evoked by working with trauma survivors.

**Research Question 6. How do rural clergy members cope with the stress of intervening with rural help-seekers who have experienced trauma?**

**Coping**. Within this domain, participants' responses were organized into six categories: social support, making time to recharge and rest, specific activities, religious practices, creating boundaries and limits, and reflection on one's sense of calling. Five participants identified using social support, creating time to rest, using specific activities, and religious practices to cope with the stress of their work with trauma survivors. Social support, particularly that of one's family, has been reported to predict a faith leader's sense of personal accomplishment and overall well-being (Chandler, 2009). Kaldor and Bullpitt (2001) also mentioned the tendency of clergy members to rely on their family and friends for social support. Previous studies of clergy coping practices have found that nearly half of clergy find ways to "get away" or take time off from their work (Kaldor & Bullpitt, 2001). The current findings support this trend.

Active involvement in spiritually renewing practices (e.g., prayer, worship, devotional reading or study, meditation, journaling, or fasting) has been found to protect against emotional exhaustion and burnout related to the stresses clergy members face (Chandler, 2009). Participants in the current study reported utilizing the following spiritual practices to manage their work-related stress: private worship with God, prayer, scripture reading, and representing God to others. Similarly, members of the current sample reported the use of intentional, specific activities to cope, including journaling, yoga, meditation, staying busy, and exercise. The benefit of regular involvement in intentional activities as part of self-care and renewal has previously been acknowledged (e.g., Meek et al., 2003).

Three participants mentioned creating boundaries around their personal time to promote personal coping. This practice has been discussed previously by Holaday et al. (2001), who provide additional examples of boundary setting, such as taking only emergency calls after working hours, using caller identification on one's personal telephone, and living away from the

church's location; socializing with one's family and friends outside of the church community; and engaging in emotional distancing or compartmentalizing practices. Similarly, Doolittle (2007) observed that more benefit from active coping strategies, such as planning ways to manage stress and promote relaxation, led to higher levels of personal accomplishment and lower levels of emotional exhaustion and depersonalization of one's work.

Three clergy members reported engaging in reflection on their sense of calling to ministry as an additional manner of coping. Meek and colleagues (2003) highlighted the role of intentionally maintaining an awareness of one's calling as beneficial and helpful in staving off the negative impact of work-related stress. There is potential for burnout among rural clergy members called upon by trauma survivors (Chandler, 2009). However, the results of the present study indicate active efforts to care for oneself and manage the ongoing stress related to one's work. Doolittle (2007) noted that clergy members must use all their coping strategies to manage the stress of their job. His findings suggest it is possible for clergy members to be engaged with their work, have a rich spiritual life, and high levels of personal accomplishment, but still experience emotional exhaustion. Thus, it is important that clergy develop strategies to cope that are effective and actively utilize them.

**Limitations and Opportunities for Future Research**

Whereas the current study confirms findings documented previously in the literature and expands knowledge related to rural locals, it is not without limitations. The current sample was comprised of 9 total participants, with 1 being excluded due to limited experience working with rural populations and limited knowledge of trauma and no encounters with help-seekers who had experienced trauma. Given the small sample size, most of the themes were found in at least half of the cases, but not all cases. In fact, the only domain in which *general* (e.g., occurring in all

cases; Hill et al., 1997) categories was found was the "how pastors assist help-seekers" domain, with all participants reporting being physically present and listening to help-seekers as part of their process. Thus, future research should strive to obtain a larger sample size to promote greater consensus among responses when possible.

It is possible that the experiences and perspectives offered by these participants are not entirely representative of all rural clergy members' experiences in assisting trauma survivors and interfacing with the mental health care system. Similarly, it is important to note that whereas rural locales are often assumed to be homogenous in their atmosphere, this is not the case. The current sample was drawn from a portion of Appalachia, located in southwestern Virginia. This region has been described as a "chronically poor" rural area that tends to rely on their faith communities and personal religious beliefs in order to cope with life-stressors (Hamilton et al., 2008); however, researchers identified three additional types of rural areas: amenity rich, declining resource-dependent, and transitional. These categorizations take into consideration the diversity of a region's residents and changes in economic, political, and environmental factors (Hamilton et al., 2008). In light of these distinct types of rurality, additional research is needed to determine if there are regional differences in rural trauma survivors' reliance upon clergy members for assistance. Additionally, it is unknown if there is variability in clergy interactions with the mental health profession across the different types of rural; thus, additional research is warranted.

