Pastoral Psychol (2010) 59:147–158
DOI 10.1007/s11089-009-0262-2

When Horror and Loss Intersect: Traumatic Experiences and Traumatic Bereavement

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Published online: 28 November 2009

Abstract Members of the clergy serve on the front lines as caregivers for individuals whose lives have been forever changed by life-threatening traumatic events, and by the sudden traumatic deaths of loved ones. This article is intended to provide useful information to clergy about the nature of traumatic experiences, predictable human reactions to them, and ways that clergy can be helpful in restoring psychological and spiritual equilibrium among their service recipients when bad things happen to good people. We first review several types of traumatic events, making a distinction between natural disasters and those that involve human perpetration. Next, two common pathologic reactions, PTSD and complicated or prolonged grief, are described. Current theoretical models for the disorders are discussed, along with description of the intersection of the two disorders. We then present aspects of spirituality as key resources in recovery from traumatic exposure and loss, emphasizing their role in making meaning of tragic experiences. Finally, key principles for clergy to follow in providing psychological first aid to those in crisis after a traumatic experience are discussed.

Keywords Trauma · Grief · PTSD · Bereavement · Violence

Whether they function as parish ministers, chaplains, or pastoral counselors, clergy members have opportunities to serve in key roles in trauma identification, early response, and recovery for many individuals. Unfortunately, traumatic events are not rare occurrences. Population estimates for the occurrence of trauma vary from study to study, but conservatively at least half of us can expect to experience a severe life stressor, or

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traumatic event during our lifetime (Kessler et al. 1995; Breslau et al. 1998). Traumatic events are, by their very nature, dangerous, frightening, unpredictable, and uncontrollable. Without warning, individuals or groups find themselves exposed to horrific suffering and threat to life that leaves them terrified, panicked, vulnerable, and sometimes injured. Functional ability can be compromised from the moment of threat until the ability to cope effectively is regained. Death of course is a universal element of human existence. All of us, should we live long enough, can expect to experience the loss of someone that we love. But for some, it will be traumatic events that bring about death, leaving an extra burden of grief and sorrow in their wake for family and friends who survive. The purpose of this paper is to provide information about the nature and prevalence of traumatic experiences and traumatic bereavement. We specifically focus on ways that clergy can help those who suffer.

What is a traumatic event?

The mental health profession has a very distinct and specific definition of trauma. A traumatic event places a person at threat to life or serious injury; it can be experienced directly, witnessed happening to someone else, or experienced vicariously when it happens to someone dear, like a family member or close friend. Traumatic events can also include experiences of intrusive personal violation such as sexual abuse or physical assault. These intense experiences are usually accompanied by strong emotional reactions, including fear, helplessness, and horror (American Psychiatric Association 2000). The perception that one is unable to control a situation (i.e., feeling powerless, out of control) or suddenness and unpredictability can intensify the traumatic experience. Traumatic events are classified into three categories. One includes natural disasters and other events sometimes labeled "acts of God," meaning terrible, life threatening occurrences in the natural world that are not brought about directly by human beings. Floods, tornadoes, earthquakes, and hurricanes all fall into this category.

A second category includes unintentional human-caused events, such as car accidents, falls, and structural collapses. These events involve some human lapse of concentration, or direct negligence that results in serious injury or life-threat, or risk thereof. A final category includes intentional human-caused traumas, such as muggings, assaults, rape, child abuse, domestic violence, military combat, and terrorist attacks.

Types of traumatic events encountered in pastoral ministry

Traumatic events occur indiscriminately, so virtually all types of trauma could potentially be experienced by members of a religious community. Traditionally, a key role for church communities has been providing for immediate physical and spiritual needs of parishioners, as well as mobilizing helpful outreach for people in need in times of large-scale accidents or disasters, such as hurricane Katrina.

