Pastoral
Crisis Intervention

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Chapter One: A Time of Need

We have entered and are one quarter through a new millennium. We make this journey with great expectations of exciting things to come. New discoveries and great improvements in life will surely be coupled with new challenges, even traumas.

A Changing World

Within recent years, we have witnessed a series of domestic and global changes that will surely alter expectations of the future and potentially serve to challenge our sense of prosperity and well-being. Consider that within recent history, we have experienced:

- the collapse of the Soviet Empire and resultant political and financial instability throughout most of Eastern Europe, followed by the rise of Russia with imperialistic motives to reclaim the former Soviet states;
- the rise of China as a major economic and military power also showed imperialistic motives with stricter governance of Hong Kong, expanding its reach into international waters, and the promise to reclaim Taiwan;
- a reorganization of the American healthcare system wherein the quality of healthcare is seen by many as having been sacrificed for the economy;
- the emergence of the most vitriolic partisan political schism in modern history;
- scandals within the banking and financial sectors, casting doubt upon the integrity and vitality of the icons of American capitalism, especially the stock market;
- the advent of the war against terrorism, “We are in a war that will set the course for a new century.” Winning the war against

terrorism is the "calling of our generation." according to President George W. Bush on 09/11/06;

- the dramatic withdrawal of American forces from Afghanistan in August 2021, leaving America with weakened international credibility;
- the SARS pandemic of 2002-2004;
- the COVID-19 pandemic of 2020-2024 and the loss of faith in public health due to potential mismanagement of the crisis;
- an immigration crisis that is challenging healthcare and social service systems;
- the rise of crime and the decay of the quality of life in many American urban centers; and
- the potential for the use of stem cells to re-grow damaged human organs while, at the same time, the rise of artificial intelligence and humanoid-like robotics.

For many, the aforementioned challenges not only have economic and social ramifications but also have psychological, spiritual, and even religious implications, as well.

Mental Health Consequences

What might be the mental health consequences of an epidemic of change and turmoil? An overarching concept that seems applicable is that of "crisis." A crisis may be thought of as a response to an event or critical incident, wherein one's usual coping mechanisms have failed, and there is evidence of clinically significant distress or dysfunction (Everly & Mitchell, 1999, adapted from Caplan, 1961, 1964).

What is the magnitude of risk for experiencing a significant critical incident or trauma that might yield a crisis or some otherwise significantly adverse impact upon one's mental and/or spiritual health? What are the mental health consequences of such exposure?

- Evidence suggests over 70% of adults globally will be exposed to a traumatic event during their lifetime (WHO, 2024).
- The rate of trauma exposure for children and adolescents has been estimated to be about 46% (SAMHSA, 2018)
- The conditional risk of developing posttraumatic stress disorder (PTSD) was found to be 13% for females and 6% for males in a general community sample (Breslau et al., 1998
- Suicide rates have been seen to increase by 62% in the first year after an earthquake, increase by 31% in the first two years after a hurricane, and increase by almost 14% four years after a flood (Krug et al., 1998
- Law enforcement Officers are 54% more likely to die from suicide when compared to other careers. (Volanti & Steege, 2020).
- While around 80 percent of first responders experience a traumatic exposure, about 1 in 3 first responders develop PTSD. (IOH, n.d.)
- COVID-19 has challenged the mental health system and, in many instances, delayed the social and academic development of many adolescents. Social isolation in childhood increases cardiovascular risk factors, including obesity, high blood pressure, and blood glucose levels as an adult.

Finally, the demand for mental health services is far greater than mental health capacity, causing long wait times to see psychologists and psychiatrists.

spirituality, or religious belief, may serve such a purpose while also serving as a solid foundation upon which stress resistance and resiliency in the wake of disasters and traumatic events may be built.

Spirituality and Religion Defined

Psychologists have often considered spirituality and religion as one and the same (Zinnbauer & Pargament, 2005). This is an oversimplification and is indeed inaccurate.

Building on the definitions compiled by Zinnbauer and Pargament (2005), spirituality may be thought of as a subjective experience with, relationship to, or faith in some transcendent, sacred, or divine presence that usually serves to provide a sense of coherency to one's understanding of existence. Religion, on the other hand, may be thought of as a system of specific scripture or doctrine-specific beliefs, practices, and rituals relating the human presence to a divine presence as well as the practice of worship toward that divine presence.