The inclusion criteria for the current study specified Christian faith leaders who had completed seminary training or were currently enrolled in a seminary training process. However, in small, rural communities, not all churches are able to attract a pastor who has completed formal seminary training. Lummis (2003) discussed the reality that many vacant

clergy positions across Christian denominations are in small congregations that are often unable to pay a full-time salary. These congregations are typically located in rural areas (Lummis, 2003). This situation creates significant difficulty in finding any candidates to fill these positions. One solution to this predicament has been to create part-time positions rather than expecting clergy to serve as a full-time pastor of one church. However, this type of position is not very attractive to clergy who have completed formal seminary training (Lummis, 2003). In order to fill the need for pastoral leadership of small, rural congregations, some denominations are developing various levels of ordination that allow ministerial work without completion of formal seminary training; these individuals are often referred to as lay pastors (Wood, 2010). This approach trains pastors whose ordination status is more limited or restricted than those who have completed seminary. Pastors with these restricted orders rarely have a seminary degree and may not have a college degree. They are, however, required to have some official ministerial training and certification for the services they provide, typically delivery of sermons on a weekly basis (Lummis, 2003). Wood (2010) acknowledged that the definition of lay pastor varies across denominations, with a range of privileges (e.g., partial to full clergy recognition). Although the use of lay pastors varies across denominations, ranging from 30-60%, it is clear that this type of clergy member fills a need that would otherwise go unmet among small, rural Christian congregations (Wood, 2010). Thus, the current study, which required participants to have seminary training, is unable to speak to the experience lay pastors have in responding to the needs of rural trauma survivors.

Whereas it has been noted in the literature that Christianity is the predominant religion within American rural areas (Vaaler, 2008), not all rural residents identify as Christian. It is possible that non-Christian rural residents are less likely to seek assistance from Christian clergy

members post-trauma. Future research studies would benefit from re-examination of the other informal support non-Christian rural residents rely on, particularly following a traumatic experience, as previous research has found rural residents to seek out their family and friends in times of need (Fox et al., 1995). Finally, members of the current sample reflected on positive experiences of intervening with trauma survivors, despite all participants reporting personal trauma histories. It would behoove future researchers to examine the potential influence of interactions between personal and professional histories of trauma exposure among rural clergy members.

**Implications for Rural Practitioners and Conclusion**

The findings of the current study highlight the role that rural clergy members play when responding to the needs of trauma survivors. These professionals are charged with responding to the needs of trauma survivors in their community, in addition to their other ministerial duties (Openshaw & Harr, 2009). Additionally, clergy are also responsible for maintaining their own health and well-being. Findings from the current study suggest that rural clergy are able to create strategies to manage the impact of assisting trauma survivors, but are still susceptible to feelings of stress as a result of this type of work. With regard to interfacing with the mental health system, participants in the current study commented on the difficulty of locating mental health professionals within their respective area due to shortages of providers. Participants also described difficulty knowing which mental health professionals would be receptive to the spiritual values of their congregants. Taken together, these findings offer the opportunity to provide recommendations aimed at ameliorating the current status of collaboration between clergy and mental health professionals in the interest of providing holistic care to rural help-seekers.

Sullivan and colleagues (2013) explored strategies to promote clergy partnerships with Veterans' Affairs (VA) mental health professionals in rural Arkansas to enhance care of returning veterans. These researchers observed that one of the largest barriers to collaboration between these two professions stemmed from the fact that clergy and mental health providers do not know each other. Opportunities such as an informal lunch meeting allowed clergy and mental health professionals to meet, leading to an increased number of referrals to and from clergy members (Sullivan et al., 2013). Additionally, collaboration on community events (e.g., providing breakfast to soldiers during drill weekends) allowed clergy and mental health professionals to increase their trust of one another and decrease stigma. Finally, Sullivan and colleagues (2013) observed that focusing on the needs of mental health providers for clergy expertise in addressing issues like guilt, shame, and moral injury may prove more effective in promoting inter-disciplinary collaboration. While these strategies were developed and implemented to promote clergy partnerships with VA mental health professionals, they could be easily adapted for the needs of non-VA mental health professionals in rural settings. Recently, Vermaas and colleagues (2017) reflected on the previously mentioned activities as potential ways to promote clergy mental health literacy and increase collaboration; they added offering low-cost services to clients who cannot afford formal treatment when referred by their clergy and providing access to counseling research and information via local clergy listservs and data bases. Additionally, Smith and Riding-Malon (in press) offered specific suggestions for rural mental health professionals seeking to collaborate with rural pastors: development and distribution of a resource manual and referral list, provision of workshops, and initiation of interdisciplinary partnerships. The use of local pastoral associations offers an inroad to collaboration between rural mental health professionals and pastors (Smith & Riding-Malon, in press). These

suggestions could easily enhance interactions between rural clergy members and mental health professionals.