For the purposes of this paper the authors would like to highlight two traumatic events that tend to receive less attention within church communities, and yet have a powerful impact on the health of some members. These are childhood abuse, and adult exposure to intimate partner violence. A few years ago, a collaboration between the Centers for Disease Control and Prevention and the Kaiser Permanente health system resulted in a landmark study related to disease and mental health risk. The study (Felitti et al. 1998) examined the role of what are called "Adverse Childhood Experiences (ACES)." This large study of nearly 14,000

participants found relationships between seven different childhood experiences (psychological, physical, or sexual abuse; witnessing domestic violence; living with family members that abuse substances, or are mentally ill/suicidal, or who are imprisoned) and risk for major physical/mental health problems including risk of early death. Individuals who had experienced 4 or more of these (ACE) events were 4 to 12 times the risk for developing alcoholism, drug addiction, depression, and suicide than those who had experienced no (ACE) events. Additionally, they were 2 to 4 times more likely to smoke, to perceive themselves as being in poor health, and to have more than 50 sexual partners. As the number of ACE experiences increased, so did the risk for major adult health risks such as heart disease, cancer, and several other leading causes of death in the U.S.

Another important but sometimes overlooked risk for trauma that clergy may encounter is intimate partner violence. Epidemiological studies suggest that at least 22% of women in the U.S. experience violence at the hands of an intimate partner during their lifetime (e.g. Tjaden and Thoennes 2000). For a pastor in a church of 100 members (of whom half are women), this would mean that 10 of those women would likely have at some point experienced violence at the hands of a spouse/partner. An early study of battered women found that abused women were somewhat less likely to attend religious services than a comparison group of women in marital distress without violence (Ogland-Hand 1992). There is some recent evidence that weekly church attendance is associated with lower levels of perpetration of partner violence among men, and that at least monthly attendance is associated with lower risk of being a victim of partner violence (Ellison and Anderson 2002).

A number of writers have noted how important the response of clergy and their religious communities can be when women choose to disclose their experiences. When clergy or religious communities respond to women with either doubt about the veracity of the disclosure or blame for the occurrence of the victimization, they contribute to greater emotional pain and suffering for the victim (Nason-Clark 2000). Physical injury is one consequence of spouse/partner violence. One hospital study found that 80% of women admitted more than three times to the emergency room (ER) with physical injuries were victims of domestic violence (Flitcraft 1995). One in six women presenting to an ER for any reason report abuse by someone they know within the past year (Frank and Rodowski 1999). From a mental health perspective, women victimized by partners are 3 to 5 times more likely than non-abused women to experience depression, PTSD, suicidality, and alcohol/drug abuse (Golding 1999).

An early study of religious involvement among victims of intimate partner violence, found that religiously committed women who were battered suffered less severe PTSD symptoms than women without a religious commitment (Astin et al. 1993). Since that time, other studies have highlighted the important role that spirituality and religious involvement in mitigating the impact of family violence. For example, a recent study (Gillum et al. 2006) found that 97% of abused women in a shelter setting reported that spirituality was a source of comfort for them. The study also found that religious involvement was associated with less depression, and an increased sense of psychological well-being. Knowledge about the prevalence of family violence and ways to effectively assist those who are victimized can aid clergy care providers in improving the physical and mental health consequences of these experiences.

What is posttraumatic stress disorder?

While most people are resilient (i.e. they will resume normal functioning after a trauma), a smaller percentage will develop posttraumatic stress disorder (PTSD). PTSD includes three clusters of symptoms that have become known because of news coverage of wars and

natural disasters. One cluster includes symptoms of intrusive memory, and several ways that the trauma is re-experienced by the survivor. This happens through memories of the event that intrude both spontaneously, or are triggered by reminders found in the person's daily experience. These memories may emerge through distressing recurrent nightmares that can disturb sleep for the individual, as well as other family members. Re-experiencing can also happen through "flashbacks," or memories that take on a vivid dissociative quality that can leave the person feeling (usually momentarily) that the traumatic event is actually occurring again.

The second cluster of symptoms consists of ways in which the survivor attempts to avoid things that trigger re-experiencing. He/she may avoid people, places, thoughts, and experiences that serve as reminders, and withdraw from formerly close relationships. Numbing of emotions is another symptom that may serve to deaden the pain of re-experiencing a traumatic event. Finally, a third cluster encompasses what are called hyper-arousal symptoms. These are thought to reflect a bodily attempt to be more alert and thus prevent the actual recurrence of another trauma. Hypervigilance is one aspect of that attempt to remain constantly alert, and may combine with avoidance to dramatically limit the person's activities, i.e. avoiding crowds, public transportation, and other places where it is difficult to be alert to everything in the environment. Other hyperarousal symptoms include loss of concentration, irritability or anger, excessive startle reactions, and sleep problems.

