

From Fear to Faith: Efficacy of Trauma Assessment Training for New York–Based Southern Baptist Church Groups

Derek H. Suite

Full Circle Health

Nyack University

Stephen A. Rollin

Florida State University

J. C. Bowman

Public Policy & Consulting, Inc.

Robert D. La Brill

Full Circle Health

Post-9/11, many faith-based responders expressed the opinion that they were neither prepared nor trained to recognize the mental health needs of long-term trauma survivors. With funding through the Red Cross, an interdisciplinary trauma training program was developed to increase the capacity of the New York Southern Baptist Church groups to provide trauma assessment and support through the Metropolitan Baptist Association of New York. Through a pretest and posttest survey, the training was evaluated. Of the workshop attendees, 91% gave positive feedback and felt the training was worthwhile. The results suggest an ongoing need for interdisciplinary training that includes faith-based groups.

Keywords: *faith based; counseling; Christian; trauma; mental health; prayer; 9/11*

A plethora of empirical studies and polls have produced overwhelming evidence of the importance of spirituality to a majority of North Americans. More than 90% of Americans believe in God or a higher power, 90% pray, 67% to 75% pray on a daily basis, 82% pray weekly, 60% deem religion to be a salient aspect in their lives, and 82% realize a personal need for spiritual growth (Lee & Newberg, 2005; McCauley et al., 2005; Miller & Thoresen, 1999).

In addition to acknowledging the importance of spirituality, significant numbers of health care consumers

express a desire to merge spirituality and health. More than 75% of polled patients desire that physicians integrate spiritual concerns into their medical treatment, about 40% would like physicians to discuss their religious faith with them, and nearly 50% want physicians to pray with them (Lee & Newberg, 2005).

Despite these trends, physicians include spiritual discussion in fewer than 20% of visits, and only 11% of physicians discuss spirituality regularly (McCauley et al., 2005). In underserved communities, particularly those of color, many also bear the additional burden of harboring historical distrust and skepticism of the medical system (Gamble, 1997; Keating & Robertson, 2004; Poussaint & Alexander, 2000; Rollack & Gordon, 2000; Whaley, 2006, 2004; Williams & Williams-Morris, 2000). It is therefore not surprising that, post-9/11, many underserved urban families turned not to traditional mental health services but to their faith leaders who traditionally meet their mental health needs after disasters (Koenig, 1998).

Author's Note: Correspondence concerning this article should be addressed to Derek H. Suite, Full Circle Health, 2105 Williamsbridge Rd., Bronx, NY 10461; e-mail: Fullcirclehealth@aol.com.

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In the immediate aftermath of the attack, health care personnel were mobilized throughout the city to disseminate psychoeducational materials and offer triage services and linkages to traditional mental health treatment providers. Many New Yorkers were effectively contacted by these outreach methods, but, for reasons elucidated earlier, many urban faith-based families would not engage with traditional mental health outreach or intervention, leaving faith-based responders with the task of providing psychoeducation, counseling, and long-term mental health support (Constantine, Alleyne, Caldwell, McRae, & Suzuki, 2005). Given the heavy use and demand for their services, faith-based first trauma responders would benefit from training on the short- and long-term effects of mass trauma and disaster and, more particularly, on adopting a basic framework for conducting trauma evaluation, identification, and triage (Reyes & Elhai, 2004). Critical components of such training would include being able to identify acute versus chronic responses to trauma, safely addressing the needs of traumatized individuals in the short and long term, and integrating spiritual reactions, sensitivities, and resiliencies in their work with traumatized individuals (Reyes & Elhai, 2004).

There is clearly a need for a collaborative approach that brings science, psychology, social theory, and spirituality together in the quest to equip the faith community to more effectively address mental health needs (Benes, Walsh, McMinn, Dominguez, & Aikins, 2000; McMinn, Chaddock, Edwards, Lim, & Campbell, 1998; McMinn, Meek, Canning, & Pozzi, 2001). However, little to no data that detail the feasibility and measurable outcomes of collaborative models providing interdisciplinary trauma training to faith-based first responders working in undeserved neighborhoods are available. The authors were particularly interested in learning whether such training would be valued and embraced by faith communities.

