PASTORAL CARE AND RESPONSE TO DISASTER
The Oklahoma City Experience

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CRISIS MINISTRY AND CLINICALLY TRAINED CLERGY

A View from Oklahoma City

The bombing of the Alfred P. Murrah Federal Building on April 19th, which killed 168 persons including 15 infants and children, was the most devastating act of terrorism on American soil. The fact that a United States Citizen and decorated army veteran pulled off this event was even more shocking. This incident created a crisis for America in many ways; it disrupted the general notion of public safety, it opened many questions about protecting federal buildings, it destroyed the notion that federal workers were safe in America, it threw into turmoil the FBI/CIA strategy of targeting foreign enemies as the likely culprits who plan terrorists acts, etc.

On a personal scale, it also created a crisis for pastoral care givers who responded to the blast. Those whom Clergy responded too included: a) the victims treated at the bomb site, b) those treated in local health care facilities, c) family members and friends who came in search of their loved ones, d) those who waited at the Notification Center to receive word of the fate of their loved ones, e) the rescue and recovery workers at the bomb site. Fr me, the nature of this event and its demand on pastors and chaplains who responded highlighted the strengths and resources of Clinically Trained Clergy.

This paper will attempt to discuss the nature of a crisis event. I will then address the crisis clergy found themselves in along with the victims, families and recovery workers. Finally,

I will lift up 12 distinctives (or advantages) we identified that characterized Clinically Trained Clergy.

The Early Development of Crisis Theory

The seeds of crisis theory were first noted in the religious writings by Anton Boison, the first practitioner of Clinical Pastoral Education. He noted that in the midst of inner conflicts, people would pass though stages as they tried to resolve their inner tension. Boison identified what he called an "intermediate" stage where in resolving inner conflicts, the person could discover new and creative ways of coping. This "intermediate" stage would lead to a higher level of functioning for the individual. However, there is a danger here; if the inner tension was not resolved in the intermediate stage, the person could be stuck in unresolved tension. Or worse, regress back to an earlier and less effective way of dealing with inner conflict.

Boison noted that an inner conflict could be created in two ways. First, it could be developmental which identified inevitable and necessary encounters as one grew through life. Second, they could be situational were events quickly came upon the person, often without warning.

Later Developments in Crisis Theory

Dr. Erich Lindemann, M.D. developed crisis theory in the early 1940's. A psychiatrist at Boston City Hospital, Lindemann treated the families who lost loved ones in the well known Coconut Grove Nightclub fire where nearly 500 patrons lost their lives. He noticed several patterns of behavior in the family members and wrote his findings in a paper entitled "Symptomatology and Management of Acute Grief." He noted that following the typical intense grief in the loss of a loved one, family members would also experience self-blame, guilt, anxiety and a sense of personal failure.

Lindemann also noticed that families began to use both realistic and unrealistic methods of coping with their loss. If the person used unrealistic methods of coping, they began to regress and were unable to reenter their world as functional as before. When realistic methods were engaged, they reentered with new strength and vitality. Often, Lindemann would use interventions to help the grieving person to place aside the unrealistic methods and use realistic means for coping with their loss.

Later, **Dr. Gerald Caplan, M.D.** followed up on the nature of a crisis, noting the difference between a developmental and an accidental crisis. The developmental crisis stemmed from the typical crises we all pass through as part of growing up, i.e., separation from parent (s) when starting school or at the onset of puberty. (This would coincide with Erik

Erikson's psychosocial stages of development). Those who were in an accidental crisis, such as the families who lost loved ones in the Coconut Grove fire, were in a sudden, unexpected and intense crisis that required a quick response. This accidental crisis demanded more from the family members(s) and therefore, would lift up their patterns of coping more quickly. Just as a realistic response to an accidental crisis would produce quick growth to a higher level of functioning, so an unrealistic response could quickly lead to paralysis or regression for the person in the crisis. This "speeding up" of the emotional and intellectual processes was always part of an accidental crisis. Note the similarities of Caplan's work and the earlier insights of Boisen, i.e., developmental and situational crisis.

Caplan, who worked with Lindemann, outlines four phases in the resolution of a crisis. These phases are:

1) The original tension (disruption of homeostasis) which produces anxiety and calls forth the usual or habitual repertoire of responses.

2) a lack of success in resolving the crisis through traditional responses would leave the person with a sense of helplessness, failure, guilt, etc.

3) The phase where we "hitch up the belt" and explore other possible responses to the crisis. We really search deep down in this phase of responding. This can include such processes as trial and error, consultation with other people and a "re-definition of ones rules and roles." If resolved in this phase, the person grows in maturity and strength.