What are current models for understanding how trauma leads to the development of PTSD?

Early models for understanding the impact of traumatic events identified the role of "fear conditioning." These models utilized Mowrer's (1960) two factor (classical and instrumental conditioning) learning theory as a way of understanding how PTSD symptoms (particularly re-experiencing and avoidance) developed. Early researchers in combat trauma (Keane et al. 1985) used Mowrer's theory to explain the development of PTSD in Vietnam veterans. They theorized that individuals exposed to life-threat become conditioned (classical) to a wide variety of stimuli present in the environment at the time of the trauma. Thus, these stimuli became associated with fear and anxiety. Instrumental conditioning is theorized to explain how learned responses that diminish fear and anxiety, i.e. avoidance and escape, lead to the development of the second and third clusters of PTSD symptoms.

During the 1980's researchers working with rape survivors highlighted the importance of thoughts, beliefs, and expectancies in the development of PTSD symptoms (Veronen and Kilpatrick 1983). Edna Foa and colleagues (Foa and Kozak 1986; Foa et al. 1989) created emotional processing theory to extend previous work and better explain symptoms they were seeing in rape victims. This theory suggested that memory for traumatic events were stored in a memory network that contained 1) information about the feared stimulus (traumatic event); 2) information about verbal, behavioral and physiological responses to the stimuli (the immediate reaction to the trauma); and 3) interpretive information about the meaning of both the stimulus and the response.

More recently, theorists have proposed more elaborate cognitive models for the development and maintenance of PTSD symptoms (e.g. Ehlers and Clark 2000) to help explain the persistence of symptoms in individuals who develop chronic PTSD. They suggest that PTSD occurs primarily when trauma survivors continue to think of their environment as a place of ongoing, current, and severe threat. This sense of threat is maintained by negative appraisals of the circumstances of the trauma and its aftermath, and by ways in which memory of the trauma is integrated into the narrative of who they are (i.e. their autobiographical memory). The sense of threat and danger that these survivors endure

is accompanied by those experiences we know as PTSD symptoms. Perceived threat also brings about behavioral attempts to reduce threat (i.e. such as avoidance, withdrawal, hypervigilance) that are fear-relieving in the short term, but over the long-term prevent cognitive adaptation that leads to recovery.

The newest emerging PTSD models are coming from the neurosciences. In continuing reviews of this rapidly changing field, Brewin (2001, 2008) notes evidence for a dual representation theory of trauma in which two distinct memory systems are engaged during periods of extreme stress, one responsible for the vivid imagery involved in re-experiencing, and one responsible for more verbally-based autobiographical memory. Improved understanding of trauma-related neurotransmitters and hormonal activities within the brain and of the function of the brain structures involved in stress reactivity will lead to further model development and improved explanations of traumatic stress and loss reactions.

Risk and resilience factors that influence the development of PTSD

Primary questions that persist related to PTSD are: who is most likely to develop it; and why does one person develop it when others exposed to the same trauma do not? Much research is ongoing to identify risk and resiliency factors that either increase risk for developing PTSD, or promote resiliency from it. One of the most consistent research findings is the presence of a "dose-response" relationship between trauma exposure and risk of developing PTSD. In other words, the more intense the experience of trauma (i.e. severity, duration, and frequency), the greater the likelihood is that an individual will develop PTSD. Beyond trauma severity, a number of other key risk and resilience factors have been identified (Brewin et al. 2000). Major environmental factors and pre-trauma experiences- such as childhood abuse or other adverse childhood experiences, prior trauma, a family or personal history of psychiatric problems, lack of social support, and current life stressors- have been linked to increased risk of PTSD. Demographic factors, younger age, female gender, lower socioeconomic status, less education, and lower intelligence have also been associated with increased risk for PTSD. There are even potential biological factors that might place individuals at increased risk for PTSD. Post-trauma brain imaging studies have shown structural differences in a key brain structure, the hippocampus, for individuals with PTSD, compared to other groups of individuals without PTSD (Bremner et al. 2003). It is not entirely clear at present whether those differences are indicators of pre-trauma biological differences, or whether these differences are indicative of changes in the brain that occurred as a consequence of the traumatic event. Generally, those factors present during the trauma and in the post-trauma recovery environment are proving to be the most powerful predictors of PTSD outcome.