Bledsoe et al. (2013) proposed a series of seminars for clergy, addressing the following topics: knowing when and how to refer to mental health professionals, developing a congregation-specific resource list, mental health issues (e.g., depression, suicidality, family violence, anger management), and working with non-mental health professionals to offer financial and job assistance to help-seekers. These seminars were to be offered at a local university's community counseling center in Southern California (Bledsoe et al., 2013). Vermaas and colleagues (2017) also discussed the possibility of mental health professionals offering post-graduate training opportunities for clergy members in the local community. Seminars covering the previously mentioned and related topics could prove very beneficial for rural clergy members serving as frontline mental health professionals. Future examination of these types of interventions on rural clergy members' comfort with and frequency of referrals to mental health professionals could speak to additional needs rural clergy may have.

Furthermore, Bledsoe and colleagues (2013) advised that faculty at undergraduate and seminary institutions should incorporate supplementary information and materials into the training curriculum of pastors to prepare them for the practical realities of the pastoral role. Whereas the participants in the current study reported completing between zero and 20 counseling classes during their training to be a minister, it is unclear if these courses also provided practical knowledge of how to interface with the mental health system when needed. Additional training related to these aspects of ministerial work may help to offset the stress related to meeting the counseling needs of one's congregants. Previous research has documented the ability of social and organizational support (Linley & Joseph, 2007; Tedeschi & Calhoun,

2004), as well as a collaborative work environment (Pack, 2014) to promote vicarious resilience among those who respond to the needs of trauma survivors. Many members of the current sample described the use of monthly clergy meetings and/or accountability partners as part of their coping strategies. Given the documented impact of organizational support on the well-being of individuals engaged in trauma work, it is likely that increased denominational support (e.g., additional training, provision of supervision, and positive professional relationships; Hernandez-Wolfe et al., 2015) would promote rural clergy members' resilience and well-being. This area of need may offer a viable inroad for increased collaboration between rural clergy members and mental health professionals, particularly in light of opportunities to offer additional trainings as discussed above. Furthermore, it is important for mental health professionals to consider what they may learn from clergy members, as the mental health field has become increasingly aware of the need for cultural competence, including within the domain of religious and spiritual identities (Delgado-Romero et al., 2012; American Psychological Association, 2010).

The findings of this study indicate that rural clergy members are open to collaboration with mental health professionals. However, they also highlight a need for mental health professionals to be cognizant of the religious and spiritual values an individual brings to the therapy process. Intervening with trauma survivors can be inherently challenging and stressful; however, it appears that rural clergy members are aware of the need to monitor their own well-being and engage in regular self-care practices.

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# APPENDICES

## Appendix A

## Screening Questionnaire

1. Have you completed seminary training/the equivalent of seminary training or are you in the process of completing it?

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2. Have you served a rural congregation at some point during your career?

---

3. Are you currently serving in an active leadership position within the church such as head or associate pastor?

---

4. Have you had experience working with survivors of trauma, past or present?

---

## Appendix B

## Demographic Questionnaire

1. What is your religious denomination?

   _____

2. How many years have you been in the ministry?

   _____

3. How large is the congregation you serve?

   _____

4. Where has the majority of your ministry been completed?

   a. Rural
   b. Suburban
   c. Urban

5. What is your age? _____

6. What is your sex? _____

7. What is your ethnicity? _____

8. What type of training did you receive to become a minister? _____

9. In your seminary training, how many classes covered topics related to counseling skills?

   _____

10. In your seminary training, how often was trauma discussed in the context of providing counseling? _____

11. Are there any trainings regarding trauma that you have completed since seminary?

    _____

12. Have you experienced trauma in your own life? _____

## Appendix C

### Semi-Structured Interview Protocol

*Thank you again for your willingness to participate in my dissertation research examining clergy knowledge of and intervention with rural help-seekers who have a trauma history. I will be asking you approximately 10 questions today and depending on how much you have to say, I anticipate the interview taking approximately an hour. I will start by asking you general questions about your definition of trauma and work with trauma survivors and then will ask you questions about the impact of this type of work on your own health and well-being.*