CURRICULUM DESIGN

Constructing a continuing education unit (CEU)-compatible training model for New York City Southern Baptist churchgoers faced with the task of providing trauma support to their constituency was an urgent yet complex task given the general lack of trust in traditional mental health interventions and the increased health risks associated with underrecognized traumatic symptoms and untreated posttraumatic stress disorder (PTSD; Pearlman & Saakvitne, 1995). Helping these faith-based responders use criteria of the *Diagnostic and Statistical*

Manual of Mental Disorders (text revision; *DSM-IV-TR*; American Psychiatric Association, 2000) to aid in sorting out acute versus chronic stress reactions, providing them with current research data on the basic differences between nonpathologic versus pathologic trauma responses, and exploring clinical indicators for conditions such as PTSD that signal the need for referral to specialized intervention were major tasks of Fear to Faith curriculum (Carlson, 1997).

With these considerations in mind, a multilingual curriculum (i.e., Creole, Korean, Chinese, Spanish, and English) was developed using a combination of biopsychosocial-spiritual theory (BPST) and constructivist self development theory (CSDT). The significance and utility of BPST from the scientific viewpoint resides in its ability to aid in differential diagnosis (Fosarelli, 2002; Moore, Kloos, & Rasmussen, 2001) and its ability to encompass the concept of healing and growth from illness (Evans, 1999a, 1999b; Larson, Larson, & Koenig, 2001). Somatic symptoms, for example, had to be explained as occurring within the context of, and not separate from, trauma; and multiple possible somatic manifestations, including musculoskeletal, gastrointestinal, neurological, cardiovascular, or respiratory problems, had to be understood as fairly “normal occurrences” in acute traumatic reactions (Miller & Heldring, 2004). It also had to be shown that psychological issues could be expressed in direct ways such as major depression and suicide and indirectly through complicated bereavement, elevated tobacco and substance abuse, family violence, increased risk taking, and other behavioral problems (Miller & Heldring, 2004). The somatic effects of spiritual distress and coping on blood pressure, pulse, and respiratory rate for example also had to be integrated into the curriculum. The curriculum addressed varying levels of understanding and general unfamiliarity with the biopsychosocial effects of trauma were addressed in a 3-hour interdisciplinary PowerPoint presentation.

In contrast to the BPST in which commonalities might be easily found among the clusters of symptoms and reactions to trauma, CSDT is a personality-driven theory that describes the impact of traumatic life events on the development of the individual (Pearlman & Saakvitne, 1995). CSDT emphasizes meaning in trauma and speaks to the idea that individuals construct unique meanings that a particular trauma has for them on a number of levels, including ego resources, self-capacities, cognitive schema, and frames of reference, such as worldview, identity, and spirituality (Pearlman & Saakvitne, 1995).

For this training, CSDT, more so than BPST, was especially helpful in attempting to explain the wide range of possible reactions by different individuals to the same

traumatic event. For example, when participants wondered why some people seem not to be bothered or upset by the September 11 tragedy, we were able to draw from CSDT to amplify the discussion about the uniqueness of an individual's response to trauma. We helped participants to examine several factors at play in an individual's trauma response, including the meaning ascribed to the trauma, the experience of self, developmental stage, psychological predispositions, temperament, relationship with God, and interpersonal factors (Pearlman & Saakvitne, 1995). This expanded discussion challenged participants to consider that the "stoic and silent" person who appears not as "affected" might very well be affected by the trauma but manifesting it differently. Interestingly, on discussing the complexities of trauma assessment raised through a CSDT focus, participants spoke of the dangers of rushing to judgment and often quoted the biblical phrase, "Lean not on your own understanding" (Proverbs 3:5, King James version).

To help participants further explore the individual meanings and manifestations of trauma from a CSDT perspective, they were invited to view *Surviving September 11th: The Story of One New York Family*, a Public Broadcasting Service (PBS) film chronicling how different members of the same family found the strength to cope with the trauma and spiritual distress resulting from 9/11. Using a CSDT focus introduced by the PowerPoint Presentation, participants formed small process groups and helped each other identify the family's psychological needs (i.e., safety, trust, esteem, intimacy, and control) and explore the multiple meanings the trauma had for each family member.