Bereavement and grief

Recently, increasing attention has been paid to issues of grief and loss, particularly when they are associated with death through traumatic events. For many years it was thought that individuals who had experienced a death needed to do "grief work" in order to adapt effectively to the loss. Grief work involved the expression of strong emotions and resolution of relationship issues one had with the deceased. It was frequently thought that failure to do adequate mourning of the loss was a risk factor for the development of worse problems later on. Recent research has made it clear that there is considerable normal variability in the way people cope with death. It is now evident that some people do not experience intense bereavement reactions, and that most individuals, even those who do

experience strong transient grief, pass through the experience with continued health and resilience. There is little evidence that "grief work" as traditionally understood actually leads to optimal resolution of the loss (Regehr and Sussman 2004). Additionally, research suggests that individuals experiencing normal grieving patterns do not seem to benefit from intervention of any kind. Rather research indicates that intervention resources are best reserved for those experiencing what has now come to be called "complicated grief." That being said, there is some indication that, for individuals with an ambivalent or hostile relationship with the deceased, relationally-based therapeutic approaches can be useful (Regehr and Sussman 2004).

Evidence now indicates that a subset of individuals do seem to get stuck in a chronic unresolved experience of grief and loss. Labels to describe those individuals have varied over the years, and include pathologic mourning, abnormal or atypical grief, traumatic grief, complicated grief, and most recently prolonged grief disorder. Research suggests that approximately 10 to 20% of bereaved persons will develop the enduring grief reactions that we now call complicated or prolonged grief (Shear et al. 2005). Higher rates of those experiencing traumatic loss (i.e. death of a loved one due to traumatic events) will experience prolonged or complicated grief.

Complicated or prolonged grief as projected for implementation in DSM-V

Within, the next few years, it is likely that prolonged grief will formally take its place alongside other psychological disorders in the new diagnostic and statistical manual, fifth edition, (Lichtenthal et al. 2004). There has been ongoing research for several years now trying to determine whether symptoms of complicated grief can be distinguished from those of Major depression and PTSD that can sometimes accompany bereavement (both traumatic and non-traumatic). Currently, the proposed symptoms of prolonged grief disorder are described as (Prigerson and Maciejewski 2007): Criterion A: Persistent yearning or longing for the person that died. Criterion B: Four of these eight additional symptoms, occuring several times per day or to a degree intense enough to be considered distressing and disruptive. 1) Trouble accepting the death, 2) Difficulty trusting others, 3) Excessive bitterness or anger related to the death, 4) Being uneasy moving on with one's life, 5) Emotional numbness or detachment, 6) Feeling that life is empty or meaningless without the deceased, 7) Feeling that the future is bleak, 8) Agitation, i.e. feeling on edge or jumpy. Criterion C: These symptoms cause persistent problems with social, occupational or other important areas of functioning. Criterion D: These symptoms last for at least 6 months.

Similarities and differences between posttraumatic stress disorder and complicated grief

One can see, by placing the diagnostic criteria for PTSD and prolonged grief side-by-side, that there are areas of shared experience and symptom overlap. Differential diagnosis will sometimes need to be done carefully with a good understanding of the various criteria for each disorder. Persistent yearning and longing for the deceased entails both recollections and rumination about the individual who was lost. This is not dissimilar from the recurrent intrusive memories that accompany PTSD, particularly when the traumatic event involved the death of a loved one. One distinction is that in grief the rumination about the loved one is intentional, i.e. it is an attempt to hold on to the person that was lost, while in PTSD those

recurrent memories are frequently experienced as painful and avoided. A number of symptoms are shared in both disorders, including anger, emotional numbing and detachment, feelings of a bleak/foreshortened future, and agitation that could manifest as anxiety or startle.