4) If they do not resolve the inner tension caused by the crisis, reality testing is reduced, unrealistic responses grow, distortions increase and the person will be stuck in a tension-filled situation. Even worse, they could adjust in ways that are not helpful to them or others. I call this fourth phase mal-adaption or regression to an earlier stage of development. Psychoanalytic theory would call this a form of "regression in service of the ego."

Rappaport noted that a crisis has three interrelated factors; A) a hazardous event that poses a perceived threat. B) a threat to an instinctual need that occurred earlier in childhood which left the person feeling vulnerable (chaining back to earlier events). C) The inability to respond adequately to the perceived threat. These threats can be found in the psychological need for safety and the sociological need for common values and social order. I add the theological need for a God of Providence who is somehow involved in the midst of the event. When an accidental crisis occurs, we are disrupted. As a result, we try to respond, alleviate our anxiety and come to a new resolution within ourselves.

Current Development of Crises Theory

Rev. Charles Gerkin proposes a more existential view of crisis. He believes a crisis is connected to the existential condition of Modern Man (I use Man here to refer to women and men). In this current culture, there is a tension between our hope for infinite possibilities and finitude. Modern Man has thrown out the paradigm of a three storied universe and replaced it with the myth of infinite possibilities through technology and human efforts (Technological Rationality). To continue infinite progress, all we have to do is increase our technology and stretch our boundaries.

While some of this myth occurred in past centuries, people at least had the sense of God's Providence that would be the framework to continue achieving. We have always known of death but knew this to be part of God's Providence. With God out of the picture for Modern Man, the only limit to our possibilities is the "unpleasant experience of death." We can master our lives only to an extent when the reality of death disrupts this. Caught in this paradox, we turn to defend ourselves through being the "hero" who faces the challenge of death alone. Our response to our vulnerability is to press ahead or "carry on."
For Gerkin, a crisis is the experience of finitude, contradiction and vulnerability whose only effective response is faith. A loss of trust in the "way things are" or "the way things are supposed to be" are built into a crisis experience. Therefore, even the most basic of human needs is disrupted. Faith gives us the larger picture in which to see our progress which includes death as a natural part of living.

The Disaster in Oklahoma City

The people who survived the explosion of April 19th, including the families who lost loved ones, the recovery workers, ancillary support personnel and those who were shocked that an American citizen could do such a thing, were all forced into a crisis of huge proportions. If a natural disaster had occurred, our response would be different. After all, we expect this to happen to us upon occasion. However, a terrorist bombing is another matter. It was more disruptive and unsettling, which is exactly what a terrorist wants to create.

Besides the nature of the disaster, the recovery workers at the Murrah Building spent 16 days working in 12 hour shifts in search of bodies. The scene was gruesome. There were about 22 bodies recovered after the first day and then the progress went very slowly. Not only were the workers finding pieces of bodies but as the search dragged on, decay and insect infestation set in. The bombing site eventually became a bio-hazard to the workers. Many saw what they hope never to see again.

The search was not only tedious but the constant discovery of body parts and dead people wore on the workers. Even the dogs trained to search for trapped victims became depressed and needed time to recover. Everyone involved in responding to the bombing was thrown into some form of crisis.

This crisis came as well to the Clergy and Chaplains who responded to the disaster. In the hospitals, the people brought in through the Emergency Room were very bloody, in shock and some very badly injured and maimed. The intensity was considerable when you realize Presbyterian Hospital took in 80 patients in 90 minutes. The visual sights were enough to disrupt you. Add to that the children killed or injured and you can imagine how very upsetting it was. When we learned it was an intentional bombing, we lost our defense of reason that tried to explain why this event happened in the first place. It was just so senseless!

We noticed a general trend in our hospital and at the bomb site. The Clinically Trained Clergy were more prepared to face the impending crisis than were the local untrained clergy. I believe one aspect of this preparedness was that Clergy in Clinical Pastoral Education had been through a supervised training process that included situational and accidental crises. Clergy involved in CPE are usually disrupted by ministry events and face the intermediate stage crisis resolution. Attempts at finding resolutions to their own inner conflicts raised by the external circumstances were good training experiences for clergy. They found their way through the crisis by reaching deeply within themselves for solutions. Often, this demonstrated itself in specific behaviors, i.e., sharing their burden with others, reality testing with peers and supervisors and growing to new levels of functioning. This experience equipped the clinically trained clergy to face the Oklahoma City disaster with a degree of confidence and strength.

THE TWELVE DISTINCTIVES BETWEEN LOCAL CLERGY AND CLINICALLY TRAINED CLERGY

Those of us working the disaster noticed differences between trained and untrained Clergy. The distinctions showed up immediately when volunteer clergy began to serve in local hospitals. The long term sites of ministry such as the bomb site and Notification Center made these distinctions more obvious.

