RELIGION, MENTAL HEALTH AND DISASTER RESPONSE IN A NEW AGE OF ANXIETY

by

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Abstract

Religion, Mental Health and Disaster Response in a New Age of Anxiety

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This dissertation shows how the attacks of September 11th, 2001, Hurricane Katrina and subsequent disasters have created the context for novel forms of expert knowledge and professional organizations designed to address the increasing perceived risk associated with what I call the "New Age of Anxiety." In particular, the dissertation focuses on the formation of "disaster religious and spiritual care" as an emerging expertise.

"Disaster religious and spiritual care" refers to a general framework comprised of loosely associated, sometimes antagonistic, individuals and organizations. Many come from the hospital chaplain world, some from pastoral counseling or from parishes, and others from military, police and firefighting backgrounds, where much of the research on critical incidents has been conducted. It also refers to a theoretical perspective, or therapeutic modality, on how to treat people suffering from disaster-caused distress.

The attacks of September 11th galvanized created institutional, political, religious/spiritual and psychological conditions that have provided fertile ground for the expertise of "disaster religious and spiritual care" to expand and increasingly define itself as a necessary component of disaster response. The changes in government policy and new funding streams on federal, state, and local levels, as well as new partnerships among government, religious and community groups dealing with disaster preparedness and response, have provided a broader niche for disaster-related expertise. While

religious organizations have long been a core component of disaster response efforts, there was no specific professional expertise focusing on disaster care.

This study largely concentrates on individuals and institutions based in New York City. It argues that lives and conditions have been altered by disasters in significant ways, leading to new forms of expert knowledge and global changes in subjectivity and self understanding, particularly in regards to ideas of trauma and conceptions of religious suffering.

The dissertation ends by showing the ways in which people experience religious, spiritual and mental health concepts--particularly trauma--as they navigate the "New Age of Anxiety." It illustrates how seemingly incommensurable ideas of religion and science are interwoven in the lives of "disaster religious and spiritual care" workers.

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Religion, Spirituality and Disaster Care in a New Age of Anxiety

Introduction

> The events of September 11, 2001, propelled the need for disaster spiritual care into the public consciousness. The breadth and depth of human suffering and death, the violence done to a nation, had almost no precedent in our lived history here in the United States. Suffering and death, intentionally caused in the name of God, brutalizes our souls. Hurricane Katrina, an act of God, brought destruction beyond our imagination. The call has gone out. We must respond (Becker et al. 2008: 86).

In September of 2001, after spending a year in Russia on a fellowship with the Civic Education Project a Soros, Foundation funded endeavor, I embarked on my graduate school career at the Graduate Center of City University of New York. About a week after the semester began, exiting the F subway stop on Houston Street and 2nd Avenue, and still sleepy, I was nearly hit by a mini van with a whirling siren, racing downtown at top speed. I stopped at the corner, cursing the driver. It was then I noticed dark smoke rising from downtown. Several people were gazing up intently. "What building is that?" I asked with mild interest. "The Trade Center," the man next to me responded. While I watched, minutes, maybe seconds later, with a flash and ground-shaking boom, the second tower burst into flames. I stood on that corner for what seemed like an hour, but might have been 15 minutes, reluctant to leave the small group of people that had formed, watching dumbfounded—until a wild-eyed man, like a dark messenger, covered in ash, made his way towards us. He maniacally said that he had seen people flinging themselves from the burning buildings. "They were falling to the ground in flame."

Thinking him a raving lunatic, I continued on to my Hindi class at New York University. Class had, of course, been cancelled. As the dutiful and zealous new graduate student—and at a loss for what else I might do— I wandered into New York University's Bobst library, which was deserted save for some befuddled looking staff.

It was then I realized my day was going to be anything but normal. Something had gone wrong. Very wrong. I became hazily and reluctantly aware that the horizon I had taken for granted the previous day had become a cracked windshield. I made my way to my friend Marc's apartment in the West village. Luckily he was home and we went to a nearby café, where we ate apple pie and whipped cream—in retrospect an appropriate choice for a day that has come to be seen as simultaneously a symbol of both America's vulnerability and fortitude. In stunned silence, we watched television with the other anxious-faced customers.

I do not remember much of what happened later that day or the day after. I am not even quite sure where I slept that night. But two days later found me ill-equipped, wearing sandals just blocks from ground zero, volunteering for the Red Cross—handing out masks and water bottles to rescue workers and other officials. The site was mayhem—grey and unrecognizable. At that point the officials had not established control of the area, and as long as you looked like you knew what you were doing, you could walk down to the smoking pit of ground zero, wade through the miasma—which later was found to cause cancer in many rescue workers—feel the heat of the flames, and with an odd sense of knowing that you were part of history, envision what you might say to your grandchildren when they came to interview you about where you were on 9/11.

You could catch a glimpse of the smoldering heap of what had once been among the tallest buildings in the world.