The role of spirituality in recovery from trauma and loss

While there are many factors that account for the varying ways in which individuals cope and recover from both loss and trauma, there has been progress in identifying factors related to resilient coping. A sense of coherence (SOC) is a concept created by Antonovsky, based on observations of survivors from Nazi concentration camps who had positive outcomes in spite of all that they had experienced (Peres et al. 2007). There are three elements that describe a sense of coherence (SOC), comprehensibility, meaningfulness, and manageability. Comprehensibility is the ability to make sense of life and even traumatic events as a whole, and to fit events into a larger framework. Meaningfulness occurs when life makes sense both cognitively and emotionally within that framework, and immediate problems are seen as challenges to be overcome rather than burdens that must be carried. Manageability is the confidence that one can use available resources to deal with life events. A recent review of the SOC literature (Eriksson and Lindstrom 2006) found that coherence is strongly related to perceived health, both physical and mental. It is likely that it is through coherence that spirituality and religiousness provide a cornerstone and foundation for resilient coping in the face of difficult trauma and loss events.

A recent, comprehensive review of the role of religion and spirituality in adjustment following bereavement was performed by Wortman and Park (2008). The authors note that although many of the 73 studies they reviewed have limitations that prevent making causal inferences, generally positive associations are found for spirituality and psychological outcomes in all but one domain (religious affiliation) studied. They also note that for several domains including general religiousness, religious coping, and intrinsic religiousness, making meaning from the event appeared to be an important pathway by which spiritual experience and positive outcomes were associated.

Another comprehensive review was conducted of nearly 50 studies examining psychological effects of religious coping following highly stressful or traumatic events (Ano and Vasconcelles 2005). The authors' analysis indicated a moderate relationship between positive religious coping (i.e. seeking support from clergy, religious helping, forgiveness, spiritual connection) and positive psychological adjustment, and a moderate inverse correlation with negative psychological adjustment to stress. Similarly negative religious coping (i.e. spiritual discontent, anger at God, feeling abandoned by God) was correlated with negative psychological adjustment. Simply stated, these results show that positive religious coping can help buffer major life stresses, while negative religious coping is associated with worse adjustment.

Meaning making, trauma and bereavement

Cognitive appraisal of a stressful or traumatic situation is an immediate and necessary means of making meaning from the event. When traumatic loss occurs, individuals use all of their knowledge and their memory of and learning from similar prior experiences to make judgments about the level of threat and the likely outcome of current stressful events.

In the process they attach significance to the situations they encountered and to their reactions in ways that can change their perceptions in the future. In particular, their beliefs about their place in the world, their value, worthiness, and self-efficacy, and the level of trust they can place in other people may be altered. The meanings made from traumatic events and losses can lead either in the direction of increased resilience, maturity, and growth, or toward hopelessness and psychological problems.

Crystal Park and colleagues (Park and Folkman 1997; Park 2005) have theorized about how meaning develops during extreme trauma and loss, and how religion and spirituality may provide a framework that affects meaning development. They suggest that two levels of meaning are involved in coping with trauma and loss. One is global belief structures. These are the internal cognitive structures that contain an individual's understanding of the nature and functioning of the world; in other words, their expectancies about how the world works. These global beliefs serve to guide life goals, direction, and functioning. The second level of meaning is the appraised meaning of specific events. These meanings include appraisals of events as threat, loss, or challenge, and also include causal attributions as to why and how these events occurred. In some cases, an individual can conclude that appraised meanings and attributions about the cause of events are in conflict with, and not reconcilable with, their global beliefs. This causes distress, and since the traumatic event or loss cannot be changed or undone, it leads to re-evaluation of these meanings—either the basic understanding of how and why the traumatic event or loss occurred or change in the larger global beliefs which often are existential or religious in nature. For some people, spiritual struggle, or "red-flags" as researcher Kenneth Pargament et al. (1998) calls this experience, can result. This struggle can include loss of faith, anger at God, the perception that negative life events are punishment from God, strong guilt / shame feelings (sometimes exaggerated), and difficulty forgiving or feeling forgiven. Findings from a number of studies show that this spiritual struggle can be associated with worse psychological outcomes (e.g. Ano and Vasconcelles 2005).