I want to offer three "cautious" comments.

First, I use the term "Clinically Trained Clergy" to identify those who completed units of Clinical Pastoral Education. In our hospital, these Clergy had already served in the hospital as Chaplains. At the bomb site and Notification Center, the settings were new for all the Clergy involved and therefore, were good places to identify the knowledge, skills and approaches' Clergy brought to these places of ministry. This helped us identify the distinctives between the two groups.

Second, not everyone who served in these locations was Clergy. CPE has made room for qualified laypersons to complete clinical training. Several of our Chaplains were laypersons serving in the Chaplain's role during the disaster. I do not intend these distinctions to eliminate laypersons from ministry. However, most of the people involved in ministry during the disaster were Clergy.

Third, not everyone who is clinically trained did better than untrained Clergy. Many local Clergy were very appropriate in their ministry during the disaster. However, there were obvious patterns of effective ministry we could identify in Clinically Trained Clergy.

Clergy and Chaplains were working in three areas; the local hospitals, the bomb site and the Notification Center. Each clergy had to deal with the response to people in crisis but were also thrown into their own crisis as well. How did the clergy and chaplains respond to the crisis of the patients and of their own crisis as well?

Below are 12 distinctives that stand out as we observed local Clergy and Clinically Trained Clergy who responded to this disaster. I will list them below with comments for each.

I am indebted to the Rev. Jack Poe, the Oklahoma City Police Chaplain whose discussion with me helped identify these distinctives.

Local Clergy	Clinically Trained Clergy
1) Minimal training in crisis situations	Trained and experienced in crisis ministry

Many, if not most clinically trained Clergy, have some theoretical and experiential knowledge of a crisis. They understand the potential for growth as well the possibility of regression. They know the possible intensity of a crisis and the importance of helping those caught up in such a situation. With this knowledge, they understood their roles more fully and knew their importance during the disaster.

2) Clergy unprepared for what they saw	More experienced in trauma scenes

Trained Clergy usually have experience in responding to bodily injury. They have been to the Emergency Room just as victims arrive and have seen the body torn up and bloody. They have seen families caught off guard with the tragic death of loved ones. While the intensity of the medical needs during the disaster was extraordinary, at least the trained Clergy had seen something like it before. Local clergy usually visit patients after an accident has occurred, mostly in the hospital room where the patients are cleaned up and "presentable." The local Clergy were inexperienced with damage to the human body.

3) The focus of attention in a church. People come to "hear" the pastor, priest or rabbi.	Not the focus of attention but one of many equals.

The local church in many ways focuses around the Clergy. This Clergy focus can take many forms, including preaching, teaching, leading church boards, performing priestly roles, i.e., sacraments, weddings, funerals, etc. The local clergy are highly visible to those they serve. The Trained Clergy know they are just one-person among many equals. In the hospital setting people come to see the physician, not the Chaplain! Clinically Trained Clergy work with others and are satisfied with that role in a crisis.

4) Accustomed to talking more than listening	Understands the importance of listening, talking only when it helps or provides a supportive role or appropriate intervention.

For many local clergy, "saying something" was the order of the day. In an effort to be helpful to victims, families and recovery workers, local clergy did much talking.

While the motivation for this was not searched out, I believe it was evidence of an "over helpful"I style of ministry and/or a way to deal with their own anxiety. This tendency to talk is akin to being the focus of attention in a church. So often, it all rests with the Clergy! Clinically Trained Clergy have had their pastoral style reviewed through supervision and by peers and most have made some helpful changes. One area always reviewed in CPE is the purpose of talking in a pastoral situation. Local Clergy just do not have this training.

5) Not aware of their "empathic gaps " — Learned to expand their ability to empathize

One characteristic of an effective pastoral ministry is the ability to empathize with another person. It is common that many novices in CPE have "empathic gaps" in their ministry. Therefore, I have to assume that most untrained Clergy have the same tendency to have these "gaps" in their ministry also. Clinical training education generally leads to the ability to identify with a larger variety of people in many different situations. I believe that identifying with someone's difficulty creates the opportunity to provide a greater degree of empathy and therefore, more effective ministry to that person. "Empathic gaps" are narrowed through clinically training.

6) Not as experienced in an ecumenical setting, Probably less knowledgeable of diversity — Accustomed to working with various faith groups in an ecumenical setting

Local Clergy often work with colleagues of their own denominational persuasion. If they attended a denominational university and/or seminary, their exposure to other faith groups was limited. They often serve with denominational colleagues on committees, attend regional church meetings and read about each other's work in denominational journals. Clinically Trained Clergy usually trained with clergy of other persuasions. For example, during the disaster our CPE residency group included six denominations ranging from Pentecostal Holiness to Disciples of Christ. It included men, women, blacks and an international student. Working closely with colleagues tends to expand the tolerance of diversity and helps each person define themselves more clearly in the midst of diversity. There is a decrease in the need to convert others.

