
Coordinating Pastoral Care of Survivors with Mental Health Providers

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Witnessing and experiencing abuse as a child significantly increases the risk that the child will demonstrate emotional and behavioral concerns later in childhood or as an adult.² For centuries, concerns such as these were considered spiritual issues to be addressed exclusively within the Church.³ The past fifty years has seen a dramatic shift in this view, and both the Church and mental health providers have a growing awareness of the benefit that each can bring to a person's overall health and functioning, especially if there is a history of abuse or trauma.⁴

A brief history

Emotional and behavioral concerns, now often referred to as mental health needs, have existed since the beginning of recorded history. In multiple passages, the Bible indicates a relationship, though not always direct causality, between sin and emotional/behavioral concerns,⁵ even if the sin is on the part of someone other than the person bearing the consequence of the sin. Seeing this connection, most of Christianity either addressed emotional/behavioral concerns within the Church or severed connection with the person. While this proved adequate for some, others were not

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sufficiently helped.

As society moved away from a more Christian-centered perspective, recognition grew that many needs were not being met. Psychology and related mental health fields emerged, partially in response to this unmet need. As they did so, Sigmund Freud's militant atheism, as well as approaches such as strict behaviorism and exclusively cognitive or biological views of human behavior and existence, contributed to deep divides, mistrust, and hostility between the mental health field and the Church.⁶

As the twentieth century unfolded, views gradually changed within both communities. Maslow introduced a hierarchy of needs that recognized spirituality as a central piece of a person's being.⁷ Mental health service delivery decentralized, and the emergence of community-based interventions drastically increased the contact the Church had with individuals with emotional/behavioral or mental health needs.⁸ As the faith community and mental health system learned more accurate information about each other, they developed a growing awareness of the need to collaborate. Reservations remain,⁹ and systems for referral and collaboration are still lacking,¹⁰ but most faith leaders and mental health providers now

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2. Vincent J. Felitti and Robert F. Anda, "The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders and Sexual Behavior: Implications for Healthcare," in *The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic*, eds. Ruthe A. Lanius, Eric Vermeten, and Clare Pain, (Cambridge Medicine, 2010), 77.

3. Clark S. Aist, "A conception of the interface connecting faith and mental health" (2015), [https://www.psychiatry.org/File Library/Psychiatrists/Cultural-Competency/faith-mentalhealth-essay-clark.pdf](https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/faith-mentalhealth-essay-clark.pdf).

4. Katherine J. Partridge and Donald F. Walker, "Addressing Spiritual Struggles Using Spiritually Oriented Trauma-Focused Cognitive Behavioral Therapy: An International Case Study," *Journal of Psychology and Christianity*, 34 (2015), 84–90.

5. Examples include a) Genesis 3, as Adam and Eve's sin leads to emotional disturbance (fear, guilt, anxiety) and more sin (lying, blaming); b) 2 Samuel 11–12, as David's sin against Bathsheba leads to his murder of Uriah, and the baby born after David's sin suffers and dies; and c) Romans 1, as Paul describes the perpetuation and growth of sin within a person or community.

6. John Peteet, "The interface between religion/spirituality and mental health," (2015), [https://www.psychiatry.org/File Library/Psychiatrists/Cultural-Competency/faith-mentalhealth-essay-peteet.pdf](https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/faith-mentalhealth-essay-peteet.pdf).

7. Robin Powers, "Counseling and Spirituality: A Historical Perspective," *Counseling and Values* 49 (2005): 217–225.

8. Aist, "A conception of the interface connecting faith and mental health" (2015).

9. "Why do pastors and churches recommend psychotherapy?" (2008), https://www.psychoheresy-aware.org/recommend_psychotherapy.html

10. Peteet, "The interface between religion/spirituality and mental

accept the need and benefit of collaboration.¹¹

Options for coordinating care

Faith communities have several options for coordinating with mental health providers to deliver care for people who have experienced maltreatment. Most options fall into either a more community-oriented approach or a more individual-oriented approach. The Church provides the best care and nurturing of her members when she pursues both avenues.