Spiritual and Religious Implications

We begin with the oft-cited statistic that 81% of Americans believe in God (Gallup Polls, 2022) and 75% pray (Gallup Polls, 2022). Further, more people believe in organized religion than any other organized social institution. A *USA Today*-*Gallup* poll sampled 1,015 American adults in 2023 (Gallup Polls, 2023). They found that 33% described themselves as spiritual, while 47% of respondents said they were religious.

In a national survey conducted by the American Red Cross from October 5th to October 8th, 2001 (American Red Cross, 2001), 59% of respondents would be likely or very likely to seek assistance from a spiritual counselor. This is in comparison to seeking help from physicians (45%) or mental health professionals (40%).

Religious beliefs may be the single best predictor of abstinence from alcohol and drug abuse, as well as abstinence from premarital and

extra-marital sexual activity (Gorsuch, 1988 as cited in Spilka et al., 2003). Following the terrorism of September 11th, 2001, surveys reported an increase in church attendance ranging from 6-24%, but that such attendance was reduced to pre-September levels by the end of the year (Spilka et al., 2003). These findings suggest that religion may serve to foster attitudes and behaviors that are pro-social and that foster community health. Further, they suggest that religion may be used as an acute stress management/ coping intervention.

The notion that spirituality and religion may be used to cope with extreme stress is not new. Indeed, the old saying, "There are no atheists in a foxhole." speaks to the idea that when confronted with extreme adversity, people often look to a higher power for understanding, if not protection.

In his book *Lifesigns*, Henri Nouwen (1986) explains that fear blocks the achievement of intimacy, fecundity, and complete joy. He argues that fear may be overcome using religious belief.

But what of the whole notion of believing in God to whom one looks in adversity? "Pascal's Wager" is the name given to a famous argument for believing in God. Pascal (1623 – 1662) was a French mathematician, physicist, and religious philosopher. In his *Pensées*, Pascal presents a "wager" for those who are skeptical about the existence of God. Pascal uses an analytical approach to the question. He notes, "God is, or He is not. But to which side shall we incline? Reason can decide nothing here . . . A game is being played at the extremity of this infinite distance where heads or tails will turn up . . . Which will you choose then? . . . Let us weigh the gain and the loss in wagering that God is. Let us estimate these two chances. If you gain, you gain all; if you lose, you lose nothing. Wager, then, without hesitation that He is."

Timothy Johnson's *Finding God in the Questions* (Johnson, 2004) may be a more modern version of Pascal's *Pensées*. In Johnson's "personal journey," he presents a compelling case for the existence of

God, but rather than using Pascal's analytic approach, or some spiritual or religious doctrine, he presents a gentle yet persuasive rhetoric based on personal doubt, experience, and exploration. In his treatise on "final judgment," Johnson addresses the dogma of some strict orthodoxies by noting that in the Christian Bible's presentation of the parable of final judgment according to Matthew there is no mention of "correct thinking," no mention of correct political or social positions, no mention of time spent in traditional religious worship, and no mention of the acquisition of power, fame, or wealth.

Summary

The spiritually-based or religion-based communities with their pastorally-oriented resources represent a large and often untapped resource in times of crisis and disaster. They possess an aggregation of characteristics that makes them uniquely valuable amidst the turmoil of a psychological crisis or simply as an infrastructure upon which a community may flourish. In critical incidents such as terrorism, mass disasters, violence, the loss of loved ones, and any events wherein human actions result in injury, destruction, and/or death, the pastoral community may possess especially powerful restorative attributes. Unfortunately, heretofore, there have existed few generally recognized and accepted ways in which the healing factors inherent in pastoral care have been functionally integrated with the well-formulated principles of crisis intervention and disaster mental health response ((Verhoff et al., 1981; Koenig, 2004),. This book represents an effort to elucidate how the principles of pastoral care may be functionally integrated with those of crisis intervention and disaster mental health. The amalgam shall hereafter be referred to as "pastoral crisis intervention" and is defined in this volume.