Beyond the constraints of the *DSM-IV-TR* and current trauma theories, the curriculum also had to encompass the faith community's experience and understanding of trauma so that it would receive approval from the faith-based leadership and participants. To gain the approval and trust of these groups, we adapted and implemented theology and exegesis that was familiar to the participants. Specifically, we used examples from familiar versions of the Protestant Bible (i.e., King James and New International) to illustrate aspects of traumatic experiences. For example, when discussing the concepts of fear, anxiety, grief, and tragic loss in context of the 9/11 disaster, we invited participants to draw theological comparisons to the experiences of biblical characters, which included Job, Joseph, Nehemiah, and Jeremiah, to name a few. In discussing and defining the word *trauma*, we were able to connect with the group by utilizing a familiar bible study practice of tracing a word to its Greek origin. For example, when introducing the word *trauma*, we briefly discussed its Greek meaning

(i.e., *wound*). This exegesis immediately caught the attention of participants who embraced the concept of trauma as *woundedness* and were able to engage in a broader discussion of trauma beyond physical destruction and explore multiple other ways individuals might be *wounded* through traumatic experience.

To ascertain whether participants were able to assimilate the information derived from the PowerPoint presentation and film, a 20-question multiple-choice pretest assessing knowledge of BPST and CSDT in relation to trauma was administered before the interactive PowerPoint and film were shown. Approximately 6 hours after the presentation and interactive training, participants received a posttest with the same pretest questions arranged in a different order. The pretest and posttest covered basic aspects of BPST and CSDT as applied to trauma. Some questions required knowledge of neuroanatomy; for example, "The primitive part of the brain that deals mostly with emotions and fear is (a) frontal cortex, (b) corpus callosum, (c) cerebellum, (d) amygdala, (e) there is no primitive part of the brain." Some questions required a knowledge of *DSM-IV-TR* diagnostic criteria:

For a diagnosis of Acute Stress Disorder (ASD), (a) symptoms must be present for at least 4 weeks; (b) re-experiencing, avoidance, and hyper arousal must be present; (c) symptoms must be present for 2 days but not more than 4 weeks; (d) symptoms must be alarming and completely disabling; or (e) both b & c are correct.

Other questions focused on knowledge of social and personal factors that adversely affect traumatized persons:

In assessing individuals who have faced recent trauma, factors that increase the risk of developing negative outcomes include: (a) Lack of support in the weeks following exposure; (b) Authoritative, disrespectful, or impersonal treatment; (c) Lack of emotional, familial, and spiritual support; (d) Lack of information about the nature and reasons for the event; or (e) All of the above.

METHOD

Trauma workshops that included the curriculum as a PowerPoint presentation with a film on trauma were presented at various venues, including churches and public meeting places. A pretest and posttest that was aligned to the objectives of the workshop were administered at the beginning and end of each meeting, along with a demographic questionnaire and a workshop evaluation form. The evaluation forms, demographic information sheet, and pretest and posttest were all designed by the researchers. Items on the posttest were the same

as on the pretest except for the fact that the order of both the questions and the responses was changed to increase reliability.

There were three instruments developed for this study. The first was to measure the gain in knowledge pre to post. Topics covered on the instrument were taken directly from the objectives presented to the attendees. Topics covered included neuropsychology, diagnostic process and criterion for PTSD, multicultural therapeutic approaches, and symptoms of PTSD. The second instrument collected demographic data on the respondents and included topics such as gender, age, ethnicity, and questions to determine the degree to which the respondent was personally affected by 9/11. The third instrument measured the overall value of the workshop as determined by the attendees. All instruments were administered at the time of the workshop.

Of the 426 total participants, 30% were Latino or Latina, 53% were African American, and 14% were Other. The mean age was between 40 and 55, with 8% having some postsecondary training. We received 279 fully completed instruments; 147 were not usable because they were incomplete or not correctly filled out or because there was not a companion posttest. A total of 31% were from the private sector (including business professionals and those not employed by public agencies), 9% were medical professionals, 7% were from the religious sector, 5% were professional counselors, and another 5% were teachers or students. The remainder were unclassified. Of the participants, 64% were female, and participants represented all five boroughs.

The faith-based respondents were those individuals who were either employed or who served as volunteers in faith-based organizations. In all, 53% indicated they knew someone affected by 9/11, and 39% indicated they were personally affected by 9/11. Also, 46% indicated they did some type of counseling either as a volunteer or professionally. All workshops and training materials were translated into Korean, Spanish, Chinese, and Creole to increase access and usage when providing training to these communities. The proctor, who administered the instrument, was a native speaker and therefore was able to answer questions from the respondents.