The Church already uses multiple community-based interventions. These include prevention efforts,¹² community healing events,¹³ support groups,¹⁴ and cross training.¹⁵ The community and issue-related focus of these efforts often feels more palatable to faith leaders and mental health practitioners alike, and this can lay the groundwork for more individualized collaboration.¹⁶

Individual efforts to coordinate spiritual and mental health care tend to give people in both arenas more pause than community efforts. Vestiges of the historic mistrust between these fields emerge, and people wonder if collaboration is an admission of inadequacy.¹⁷ Viewing this partnership as cooperative with defined roles, rather than an abdication of authority and expertise, can

health,” (2015).

11. In the article “Counseling and Spirituality: A Historical Perspective,” Powers searched for psychological and pastoral articles, books, and chapters that referenced “counseling” and “spirituality” together. Powers found a clear increase over time for the frequency of these terms appearing together: 1930-39, 3; 1940-49, 4; 1950-59, 19; 1960-69, 11; 1970-79, 112; 1980-84, 119; 1985-89, 256; 1990-94, 412; 1995-99, 433; 2000-04, 531. Robin Powers, “Counseling and Spirituality: A Historical Perspective,” *Counseling and Values*, 49 (2005), 217–225.

12. For example, Shared Hope International has done significant work to prevent human trafficking. See more at <https://sharedhope.org/>.

13. For example, Ebenezer Baptist Church and many other congregations continue holding “community healing services” following the violence in Charleston, S.C. See more at <http://www.ebenzerameonline.org/>.

14. For example, Eagle Brook Church, a multi-campus congregation in the Minneapolis/St. Paul area of Minnesota, facilitates faith-based 12-step addiction recovery groups called Quest 180. See more at <https://eaglebrookchurch.com/next-steps/find-support/addiction--recovery/>.

15. For example, Bethel Seminary in Minnesota has a Marriage and Family Therapy Program (<https://www.bethel.edu/seminary/academics/marriage-family-therapy/>); The National Child Protection Training Center, a program of Gundersen Health System, has presented a conference titled “Chaplains for Children” that aims to equip clergy to respond to and prevent child maltreatment (<http://www.gundersenhealth.org/ncptc/trainings-education/chaplains-for-children/>); and the American Psychiatric Association has developed training around their “Quick Reference on Mental Health for Faith Leaders” pamphlet (<https://www.psychiatry.org/psychiatrists/cultural-competency/faith-community-partnership/>).

16. Kathryn M. Benes, Joseph M. Walsh, J.M., Mark R. McMinn, Amy W. Dominguez, and Daniel C. Aikins, (2000). “Psychology and the Church: An Exemplar of Psychologist-Clergy Collaboration,” *Professional Psychology: Research and Practice*, 31 (2000): 515–520.

17. Petecet, “The interface between religion/spirituality and mental health,” (2015).

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Consultation and referral are the primary individual-centered ways to coordinate pastoral and mental health care.¹⁸ Consultation is most beneficial as a two-way relationship in which a mental health provider seeks input on the relationship between a faith system and the emotional/behavioral issues being addressed in counseling, and a pastor seeks input on how mental health may impact a person’s spiritual journey.¹⁹ While this type of relationship is often centered around specific people, names are generally not shared, and a referral is often not made.

Reasons for referral

Making a referral is significantly more involved than consultation. Experiencing abuse takes an incredible toll on the whole person. Because of this, spiritual and mental health care are often both indispensable. The Survivor or their family often realize this and seek help. When they do, more than 50 percent turn to a faith leader before they approach anyone else,²⁰ prompting many mental health publications to refer to faith leaders as front-line mental health workers.²¹ This places a huge responsibility on pastors to know their capacity, based both on the level of need and the sheer volume of people who have experienced abuse or have other counseling needs.²² When that capacity is stretched, or when other needs arise, referral to a mental health provider may be the best way to care for the Survivor. Such a referral is often beneficial, and in many situations, necessary.