Chapter Two: Pastoral Crisis Intervention

The term *Pastoral Crisis Intervention* (Everly, 2000a) is offered as a term that represents the functional integration of psychological crisis intervention with pastoral care. This chapter will examine the widely used definitions of both domains and will further seek to elucidate the foundations of functional integration.

Crisis Intervention

Crisis intervention is best understood in the context of the term crisis. A *crisis* may be thought of as an acute *response* to an event wherein homeostasis is disrupted, one's usual coping mechanisms have failed, and there is evidence of significant distress or functional impairment (Everly & Mitchell, 1999, adapted from Caplan, 1961, 1964). The stressor event that precedes the crisis response is commonly referred to as the *critical incident*. The term *crisis intervention* refers to the provision of an acute helping process to progressively achieve 1) stabilization of symptoms of distress, 2) affect mitigation of symptoms, and 3) restore adaptive, independent functioning, if possible, or facilitate access to further support (Everly & Mitchell, 1999; Flannery & Everly, 2000).

In the formative years of crisis intervention, Rapoport (1965) noted, "A little help, rationally directed and purposely focused at a strategic time, is more effective than extensive help given at a period of less emotional accessibility" (p. 30). Later, Swanson and Carbon (1989) writing for the American Psychiatric Association Task Force Report on the Treatment of Psychiatric Disorders stated, "Crisis intervention is a proven approach to helping in the pain of an emotional crisis" (p. 2520).

The aforementioned assertions were made not based upon case study and field empiricism alone but also upon well-controlled clinical

investigations. Let us briefly review the early foundations of crisis intervention and thus pastoral crisis intervention.

Langsley et al. (1971) used random assignment (RCT) of 300 patients to inpatient treatment vs. family crisis intervention. Results indicated crisis intervention was superior to inpatient treatment for preventing subsequent psychiatric hospitalizations. Decker and Stubblebine (1972) followed 540 psychiatric patients for 2.5 years subsequent to an initial psychiatric hospitalization. Traditional follow-up treatment was compared to crisis intervention services. Results supported the superiority of the crisis intervention services in preventing subsequent hospitalizations.

Bunn and Clarke (1979), in a randomized controlled design with 30 individuals who had accompanied relatives to the hospital after a serious injury, found 20 minutes of supportive crisis counseling superior to no intervention in reducing anxiety.

Bordow and Porritt (1979) employed a three-group RCT of individual crisis intervention with hospitalized motor vehicle accident victims. Results were indicative of a dose-response relationship between intervention level and the reduction of reported distress.

When crisis intervention principles and practices were applied to victims of bank robberies, the crisis interventions were found to be effective in reducing distress (Campfield & Hills, 2001; Richards, 2001). In military applications, Solomon and Benbenishty (1986) found the core crisis intervention principles of “proximity, immediacy, and expectancy” to be effective in response to combat; this is consistent with the seminal observations of Salmon (1919) and Artiss (1963). Deahl et al. (2000) found small-group crisis intervention to be effective in reducing alcohol use in military personnel after returning from peace-keeping activities in a war zone. Most importantly, however, are the implications of a 20-year longitudinal study by Solomon, et al. (Solomon, et al., 2005). The study evaluated the long-term effectiveness

of frontline treatment provided to combat stress reaction casualties. Using a longitudinal quasi-experimental design, combat stress reaction casualties of the 1982 Lebanon War who received frontline treatment (N=79), were compared to comparable combat stress reaction casualties who did not receive frontline treatment (N=156), and other soldiers who did not experience combat stress reaction (N=194). Twenty years after the war, traumatized soldiers who received frontline crisis intervention, following the core principles of proximity, immediacy, and expectancy, had lower rates of posttraumatic and psychiatric symptoms and reported better social functioning than similarly exposed soldiers who did not receive frontline intervention. The cumulative effect of the core crisis principles was documented in that the more principles applied, the stronger the effect. The authors conclude, "Frontline treatment is associated with improved outcomes even two decades after its application. This treatment may also be effective for nonmilitary precursors of posttraumatic stress disorder" (p. 2309).