Without belaboring the point—I am well aware that the attacks of September 11th were not among the worst tragedies to befall humankind—with the distance of memory and gaudy efflorescence of media hype, it has become nearly passé to speak about one's experiences on that day (particularly in New York), yet it was the single most dramatic experience of my life. Thankfully, it is not everyday that one walks to school on a lovely late summer day only to watch two towering columns of steel vaporized along with the people inside followed by a near military occupation of lower Manhattan, and subsequent invasions of two countries, resulting in war that persists now 7 years after September 11, 2001.

While it is often difficult to date the beginning of a long-term research project – where the actual interest began, where the question came from, how circumstance led to circumstance, leading to a more defined path—I trace the origins of this project to that now-infamous day. After all, without the attacks I might now be in India, studying local participation in politics in the nascent state of Uttaranchal—my original graduate school project. But instead, I am here in NYC, like those I have studied, caught in the shifting patterns of history, moved along by forces beyond my control, studying the development of an expertise combining religion and spirituality with mental health theory and practice, designed to address disaster[1]-related distress.

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[1] In my fieldwork "disaster" was typically used in its conventional meaning: a large-scale catastrophe with a discrete beginning and end, conforming to specific criteria of response and recovery. As a category of analysis, disasters are not universal and are deeply connected to political and economic concerns. For instance, whether or not an event gets defined as a disaster has everything to do with the kinds of federal state and local aid that

Whether through ritual, prayer or technology, creating prophylactics against the unknown is a pervasive characteristic of human social life. In 21st century America, expert knowledge and professions are the dominant ways we attempt to bring the inevitable unruliness of life under control. But our attempts are necessarily imperfect. Medicine cannot cure all diseases; psychiatry cannot medicate away all human suffering; psychotherapy, whether cognitive-behavioral, existential or relational, does not dissolve all anguish; we cannot control storms and earthquakes, or even predict them with great assurance; and we cannot prevent violent attacks. Religion and spirituality pose questions about ultimates: Why are we here? What happens when we die? Why do we suffer? These questions, a common argument goes, often become intensified during times of distress. The technical-rational discourse of secular experts is not up to the task of dealing with ultimate questions, leaving an "existential deficiency (Harrington 2008:17)," a lacuna in the techno-rationalist cocoon.

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will be made available. Also, not all survivors of disaster are treated alike: to be a survivor of the attacks of 9/11 carries with it much greater currency then, for instance, to survive fires in Southern California. The distinction in this case, on the surface, lies in part with "natural" versus "manmade" disasters or "terrorism". But as many have shown, natural disasters are not necessarily so natural and many long-standing tragedies like AIDS, for example, are not considered. What's important, then, has less to do with the toll of suffering and death and more to do with perception, with human imagination, moral panic, and what we are willing, or not willing, to consider valued suffering. Focusing on 9/11 is in many ways easier and more psychologically gratifying than dealing with the problems of infant mortality rate in Harlem (an ongoing tragedy that does not get categorized as a disaster). The difference lies in part with the circumscribed nature of the event. For the sake of this dissertation, disaster refers to events that have been identified by my interviewees along with other key social institutions—which includes the media, government, public relations and general perception—as disasters. 9/11, most would agree, constitutes a significant disaster, as does Hurricane Katrina. The people I worked with mostly used the term in its common usage, to describe discrete large-scale events. Some, particularly several African Americans, pointed out that the focus on 9/11 obscured ongoing disasters of racism and structural violence.

This dissertation examines the development of the expertise of what specialists call "disaster religious and spiritual care." It tells the story of how that expertise has emerged, gaining much of its more recent momentum from 9/11 and subsequent disasters, including Hurricane Katrina, the Indian Ocean Tsunami, and more recently, the ubiquitous looming threats of catastrophe associated with climate change. It is also concerned with how expertise is inevitably and inextricably tied to history—to complex ecologies, ideas and practices.

The attacks of September 11th have, I argue, exploded into a network of ideas and practices of health, healing, suffering, optimism, resilience and distress, rearranging old relationships, fostering new on ones, and creating what can be called a New Age of Anxiety. The term "Age of Anxiety" was coined by The Poet W. H. Auden to describe the pervasive sense of distress and fear following World War II and the atomic attacks by the United States on Hiroshima and Nagasaki**,** as well as the threat of global nuclear destruction in general. The original "Age of Anxiety" also led to debates about the nature of scientific progress and its relationship to religious and scientific debates (Rozario 2007).

Religion and psychoanalysis were seen as competing frameworks, irreconcilable foes in competition over definitions of distress (Ellenberger 1970). By the end of the 20th century, the therapeutic ethos had become a defining feature of the age (Rieff 1966). But as many of those I interviewed articulated, a peculiar and unexpected turn of events occurred— religion and mental health theories are often no longer seen in opposition. Prayer and mediation, I was told, have proven physiological benefits. This dramatic shift allows for a very different framing of disaster-related distress—and distress in general—

which, with the pun on "new age," has become a defining feature of the "New Age of Anxiety."