18. Craig Rennobohm, “A call to healing,” (2014) retrieved from <https://www.psychiatry.org/File+Library/Psychiatrists/Cultural-Competency/faith-mentalhealth-essay-rennobohm.pdf>

19. For example, an area church recently contacted this therapist when a young girl revealed she had been sexually abused by a family member. No identifying information was exchanged, but the pastor who called was able to develop a trauma-informed approach for addressing the situation, and the pastor later called to say that the situation appeared to have a good resolution. In another example, an area therapist relates the story of seeing a client diagnosed with Autism and Gender Dysphoria, who revealed to his family that he is transgender. The client attends an Evangelical church and youth group. At the client’s request, the therapist and youth pastor consulted, which allowed both to better meet the needs of this teen.

20. Aist, “A conception of the interface connecting faith and mental health” (2015).

21. Julia E. Oppenheimer, Kevin J. Flannelly, and Andrew J. Weaver, “A Comparative Analysis of the Psychological Literature on Collaboration Between Clergy and Mental Health Professionals—Perspectives from Secular and Religious Journals: 1970–1999,” *Pastoral Psychology*, 53 (2004): 153–162.

22. Rennobohm, “A call to healing,” (2014).

Several factors influence the choice to refer a person in the Church to a mental health provider,²³ including the person's level of distress. Every person responds to trauma in their own unique way. For some, the level of distress may be relatively low, especially if they have loving support and the abuse was an isolated experience. Others may encounter intense distress and seem inconsolable. They know they need to work through the abuse, but the very mention of it sends them into a downward spiral that reason seems unable to interrupt. Still others seem on the surface to have little distress, but, in reality, have entered a dissociative state that separates their awareness from the trauma. The more intense the distress, and the more pervasive the dissociation, the more essential it is to make a referral to a mental health provider.

The person's level of functioning also determines the importance of making a referral. Many people are able to contain the effects of the trauma, using both healthy and unhealthy means. Those who do may have little noticeable impact on their functioning at home, work, school, or other areas of their lives. If this compartmentalization occurs without making some sense of the trauma, or if the trauma overwhelms the person's ability to contain it, functioning eventually suffers. Children develop defiant behavior. Parents become harsh or absent. Marriages dissolve. People lose their jobs or see work and school performance plummet. They withdraw from relationships. They may abuse someone else. As the intensity of these functional impacts increases, the urgency of a referral also rises.

The most extreme consequence for Survivors is future harm to self or others. This includes suicide risk. For every age group in the United States from ten to fifty-four years of age, suicide is between the second and fourth leading cause of death.²⁴ Other forms of self-harm, such as cutting and burning, are on the rise. The frequency of verbal and physical assaults also increases for those who have been abused,²⁵ with Survivors of childhood abuse from two to seven times more likely to be arrested for violent crime as adults.²⁶ The more specific and realistic a person's comments about harming self or others, the more likely that they will follow through. No other factor increases the urgency of referral more than the risk of harm to self or others.

Some factors that indicate the need for referral relate to the pastor, rather than the person who is seeking help. Counseling someone

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who was abused by another person in the same congregation may raise ethical concerns and cloud the pastor's judgment. The pastor may struggle to relate to the experiences of the Survivor, or they may relate too much if they have also been impacted by abuse. The particular areas of struggle may be outside the pastor's areas of competence or may involve both a spiritual and clearly psychiatric component. Time may limit capacity, as over 25 percent of people meet criteria for at least one mental health disorder, and at least 50 percent of people who have diagnosed mental health disorders have at some point used pastoral counseling.²⁷ Pastors may simply not have the ability to see that many people, especially if there has been systematic or institutional abuse in the area.