Meaning-making is one of the recovery tasks for family and friends who lose a loved one to a traumatic event. Researchers who have studied meaning-making in the context of bereavement have suggested two important ways that individuals find meaning (Davis et al. 1998). Meaning as making sense from loss is one of these ways. This happens when survivors appraise an event as fitting their existing worldview. For example, people sometimes report making sense of a loss by attributing it to God's will, or by attributing it to lifestyle choices made by the deceased, or even by taking on some element of blame themselves. A second way of making meaning is to focus on or consider positive implications or benefits of the loss, while paying less attention to negative aspects. Individuals will report gaining a greater appreciation for life, or experiencing personal growth from the event, or perhaps placing a higher value on their relationships following the loss. This has been called meaning through construed benefit.

Traumatic and particularly violent death frequently makes these two usual ways of finding meaning extraordinarily difficult. Individuals report that they find it impossible to make sense of the violent death of someone close to them, or to see any benefit derived from it. One researcher with knowledge about the impact of death by homicide (Armour 2006) suggests that, in addition to cognitive changes that result in meaning, many survivors ultimately find meaning through actions. She labels these actions "the intense pursuit of what matters," and notes that a qualitative study of family members of homicide victims found that 83% of these individuals felt that this label substantially represented their experience of coping after the death (Armour 2002). Dr. Armour suggests three types of actions associated with meaning-making for family members of homicide victims. 1)

Declarations of the truth. Often family members of homicide victims report feeling ignored by legal proceedings focused on the perpetrator, and by news coverage of events. They will sometimes find a platform to speak out and express their feelings. This can include exposing perceived ignorance, incompetence or hypocrisy on the part of civic officials or the legal system. 2) Fighting for what's right—is another form of meaningful action. This advocacy work can take the form of survivors standing up for themselves and their interests and emotional responses, as well as working to change bureaucratic systems that failed to protect victims. 3) Living in ways that give purpose to the loved one's death. Frequently survivors will engage in actions that create resources or provide support for other victims and their families. It is important to note that at times strong emotions such as anger or resentment may provide the energy for actions that create meaning. Care providers should be slow to pathologize these normal strong emotional reactions. Rather, they should help survivors reframe and understand these emotional reactions positively, and to use the energy provided to do positive things that enhance the meaning making process and better memorialize the lost loved one.

Suggestions for clergy care providers

Clergy stand on the front line as care providers and are frequently the first and sometimes the only help sought by those who've experienced trauma and loss. As such it is important to know those factors associated with resilient outcomes for these individuals, so that the unique helping abilities of the clergy can be best applied. The American Psychological Association (2004) website lists five research-based factors associated with resilient outcome following stress that clergy members should know. First, and most important, is social support within and outside the family. Church communities promote recovery when they helpfully accept and support trauma victims. Other resilience factors include making realistic plans, having a positive view of self and confidence in one's strengths and abilities, the ability to manage strong emotions and impulses, and finally, problem-solving and communication skills. Programs provided by spiritual communities, and the human relationships they foster, can help enhance those recovery factors.

A helpful set of tools, originally designed to teach basic helping skills to disaster/relief workers in the immediate aftermath of natural disasters, is collectively called "psychological first aid" (Brymer et al. 2006). A training manual for the use of psychological first aid designed specifically for clergy engaged in post-disaster helping has also been recently developed. These five basic "first aid" principles can provide guidance for clergy in helping those who seek their aid in times of trauma and loss.

The first principle is safety. For individuals who been exposed to life threat and death, safety becomes a primary concern. Helping trauma survivors find safety when the danger is found in their own home can be challenging for clergy when all members of the family, including the perpetrator, are part of the church. However, taking action to protect the most vulnerable is an enduring biblical principle. Ensuring physical safety is the first and most basic element of the safety principle. However, helping individuals find a way of thinking about what has happened to them in a way that preserves their sense of emotional safety for the future and reduces exaggerated levels of perceived threat in the present moment is another way that clergy can help facilitate the long-term meaning making process.

Arousal reduction is a second basic principle. Perceived danger and life threat elicit a great deal of physiological arousal, i.e. fear and anxiety. Not only is a high level of arousal uncomfortable, but it can greatly interfere with day-to-day functioning. There are many

self-help resources aimed at relaxation and stress management. Often these resources will instruct in meditation techniques or relaxation exercises that may come with audio-tapes or CDs. From a spiritual perspective there is evidence that both prayer and meditation can bring about similar levels of arousal reduction for many people. Helping trauma survivors develop necessary relaxation skills is something anyone can assist with.