1. What does the word trauma mean to you?
2. How has trauma affected members of your congregation and community?
3. As a pastor, what has been the role of assisting people who have experienced trauma?
    - How do help-seekers come to your attention?
    - What does your process look like?
    - How comfortable are you in working with these issues?
4. How often do you consult with other clergy members about difficult cases?
5. How often do you refer help-seekers to mental health care providers in the community?
    - How often do mental health care providers follow-up with you regarding a referral you have made?
6. What are barriers to working with mental health care providers that you have experienced?

*Now I would like to ask you three questions about how working with trauma survivors has impacted your personal health and well-being.*

7. What was it like the first you heard a traumatic story from a help-seeker?
    - How has this changed over the course of your ministry?
8. What impact has working with trauma survivors had on your life?
    - How has it impacted your relationship with your spouse and family?
    - How has it impacted your personal faith?
    - How has it impacted your physical health?
    - How has it impacted your mental health?
9. How do you cope with the challenges and stress of working with trauma survivors?

## Appendix D

### Letter Requesting Participation in Interview Research

Psychology Department

RADFORD UNIVERSITY

*P.O. Box 6946*
*Radford, VA 24142*

*(540) 831-5019*
*FAX (540) 831-6113*

*www.radford.edu*

Dear _____,

We are seeking participants for a small study to gather information about clergy knowledge of trauma and intervention with churchgoers in rural areas. We are seeking 8-15 people for these interviews. Most interviewees will find these interviews to be interesting and thought provoking. This study is being conducted by Anna Vandevender as part of her degree requirements for completion of her doctoral studies at Radford University. Participation in this study is voluntary and there will not be any compensation for your participation. The interviews will last about one hour. The interview will be recorded and then transcribed by members of the research team who will give each interview an anonymous codename to protect your confidentiality. These transcripts will be studied for themes and determinations will be made for how the field of Psychology and clergy members can better support one another.

Sincerely,

Anna Vandevender
avandevender@email.radford.edu

Ruth Riding-Malon, PhD
rridingmalon@radford.edu
(540) 831-6892

## Appendix E

## Consent for Participation in Interview Research

Psychology Department

RADFORD UNIVERSITY

*P.O. Box 6946*
*Radford, VA 24142*

*(540) 831-5019*
*FAX (540) 831-6113*

*www.radford.edu*

I volunteer to participate in a research project conducted under the supervision of Dr. Riding-Malon by Anna Vandevender as part of her degree requirements for her doctoral studies at Radford University. I understand that this project is designed to gather information about clergy knowledge of trauma and intervention with churchgoers in rural areas. I am aware that I will be one of approximately 15 people being interviewed for this research.

1. My participation in this project is voluntary. I understand that I will not be paid for my participation. I may withdraw and discontinue participation in the study at any time without penalty. If I choose not to participate or quit the study, no one in my community will be told.

2. The interview will last approximately one hour. I understand that most interviewees will find the interview interesting and thought provoking. If, however, I feel uncomfortable in any way during the interview session, I have the right to not answer any question or to end the interview.

3. Participation involves being interviewed by researchers from Radford University. An audio tape of the interview and subsequent transcript will be made and will be filed so that no personally identifying information is visible on them. Recordings will be retained after completion of this study for possible further analysis. Audio recordings will be used only for research purposes by the investigator and her research team.

   Please sign below if you are willing to allow us to record an audio track of interview.

---

Participant Signature Date

4. I understand that the researcher will not identify me by name in any reports using information from this interview and that my confidentiality as a participant in this study will

remain secure. Any additional uses of interview data will protect the anonymity of individuals and their faith communities.

5. There are no known risks to participation in this study. The information gathered through this study is anticipated to gain insight into clergy knowledge of trauma related issues and ways that clergy help their church goers with these experiences. A resource sheet will be provided to each participant at the end of the interview session with information about mental health and faith community resources that are available to address any discomfort that may result from participation in this study.

6. I understand that this research study has been reviewed and approved by the Institutional Review Board (IRB) for studies involving human subjects at Radford University. For research problems or questions regarding participants, contact Dr. Dennis Grady, Dean, College of Graduate and Professional Studies, Radford University, dgrady4@radford.edu, 1-540-831-7163.