Strategies for referral

Deciding to refer someone to a mental health provider is the first step. Finding a way to effectively make the referral is the often-confusing next step, but several actions can greatly reduce this uncertainty.²⁸

Develop a list of trusted mental health providers to whom you feel comfortable making a referral. While some areas have few available, others have over 100 within ten miles.²⁹ Not all providers know how to work with trauma, and not all understand how a person's faith interacts with their mental health and the way they process the abuse. Developing this list may require calling providers and interviewing them, or reaching out to other pastors and faith leaders in the area to see if they have providers to whom they usually refer. Many communities have Children's Advocacy Centers,³⁰ and they can be an invaluable resource for consultation and referral options. It takes work, but developing this list allows a pastor to confidently choose a mental health provider or agency. In some situations, other members of the church staff may be able to help with this step.

23. American Psychiatric Association Foundation, *Quick Reference on Mental Health for Faith Leaders* (American Psychiatric Association Foundation: Arlington, Va., 2016), <https://www.psychiatry.org/psychiatrists/cultural-competency/faith-community-partnership>.

24. Center for Disease Control and Prevention, *10 Leading Causes of Death by Age Group, United States – 2010*. (Centers for Disease Control and Prevention: Atlanta, Ga., 2010), https://www.cdc.gov/injury/wisqars/pdf/10lcid_all_deaths_by_age_group_2010-a.pdf.

25. Margaret C. Cutajar, James Ogloff, and Paul E. Mullen *Child Sexual Abuse and Subsequent Offending and Victimization: A 45-Year Follow-Up Study*. (Canberra, Australia: Criminology Research Council, 2011) <http://www.crg.aic.gov.au/reports/0910-13.pdf>.

26. Janet Currie and Erdal Tekin, *Does Child Abuse Cause Crime?* (Cambridge, Massachusetts: National Bureau of Economic Research, 2006), <http://www.nber.org/papers/w12171.pdf>.

27. Oppenheimer et al., "A Comparative Analysis of the Psychological Literature on Collaboration Between Clergy and Mental Health Professionals" (2004), 153–162.

28. American Psychiatric Association Foundation, *Quick Reference on Mental Health for Faith Leaders* (2016).

29. While in a suburban neighborhood of St. Paul, Minn., the author used the resource search engine www.minnesotahelp.info to search for "individual therapy." The search revealed ninety-two providers within ten miles. The same search for a rural town in Minnesota revealed two providers within ten miles.

30. The National Children's Advocacy Center states on their website (<http://www.nationalcac.org/>) that there are over 1,000 Children's Advocacy Centers (CAC) in the United States. The website has a helpful tool to locate CACs by location.

Communicate clearly to the Survivor that this is a need. If the Survivor believes the pastor sees it as unimportant or doubts the efficacy of mental health supports, that person will likely not follow through on getting the needed help. Even if the Survivor does follow through, effectiveness could be limited by the doubt the pastor sowed. During this phase, the pastor may indicate the importance of the referral by offering the church's help to cover some of the costs of therapy.

Make the referral a collaborative process. The Survivor may have tried therapy before or have preferences regarding the mental health provider's gender, location, age, or style. They may also want control of the information that is shared. Discussing these and other aspects of the referral ahead of time with the Survivor, or making the referral with the Survivor, can greatly increase their involvement and connection with the mental health provider.

Reassure the person that you will accompany them through the process.³¹ This unfolds differently in each situation. For some, it includes praying they connect with the mental health provider and then occasionally checking in. For others, it involves talking with the provider or offering to attend some appointments. For many, it involves integration or reintegration into church or community life, or helping them access additional supports. Regardless of how it unfolds, this is an excellent opportunity to truly *pastor* the Survivor.

Be clear about the difference between spiritual care and professional mental health care. Boundaries can be fuzzy for everyone in this process, but having a proactive conversation with the mental health provider and the Survivor can remove some of the guess work. The process begins by simply acknowledging that a pastor and mental health provider have different roles.

Respect confidentiality and privacy. This is especially true when the person is dealing with such personal things as abuse; it impacts both the information the pastor shares and what they expect to receive. Using a release of information form that specifies ahead of time what information can be shared is a wise step that can avoid misunderstanding and damaged trust. Even with a release in place, it is good to occasionally confirm what information the person wants shared.