The critical importance of social support in promoting recovery following life crises has been mentioned previously. Helping family members reconnect, engage and interact effectively among themselves and with other people is very important. Self-efficacy is another basic principle. Self-efficacy is confidence in one's own abilities and capacity in overcoming the tasks at hand. Helping survivors recognize the strengths and skills that they still have and supporting them as they recover confidence in their own abilities will be very useful. The final core principle is one that is highly consistent with spirituality—it is restoring hope. Hope for the future is a key to making present progress in life. While despair can keep a person passive and stuck, hope can motivate an individual to move toward a better future. Relationships and activities that build hope can be foundational in helping assure resilient recovery. Serving others through volunteering and seeing hope rebuilt in the lives of others through one's own efforts, can play a strong role in rebuilding hope for oneself. Service and volunteering are ways that survivors and church community members can promote connection within the community. Service also creates awareness and empathy of the needs of others, and may provide mental and physical health benefit as well (Piliavin and Siegl 2007).

Conclusion

This article provides updated information on the nature and causes of traumatic victimization and bereavement that may help clergy in their care-giver roles. Theoretical perspectives on PTSD have progressed from early learning-based models to current views that also incorporate the cognitive neurosciences. PTSD and complicated grief are common reactions to traumatic events and loss that clergy need to be aware of when tragedy happens. Meaning making is a key aspect of recovery from trauma exposure and loss that can be promoted by spiritual care-givers. Clergy members can be better prepared to help in times of crises if they are knowledgeable about basic principles of psychological first-aid.

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References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders DSM-IV-TR* (Fourth ed.). Arlington: American Psychiatric Publishing, Inc.

American Psychological Association. (2004). Resilience factors & strategies. Retrieved 3/4/08, http://apahelpcenter.org/featuredtopics/feature.php?id=6&ch=3.

Ano, G. G., & Vasconcelles, E. B. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology, 61*(4), 461–480.

Armour, M. P. (2002). The journey of homicide families: A qualitative study of their post homicide experience. *American Journal of Orthopsychiatry, 72*, 372–382.

Armour, M. P. (2006). Meaning making for survivors of violent death. In E. K. Rynearson (Ed.), *Violent death: resilience and intervention beyond the crisis* (pp. 101–121). New York: Routledge.