Flannery (2001) and Flannery et al. (1995) pioneered the development of a multi-component critical incident stress management program referred to as the Assaulted Staff Action Program (ASAP). The ASAP program was chosen as one of the ten best programs in 1996 by the American Psychiatric Association. A 10-year review of ASAP practice revealed ASAP to be clinically effective (Flannery, 2001). In a follow-up investigation, Flannery et al., (2011) reported on a fifteen-year study of a CISM-oriented crisis intervention procedure to attend to the aftermath of workplace violence. The sample consisted of 1,071 male and 1,049 female inpatient and community mental health facilities staff victims of patient assaults in the Massachusetts Department of Mental Health's seven inpatient state hospitals, five state community mental health centers, one state homeless shelter program, two vendor-operated sets of community residences, and one private general hospital that accepted DMH patients. The crisis intervention procedures were

associated with sharp declines in disruptions in the three health domains and the three symptom clusters. The findings demonstrate significant recovery and functioning within a ten-day period associated with the CISM intervention.

In the wake of a terrorist mass disaster, Boscarino et al. (2005) conducted a random sample of 1,681 New York adults interviewed by telephone 1 year and 2 years after 9/11. Results indicate that crisis interventions, referred to as Critical Incident Stress Management (CISM), had a beneficial impact across a variety of outcomes, including reduced risks for binge drinking, alcohol dependence, PTSD symptoms, major depression, somatization, anxiety, and global impairment, compared with individuals who did not receive these interventions. A follow-up analysis (Boscarino, et al., 2006), found that 1 to 3 sessions of brief crisis intervention were useful in reducing various forms of distress from mass disasters.

Stapleton et al. (2006) conducted a meta-analysis of 11 studies of crisis intervention with medical and surgical patients. The analysis included 2,124 subjects. Stapleton et al. found crisis intervention to be generally effective overall (Cohen's d = .44), with specific mitigating effects on anxiety (.52), depression (.24), and posttraumatic stress (.57).

Finally, Everly et al. (2008) employed a systematic statistical review of experimental and quasi-experimental research on workplace-based crisis intervention programs. Nine studies were identified that met inclusion criteria for further analysis. Results suggest that the workplace can be a useful platform from which to provide crisis intervention programs (overall effectiveness measured in Cohen's D statistic (expressed in standard deviations) = 1.53; d = .60 with assaults removed from the analysis). More specifically, evidence was found that crisis intervention programs could reduce specific undesirable factors in the workplace:

- Posttraumatic distress: mean effect size: .65

- Assaults: mean effect size: 3.68
- Alcohol use: mean effect size: .83
- Depression: .81
- Anxiety: .98
- Global impairment: mean effect size: .166

Pastoral Intervention

As defined herein, pastoral care may be seen as the function of providing spiritual, religious, or faith-oriented leadership. Pastoral care is typically provided by someone (often ordained, but not always) who has been commissioned or otherwise selected by a faith-oriented group or other organization to provide interpersonal support, assistance in religious education, worship, sacraments, community organization, ethical-religious decision-making, and related activities of spiritual support. From a more formal perspective, pastoral care is commonly provided by congregation-based clergy (and sometimes formally trained laity), chaplains, pastoral counselors, and clinical pastoral educators while recognizing that these terms and functions are not mutually exclusive.

The opportunity for pastoral care interventions was formalized in the military on July 29th, 1775, by an act of the Continental Congress. At that time Congress allowed for the creation of an organized military chaplaincy. The opportunity for pastoral care, of course, existed prior to that informally at any time a member of the "flock" would seek guidance or support from anyone held to be in a position of pastoral leadership.

Pastoral Counseling

One specialized form of pastoral care that has emerged is pastoral counseling. The process of pastoral counseling, in the generic sense, may be thought of as the utilization of psychological, spiritual, and theological resources to aid persons in psychological and/or spiritual

distress (Clinebell, 1966; Hunter, 1990). Pastoral counseling is an approach to the therapeutic process wherein theology and spirituality are integrated with the principles of psychology and behavioral science to help individuals, couples, families, groups, and institutions achieve mental health and promote wellness at all levels. Those who seek pastoral counseling typically feel that there is added value in a pastoral approach to healing over and above traditional counseling and psychotherapeutic practices. They come seeking counseling for personal, relationship, family, and even work-related concerns. Pastoral counselors may use traditional psychodiagnostics techniques, spiritually-based assessments, traditional psychotherapeutic and behavioral therapy processes, in addition to spiritual and even religiously-based interventions.