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Putting these strategies into motion: a case scenario

In order to get a sense of how these strategies or steps may play out, consider the following hypothetical case scenario. Pastor John was new to the area. He had been a pastor in another state for five years before receiving a call to his new congregation. The small-town church seemed welcoming, and he developed trusting relationships in the congregation. The town was slower to accept him, but the church's history of outreach opened doors, and he began to feel at home after a year.

As he got to know the community, Pastor John contacted area businesses and churches. He asked other pastors whether they referred people to mental health professionals. Most did not, but a couple said they sent people to see Ann, a therapist in the next town. Pastor John called and spoke with Ann, and he felt satisfied that he could refer both children and adults to her if needed. Ann told him about a Children's Advocacy Center (CAC) in a town about 25 miles away, so he called them. They assured him that Ann was a good therapist, and they gave him the names of two others within 45 minutes. Pastor John called them. While they were further away, he felt he could use them if needed.

Mary was a long-standing member of the congregation. Pastor John was surprised when he received an urgent call from her asking to meet. They met later that day, and Mary burst into tears as she poured out her heart. Mary had hidden a history of abuse since she was a child, but for some reason she felt like she was experiencing it all over again. She felt disconnected from her husband and daughter, and she dreaded physical and emotional intimacy. She couldn't sleep at night or focus during the day. She had intense bouts of overwhelming sadness a few times each week. She had received a warning at work. She felt bitterness toward God for allowing this to happen to her as a child and not healing her pain now. That morning had been a period of intense sadness, and she had briefly considered suicide. Though she had no intent and no concrete plan, she panicked that she would entertain such a thought, and that had prompted her call to Pastor John.

Pastor John offered comfort. He assured her that she was not to blame for the abuse. He promised to walk through this journey with her or to find another spiritual mentor with whom she felt more comfortable. He gently explained that abuse has a spiritual impact as well as an emotional impact that may require specialized help. He told her about Ann and his confidence in her, and he urged Mary to meet with her. Mary was reluctant, offering several reasons not to, including cost and fear that others would find out.

31. This can be very demanding, especially if multiple people are seeking help. Pastors and other shepherds within the congregation may benefit from accessing ministries and supports such as Stephen Ministries (<http://stephenministries.org>) or Tree house (<https://www.treehouseyouth.org>).

Pastor John was careful to not become too forceful or directive. He promised to keep the matter confidential and offered to have the congregation defray much of the initial cost. He assured her that it was her choice, but that he would be happy to make the call with her and to support her through the process. He said she could talk to both Ann and him. He briefly explained that he and Ann had different roles, leaving a further explanation for later.

Throughout the conversation, Pastor John followed Mary's lead. He was caring and assuring, balancing the need to simply be with her in the pain and to help her find a way forward. After considering what Pastor John said, Mary decided to see Ann. She asked Pastor John to help her. After clarifying what she wanted him to say, he left Ann a message. Mary assured Pastor John that she was no longer considering self-harm, and she said their conversation had helped. She felt hope that she could make it through. Before Mary left, Pastor John prayed with her. He also wrote down what she wanted him to say to Ann and asked her to approve it. He scheduled a time to meet with her the following day. Pastor John continued helping Mary for over a year, consulting with Ann as Mary wished. He even attended an appointment with her when Mary asked. Much healing remained, but it had started because Pastor John was prepared.

Conclusion

Child maltreatment produces pervasive emotional, behavioral, and spiritual ramifications in the lives of those affected by it. The extent of the impact and the prevalence of the problem make it essential to develop a collaborative strategy that allows faith leaders to effectively coordinate pastoral and mental health care. Knowing ways to collaborate, understanding factors that increase the urgency of collaboration, and having a concrete plan in place all provide a pastor with the necessary tools to coordinate pastoral care of Survivors with mental health providers.

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