7. I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction and I voluntarily agree to participate in this study.

8. I have been given a copy of this consent form for my personal records.

_____

Participant Signature Date

_____

Printed Participant Name Signature of Investigator

For further information about this study, please contact:

Anna Vandevender
avandevender@email.radford.edu

Dr. Ruth Riding-Malon
rridingmalon@radford.edu
(540) 831-6892

**Table 1**

*Demographic Information*

| **Denomination** | ***n*** | **Mean** | **SD** |
|---|---|---|---|
| United Methodist | 3 | | |
| Nondenominational | 2 | | |
| Evangelical Lutheran | 2 | | |
| Presbyterian | 1 | | |
| **Years in Ministry** | | 11.8 | 6 |
| **Congregation Size** | | 123.1 | 49.7 |
| **Majority of Ministry Locale** | | | |
| Rural | 6 | | |
| Suburban | 2 | | |
| Urban | 0 | | |
| **Age** | | 48.6 | 13.9 |
| **Sex** | | | |
| Male | 5 | | |
| Female | 3 | | |
| **Ethnicity** | | | |
| White | 6 | | |
| Black | 1 | | |
| Sri Lankan | 1 | | |
| **Ministerial Training** | | | |
| Master's Divinity | 4 | | |
| Seminary in Progress | 2 | | |
| Alternative training | 2 | | |
| **Counseling courses** | | 6 | 7.4 |
| **Post-seminary trauma training** | | | |
| Yes | 3 | | |
| No | 5 | | |
| **Personal Trauma History** | | | |
| Yes | 8 | | |
| No | 0 | | |

**Table 2**

*Cross Analysis Summary*

| Domain & Category | Interview | Frequency w/in Interviews | Core Ideas |
|---|---|---|---|
| **Definition of trauma** | | | |
| Negative experience | 1, 2, 5, 8, 9 | 5 | Intense physical, emotional, or spiritual experience |
| Lasting impact | 1, 4, 6, 7 | 4 | For some it is the end of their world; leads to immersion in the experience that limits recognition of change |
| Physical and/or psychological injury | 4, 6, 7 | 3 | Leaves a deep wound that is difficult to recover from |
| Individual responses vary | 4, 5, 6 | 3 | What is traumatic for one may not be for another |
| Can lead to growth | 7 | 1 | Trauma is wounding but can also lead to growth |
| **How pastors get involved with help-seekers** | | | |
| Word of mouth | 1, 4, 6, 8, 9 | 5 | Network of family and community members share concerns; hear about event in conversation |
| Phone calls | 5, 6 | 2 | People call asking for a visit from clergy or prayers for themselves or on behalf of someone |
| Innate sense | 2, 7 | 2 | Can spot a hurting person; if you pay attention to body language |
| With person at the time of the event | 4 | 1 | "Usually I'm with them." |

| | | | |
|---|---|---|---|
| Concerns voiced during service or meeting | 8 | 1 | Time set aside during weekly meetings for any concerns to be shared |
| **How pastors assist help-seekers** | | | |
| Being physically present | 1, 2, 4, 5, 6, 7, 8, 9 | 8 | Letting help-seekers know that they are not alone; in-person or digitally dependent upon age of help-seeker |
| Listening to help-seeker | 1, 2, 4, 5, 6, 7, 8, 9 | 8 | Letting the help-seeker "talk it out"; "talking often seems cathartic" |
| Authenticity | 1, 2, 7 | 3 | Being honest and transparent |
| Help individual develop ways to cope | 4, 6, 8 | 3 | Watching for ways help-seekers will manage distress; "finding and developing a new normal"; help them figure out what works for them |
| Incorporating the help-seeker's faith | 1, 2 | 2 | Speaking to what one's beliefs mean for the afterlife with loved ones of a deceased; praying with the help-seeker; reading and discussing scriptures with help-seeker |
| Using "movement of Spirit" as a guide | 2, 5 | 2 | "This is what God just said to me to tell you"; "truly listening to things happening in the Spirit" |
| Using own life as a testimony | 2, 4 | 2 | "This is how God helped me"; Trying to accumulate God's "track record" |
| Connect help-seeker to crisis resources | 4, 5 | 2 | Frank discussion about crisis and sharing of local emergency resources; point person for crises |
| **Reaching out to other clergy** | | | |
| Informal conversations as needed | 1, 2, 7, 8 | 4 | Talking with other church leaders to process how to approach situations |