The clinical pastoral education movement, beginning in the 1920s with the pioneering efforts of Richard Cabot and others, served as somewhat of a foundation for the outgrowth of the pastoral counseling emergence. During World War II, the function of pastoral counseling emerged as an important element of the services provided by military chaplains (Barry, 2003). Post WWII, the recognition of the need to provide chaplains with formalized training in counseling led to chaplains being sent to Catholic University and the Menninger Clinic in pursuit of such training (Barry, 2003).

The American Association of Pastoral Counselors was formed in 1963. Thus, the integration of psychological principles and practices with pastoral care appears to be currently manifest in two formalized movements: pastoral counseling and clinical pastoral education.

Pastoral Crisis Intervention

It seems clear that anyone who serves the function of providing pastoral care will be confronted with the challenge of an acute psychological and/or spiritual crisis. Whether, in a house of worship, a

hospital, a nursing home, at the scene of an accident or disaster, a funeral home or gravesite, a battlefield, or even in a formalized counseling office setting, the manifestations of a human being in a state of crisis can be in evidence. The crises may manifest themselves in concrete and tangible concerns regarding safety, security, and general welfare, or they may manifest themselves in less tangible concerns regarding self-identity, affiliative crises, existential, spiritual, or even theological or theodolitic crises (a crisis of faith). But, contrary to some commonly held pastoral perspectives, not all crises are spiritually or theologically based (Sinclair, 1993). For those who rise to meet such challenges, a solid grounding in theology, spirituality, and pastoral care is only the beginning. Also requisite will be skills in psychological triaging, basic crisis intervention, and finally, a familiarity with other supportive resources, including psychological, psychiatric, and even other pastoral resources.

This, then, is the practice of *pastoral crisis intervention*. Simply stated, pastoral crisis intervention is the functional integration of any and all religious, spiritual, faith-based, and pastoral resources with the assessment and intervention technologies germane to the practice of crisis intervention and disaster mental health. Clearly, as is evident from the definition afforded earlier, crisis intervention is not the same as counseling and psychotherapy (Everly, 1999). Some psychotherapeutic tactics would even be contraindicated in crisis intervention due, in part, to the highly focused and time-limited nature of crisis intervention. Similarly, pastoral crisis intervention is not the same as pastoral counseling or pastoral psychotherapy. Thus, by way of summarial parallelism, as crisis intervention is to counseling and psychotherapy, so pastoral crisis intervention is to pastoral counseling and pastoral psychotherapy.

Webb (2004) has contributed the following notion of pastoral crisis intervention. “Shock waves from a traumatic event impact the entire

individual and affect one's relationships horizontally with family, friends, and co-workers and vertically with God. Individuals can exhibit symptoms of traumatic stress in any or all of the five major domains: physical, cognitive, emotional, behavioral, and spiritual. For this reason, [pastoral] crisis intervention combines the identity and skills from the spectrum of religious, spiritual, and pastoral resources with the assessment and intervention strategies pertinent to the practice of emergency mental health (Everly, 2000b). The "value added" of pastoral crisis intervention stems from hope-giving pastoral care and/or religious tradition and ritual resting upon a foundation of communication skills, differential recognition of patterns of acute stress, and traditional mechanisms of crisis intervention, such as early intervention, cathartic ventilation, social support, problem-solving, and cognitive reinterpretation (Everly, 2000b)" (Webb, 2004, p. 217).

Mechanisms of Action

The mechanisms of action that support pastoral crisis intervention include all of the same mechanisms that support non-pastoral crisis intervention such as education, reassurance, social support, problem-solving, cathartic ventilation, and cognitive reinterpretation (Everly & Mitchell, 1999). In addition, the pastoral crisis interventionist benefits from the ability to use, where appropriate, scriptural education, insight, and reinterpretation (Brende, 1991), individual and conjoint prayer, a belief in the power of intercessory prayer, a unifying and explanatory spiritual worldview that may serve to bring order to otherwise incomprehensible events, the utility of ventilative confession, a faith-based social support system, the use of rituals and sacraments, and in some religions, such as Christianity, the notion of divine forgiveness and even a life after death. All of these factors may make unique contributions to the reduction of manifest levels of distress (Everly & Lating, 2004). Finally, the pastoral crisis interventionist may also