Astin, M. C., Lawrence, K. J., & Foy, D. W. (1993). Posttraumatic stress disorder among battered women: Risk and resiliency factors. *Violence & Victims, 8*(1), 17–28.
Bremner, D., Vythilingam, M., Vermetten, E., Southwick, S., McGlashan, T., Nazeer, A., et al. (2003). MRI and PET study of deficits in hippocampal structure and function in women with childhood sexual abuse and Posttraumatic Stress Disorder. *American Journal of Psychiatry, 160*, 924–932.
Breslau, N., Kessler, R., Chilcoat, H., Schultz, L., Davis, G., & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: The 1996 detroit area survey of trauma. *Archives of General Psychiatry, 55*, 626–632.
Brewin, C. R. (2001). A cognitive neuroscience account of posttraumatic stress disorder and its treatment. *Behaviour Research and Therapy, 39*, 373–393.
Brewin, C. R. (2008). What is it that a neurobiological model of PTSD must explain? *Progress in Brain Research, 1677*, 217–228.
Brewin, C., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for Postraumtic Stress Disorder in trauma exposed adults. *Journal of Consulting and Clinical Psychology, 68*(5), 748–766.
Brymer, M., Jacobs, A., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., Watson, P. (2006). *Psychological first aid: Field operations guide* (2nd ed.). National Child Traumatic Stress Network & National Center for PTSD.
Davis, C. G., Nolen-Hoeksema, S., & Larson, J. (1998). Making sense of loss and benefiting from the experience: Two construals of meaning. *Journal of Personality and Social Psychology, 75*(2), 561–574.
Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*, 319–345.
Ellison, C. G., & Anderson, K. L. (2002). Religious involvement and domestic violence among U.S. Couples. *Journal for the Scientific Study of Religion, 40*(2), 269–286.
Eriksson, M., & Lindstrom, B. (2006). Antonovsky's sense of coherence scale and the relation with health: a systematic review. *Journal of Epidemiology and Community Health, 60*(5), 376–381.
Felitti, V. J., Anda, R. A., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14* (4), 245–258.
Flitcraft, A. (1995). Clinical violence intervention: Lessons from battered women. *Journal of Health Care for the Poor and Underserved, 6*, 187–197.
Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*, 20–35.
Foa, E. B., Steketee, G., & Rothbaum, B. O. (1989). Behavioral/Cognitive conceptualizations of Post-traumatic stress disorder. *Behavior Therapy, 20*, 155–176.
Frank, J. B., & Rodowski, M. F. (1999). Review of psychological issues in victims of domestic violence seen in emergency settings. *Emergency Medicine Clinics of North America, 17*(3), 657–677.
Gillum, T. L., Sullivan, C. M., & Bybee, D. I. (2006). The importance of spirituality in the lives of domestic violence survivors. *Violence Against Women, 12*(3), 240–250.
Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*(2), 99–132.
Keane, T. M., Zimmerling, R. T., & Caddell, J. M. (1985). A behavioral formulation of post-traumatic disorder in Vietnam veterans. *The Behavior Therapist, 8*, 9–12.
Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the national comorbidity suurvey. *Archives of General Psychiatry, 52*, 1048–1060.
Lichtenthal, W. G., Cruess, D. G., & Prigerson, H. G. (2004). A case for establishing complicated grief as a distinct mental disorder in DSM-V. *Clinical Psychology Review, 24*, 637–662.
Mowrer, O. H. (1960). *Learning theory and behavior*. New York: Wiley.
Nason-Clark, N. (2000). Making the sacred safe:Woman abuse and communities of faith. *Sociology of Religion, 61*, 349–368.
Ogland-Hand, S. M. (1992). *Post-traumatic stress disorder and religiosity: Comparisons between battered and maritally-distressed women*. Pasadena: Graduate School of Psychology, Fuller Theological Seminary.
Pargament, K. I., Zinnbauer, B. J., Scott, A. B., Butter, E. M., Zerowin, J., & Stanik, P. (1998). Red flags and religious coping: identifying some religious warning signs among people in crisis. *Journal of Clinical Psychology, 54*(1), 77–89.
Park, C. L. (2005). Religion as a meaning-making framework in coping with life stress. *Journal of Social Issues, 61*(4), 707–729.
Park, C. L., & Folkman, S. (1997). Meaning in the context of stress and coping. *General Review of Psychology, 1*, 115–144.

Peres, J. F., Moreira-Alameida, A., Nasello, A. G., & Koenig, H. G. (2007). Spirituality and resilience in trauma victims. *Journal of Religion and Health, 46*, 343–350.

Piliavin, J. A., & Siegl, E. (2007). Health benefits of volunteering in the Wisconsin longitudinal study. *Journal of Health and Social Behavior, 48*, 450–464.

Prigerson, H. G., & Maciejewski, P. K. (2007). A call for sound and triple testing and evaluation of criteria for complicated grief proposed for DSM-V. *Omega, 2*(1), 9–19.

Regehr, C., & Sussman, T. (2004). Intersections between grief and trauma: Toward an empirically based model for treating traumatic grief. *Brief Treatment and Crisis Intervention, 4*(3), 289–309.

Shear, K., Frank, E., Houck, P. R., & Reynolds, C. F. (2005). Treatment of complicated grief: A randomized controlled trial. *Journal of the American Medical Association, 293*(21), 2601–2608.

Tjaden, P., & Thoennes, N. (2000). *Extent, nature, and consequences of intimate partner violence: Findings from the national violence against women survey.* U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

Veronen, L. J., & Kilpatrick, D. G. (1983). Stress management for rape victims. In D. Meichenbaum & M. E. Jaremko (Eds.), *Stress reduction and prevention* (pp. 341–374). New York: Plenum.

Wortman, J. H., & Park, C. L. (2008). Religion and spirituality in adjustment following bereavement: An integrative review. *Death Studies, 32*, 703–736.