7) Unaccustomed to pastoral interventions — Understand the importance of interventions.

Untrained Clergy have little knowledge of appropriate and effective interventions when working in a crisis. The two patterns I have noticed are the Clergy who intervene to rescue or correct parishioners or who intervene to settle down their own

anxiety. Neither intervention is the most helpful. The Clinically Trained Clergy learns to identify unrealistic or damaging responses by those in a crisis and will intervene to help the person see more appropriate choices. Interventions ranged from "you appear tired" or "your eyes seem wet" to "it may be time to consider leaving here for a while" or "This may not be the best time to make such an important decision."

8) Accustomed to working independently without consultation; little interdisciplinary experience.

Accustomed to working as a team with multi-disciplines. Their role is for a larger purpose which all are pulling toward.

Local Clergy often work independently. Congregations' reward being a self-starter and working independently in the church. At times, Clergy work outside the church in other helping settings but the contacts are often Clergy as well. The Clinically Trained Clergy have experience in a larger context. They have worked with multi-disciplines and help the other disciplines to function. They support the other disciplines while making their own contribution to the larger goal of the organization.

9) Risk of traumatizing the volunteer clergy

Less risk of trauma for Clinically Trained Clergy, knowledge of how to talk through their experiences

I link this to #2 where I mention most Clergy being unprepared for what they saw. At least one Clergy working the bomb site was admitted to a psychiatric facility. The cost for treatment exceeded $15,000. I mentioned above that the Clergy working such an event have their own crisis to contend with. We can not avoid the crisis nature of a disaster ministry and indeed, should not be avoided. Clinically Trained Clergy are more accustomed to seeing and hearing stories about what a disaster is like. Usually, this reduces the intensity of the crisis of the Clergy.

Perhaps the most important part of this is how the Chaplains strained to deal with their own experience of a crisis. In Clinical Pastoral Education, you learn to talk about your experience with other Clergy. Talking helps to heal, to help us do a reality check and enables us to draw on our spiritual strengths as we cope with our own crisis. In addition, many Trained Clergy learn their own unique pattern of behavior when dealing with a crisis - something few clergy are aware of without clinical training.

10) Risk of re-traumatizing the health care and recovery workers

Trained clergy are more helpful to the health care and recovery workers

Working with the victims, their families and the recovery workers was a difficult task. The disaster exposed recovery workers with hands-on responsibilities to horrendous sights. This is coupled with the profound challenge of making some sense of why this whole event occurred. It was not uncommon for the workers to ask questions like "Who would do such a thing?" or "Why did this have to happen?" Another question would be "Where was God when this happened to the children?" Some said "Why did God let this happen!" The temptation for local clergy was to provide an answer, which did little good for anyone. The real risk was when the untrained Clergy would tell the workers they should not even be raising these questions. After all, they would think, who are we to question God! This response discounts the experience of the workers who are already in a crisis and trying to find their way through it. These questions are part of their process of finding new ways to cope and to find strength through a very difficult situation. Discounting, dismissing or challenging this process can lead to a stilted response by the workers. Not only are they in a crisis but their process of trying to get through it is also not helpful, or so the untrained Clergy tell them. Clinically Trained Clergy know not to discount these profound questions but to appreciate them as the human process of finding ways to gain renewed spiritual strength.

11) Not tested for chemical dependency — Tested for chemical dependency

One concern about those who help others is their own possible issue of chemical dependency. This impairment clouds judgement, develops unreliable helpers and creates rather than reduces problems. Our CPE residents and extended students test for chemically dependency when they enter our program. I do not think any denomination requires their Clergy to do this. This is a new aspect of clinical training but an important one. The last thing you want in Clergy who are responding to a disaster is someone who is problematic. Chemical dependency surely leads to problematic Clergy! While I realize the testing only applied while the Clergy joining our program, at least they were once screened. This is not so for local Clergy.

12) Not updated for TB, Tetanus and other Illnesses — Updated tests, inoculations and Screenings

Local clergy may have updated tests, inoculations and screening but probably not. When was the last time a local clergy had a Tuberculoses or Rubella screening? The ones working at the bomb site eventually received Tetanus shots, regardless of their medical history. However, everyone in our training program had these up to date and documented. Even if they completed the program several years earlier, they had a documented medical record to fall back on. Most local clergy just do not have this.