RESULTS

The participant responses to the training were generally very positive. When asked how they would rate the training overall, 88% responded "excellent" or "very good," 10% responded "good," and 3% responded "fair" or "poor." When asked if the workshop was timely and

relevant, more than 83% responded "excellent" or "very good," 12% responded "good," and less than 5% responded "fair" or "poor." There was nearly universal agreement that the trainers were knowledgeable and that what was presented would be used in the participants' work with individual suffering from PTSD as a result of 9/11. All the respondents indicated a willingness to recommend the workshop to others. Many participants stated that the workshop was a useful, informative experience and what they learned could be used in their work with faith-based individuals who experienced a traumatic event in their lives.

The question as to whether or not the respondents actually used the information in working with affected individuals is unknown at this time and would require a specific follow-up. However, through the pretest and posttest, we were able to assess the degree to which the participants may have learned the material that was presented. On the 20-item pretest, the mean number of correct answers was 6.46 ($SD = 4.2$), and on the posttest, the mean number of correct answers was 14.23 ($SD = 3.43$). The evidence of learning was consistent across all the different language groups of participants, but the subgroups were not large enough to analyze separately and make comparisons. A paired-sample t test was calculated to determine whether or not the gains from pre to post were because of chance, $t(1, 134) = 20.7, p < .01$. This result would suggest that the improvement in scores from pre to post was not random. It would appear that the respondents were able to retain the information presented. Moreover, it may be relevant to keep in mind that many of the participants were not medical or counseling professionals.

DISCUSSION AND APPLICATIONS TO PRACTICE

To our knowledge, this article is the first of its kind to document outcomes emanating from a federally funded, spiritually sensitive, collaborative, trauma-training initiative aimed at the urban faith community, using traditional mental health providers and educators. We were concerned about achieving widespread acceptance for a scientifically oriented mental health training program from a fairly conservative Southern Baptist community. In addition to presenting the scientific material in an interactive, easy to digest format that included multimedia, we applied "literal" biblical interpretations and assumptions (i.e., biblical stories really happened and are not myths) to encourage program participation and acceptance. We noted that participants demonstrated great interest in wanting to learn more about the scientific and psychological aspects of

trauma. We also noted that participants from diverse cultural positions, including Haitian Americans, Asian Americans, African Americans, Latino or Latina Americans, and Anglo Americans were uniformly able to draw comparisons between the scientific and biblical manifestations of fear, uncertainty, and healing as they relate to trauma. Each cultural group independently discussed the application of the BPST to the passion of Christ and the CDST to his unique response of forgiveness of his tormentors. This suggests that the discussion of the passion of Christ has the potential to cross cultural lines in the discussion of trauma. Given that Christ represents a salient symbol in most, if not all, Christian denominations, it would be a reasonable assumption that the passion of Christ has similar potential to cross-denominational boundaries in the discussion of trauma. The feasibility of identifying similar passion narratives within different religious traditions to create an ecumenical dialogue on trauma merits further research.

We suggest that the theology adopted by any training program be compatible with the specific religious or theological and cultural traditions of the intended participants. The Fear to Faith Program is ecumenical and culturally sensitive because it seeks to adopt the language of trauma, grief, pain, hurt, and healing located in the specific traditions and canons of religious and cultural groups.

Based on the outcomes and responses to this training, we agree with the body of research documenting that caregivers from the faith community would significantly benefit from similar opportunities for training (Benes et al., 2000; Evans, 1999a; McMinn et al., 1998, 2001; Plante, 1999).

Clearly, there are some limitations associated with this study, and it is important to identify those. We have no follow-up data to know whether or not the skills and knowledge acquired were put to use, but we do have an indication that the respondents found the information useful and would recommend the workshop to others. There was concern about the cultural and language issues associated with the presentation and evaluation, but we did not find major differences in cultural groups in their responses to the instruments, and their responses were overwhelmingly positive. We acknowledge that we have no information about the validity of our outcome measure, which is a serious limitation in the evaluation of training effectiveness. And there is concern about the loss of 35% of the questionnaires because of incomplete answers or no answers or because they were not turned in at the appropriate time. However, we believe that the apparent success of our project demonstrated the usefulness of the training and justifies ongoing implementation and further research with more rigorous methodology.

This project has now produced usable information for researchers and other clinical teams working with immigrants and low-income minority populations who first rely on their faith before they seek professional help. The training data also reveal how the participants were affected, if they have ever sought help, and how the training can help them and if in fact they can use the information provided. Fear to Faith also teased out the interest in a spiritual approach to trauma strategy and provided data to form the basis for further research on effective, evidence-based models of interdisciplinary mental health approaches to long-term trauma recovery for hard-to-reach survivors of September 11 and other major disasters.

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