| | | | |
|---|---|---|---|
| Monthly clergy groups | 5, 6, 8 | 3 | Monthly discussions with clergy about counseling issues |
| Individual mentoring | 2, 6 | 2 | Using one's mentor for advice |
| Infrequent | 4 | 1 | Time with colleagues is rare and focused on "nuts and bolts" |
| **Barriers to mental health care** | | | |
| Stigma of mental illness | 4, 5, 6, 7, 8 | 5 | Stigma is one of the largest barriers to counseling; "nobody wants to be crazy" |
| Help-seekers' concern that therapy does not complement their faith | 1, 2, 6 | 3 | Secular therapists may have a non-Christian agenda; recommendations from providers and clergy are not always compatible; fear that counseling is not faithful to God |
| Help-seekers' readiness to address trauma | 5, 7, 8 | 3 | Not everyone is ready to talk about the trauma; "people just don't want to admit it's something they need" |
| Financial limitations | 4, 8 | 2 | Limited income; lack of insurance coverage |
| Too few mental health providers | 4, 8 | 2 | Too few providers to meet the need; in rural areas there are not many places to send people |
| Help-seeker concerns about confidentiality | 5, 6 | 2 | Concern in small communities about one's vehicle being seen at counselor's office |
| **Referrals to mental health professionals** | | | |
| Used when issue is beyond clergy's | 1, 2, 8, 9 | 4 | Clergy aren't fully equipped to deal with major issues; go to the edge of scope and then refer |

| | | | |
|---|---|---|---|
| comfort level or scope | | | |
| Clergy's limited knowledge of trusted providers | 4, 5 | 2 | Lack of a "good referral base to pull from"; changing church assignments creates challenges in knowing local mental health resources |
| Desire for help-seekers to trust in counseling | 5, 6, 7 | 3 | Work with help-seeker to build trust in the idea of counseling before referral so that it is seen as the best solution; creation of a relationship with counseling centers |
| Comfortable making mental health referral | 1, 6 | 2 | Keen to refer for a few sessions; not afraid to refer |
| Appreciation of learning when a referral has been used | 6, 9 | 2 | Confirmation of referral follow-through gives a sense that the connection has been made |
| Use of crisis resources | 4 | 1 | Monitor help-seeker for risk and refer them to local crisis services |
| **Impact of trauma-work on pastor** | | | |
| Transition from overwhelmed to greater confidence | 1, 4, 5, 6, 7, 8 | 6 | Initially an unfamiliar and overwhelming experience, but now accept that it is part of life; increased feelings of comfort in supporting trauma survivors; initial need to have an answer always, but now value being present; metaphor of physical callus to represent increased confidence |
| Greater self-awareness and perspective | 2, 5, 6, 7, 8 | 5 | Increased awareness of when trauma-work leads to feelings of depletion and emptiness; awareness of when "over my head" led to more training; recognition of one's ability to process difficult emotions; increased openness with one's own life |
| Faith enhanced | 1, 2, 4, 8 | 4 | Working with trauma survivors solidifies faith through hope and inspiration; continues to exercise faith |

| | | | |
|---|---|---|---|
| Stressful | 1, 2, 4, 9 | 4 | Difficulty being present when worried about someone; draining; heart-wrenching; frustration with problems that cannot be easily fixed |
| **Coping** | | | |
| Social support | 1, 2, 4, 5, 7 | 5 | Network of people to process personal emotions; use of spiritual mentor; celebrating successes with congregations; accountability partner |
| Making time to recharge and rest | 1, 2, 5, 6, 7 | 5 | Time to replenish mental, emotional, and spiritual tank |
| Specific activities | 5, 6, 7, 8, 9 | 5 | Journaling; yoga; meditation; working outside; exercise |
| Religious practices | 2, 4, 5, 8, 9 | 5 | Private time of worship; representing the love of God to everyone; prayer; scripture readings; devotional readings |
| Creating boundaries and limits | 1, 6, 8 | 3 | Set boundaries around time that allows disconnection from work; “rabid” about taking all of vacation |
| Reflection on sense of calling | 2, 7, 9 | 3 | Feeling that one is doing exactly what they were meant to do; “it’s what I have to do” |