The current Age of Anxiety, like the old one, at least in the United States, has been characterized by the general perception of many Americans that our world has become an increasingly dangerous place. Not only are we continually living in fear of foreign terrorists, but additional threats, be they the Oklahoma City bombing, Hurricane Katrina, climate change, or even a careening economy, constantly pervade our psyches with a collective sense of anxiety. Novel forms of professional expertise have emerged: disaster management, disaster mental health, and disaster chaplains, to name a few—many designed to quell anxiety and bring comfort and reassurance to an increasingly uneasy populous.

"Disaster religious and spiritual care" refers to a general framework comprised of loosely associated, sometimes antagonistic, individuals and organizations. Many come from the hospital chaplain world, some from pastoral counseling or from parishes, and others from military, police and firefighting backgrounds, where much of the research on critical incidents has been conducted. It also refers to a theoretical perspective, or therapeutic modality, on how to treat people suffering from disaster-caused distress. For many years there have been debates internal to religious groups and theological circles over the role of pastoral counseling in a congregational setting. 9/11 created great concern over the manner of mental health care that responders were receiving. Widespread concern about trauma, as evidenced by subway advertisements, brochures and public service messages spoke to extremely high levels of anxiety about

the mental health impacts of the attacks. Seeley[2], a therapist who was active in 9/11 recovery efforts writes,

> The fact that diagnostic categories are contingent on specific external occurrences calls attention to the limitations of medicalization in addressing human suffering. After 9/11, many therapists recognized that medicalized notions of mental diseases were not useful for understanding the ways in which the attack and its myriad consequences suffused the everyday lives of individuals, disrupting social relationships, damaging collective identities, threatening economic security, and undoing community ties (2008:195)

It is this recognition of contingency and fallibility that creates openness to new ways of dealing with problems of distress.

Until the 20th Century, religion was the primary lens through which Americans understood distress. The idea of experts who dealt with the "problems of living" did not exist (Abbott 1988). But the 20th century saw the rise of a host of professions—neurology, psychiatry and psychology—that wrested professional jurisdiction[3] from clergy and chaplains[4], often leaving them on the sidelines of conversations about distress

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[2] Seeley has written extensively on the New York's psychotherapeutic response to the attacks of September 11th. She teaches in the anthropology department of Columbia University and is a therapist in Barnard College's counseling center.

[3] The particular way I use the concept of jurisdiction draws from Andrew Abbott's work on the professions. By jurisdiction, I simply mean the extent to which experts and professionals maintain control over a set of problems. In Abbott's view, a defining component of the development of professions is competition over jurisdiction and the authority to diagnose and treat problems: "jurisdictional boundaries are perpetually in dispute, both in local practice and in national claims. It is the history of jurisdictional disputes that is the real, the determining history of the professions" (Abbott 1988: 2).

[4] Chaplains refer to religious care providers working in institutional settings—hospitals, military, corporations and fire and police departments—both lay and ordained. Many of the people I interviewed have worked as chaplains in the various institutions mentioned above but felt that disasters were unique enough to require specific expertise. One of the organizations I studied, Disaster Chaplaincy Services, aims explicitly at the creation of a new kind of disaster chaplain. Many chaplains, particularly those who work in hospitals, receive Clinical Pastoral Education (CPE), a training program combing psychology

and mental health. Religion quickly began to lose jurisdictional hold over many of the problems now associated with mental health. Disaster religious and spiritual care, to gain legitimacy, justifies itself through invoking therapeutic, scientific and techno-rational reasoning, using tropes of holism and mind/body medicine.

9/11 intensified cultural processes that were underway prior to the attacks, including the increased inclusion of religion into medical settings (Harrington 2005; Koenig 2006); the development of expertise around disaster mental health response (Halpern and Tramontin 2007); and the increasing synthesis of spirituality and psychotherapy (Kirschner 1996). The attacks of September 11th galvanized these processes (Seeley 2008) creating institutional, political, religious/spiritual and psychological conditions that have provided fertile ground for the expertise of "disaster religious and spiritual care" to expand and increasingly define itself as a necessary component of disaster response. The changes in government policy and new funding streams on federal, state, and local levels, as well as new partnerships among government, religious and community groups dealing with disaster preparedness and response, have provided a broader niche for disaster-related expertise. Along with these changes came a host of new justifications for why and how the new partnerships

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religion and personal development designed for those seeking to provide religious care in hospital settings. While Christian in origin the trainings, along with the concept of chaplains, are designed as interfaith. "Clergy", though somewhat of a contested designation, refers to ordained religious leaders. When contrasting clergy with mental health professionals it is important to remember that there are many clergy members who have MSW degrees or who are psychologists. One of my subjects, for instance, was a nun with a PhD in psychology. The variety of clergy and the various institutional structures they are beholden to further complicates this category. Some informants said that the word clergy was Christian in origin and that "faith leader" was a more inclusive term.

between government and religious and community groups ought to occur. While religious organizations have long been a core component of disaster response efforts, there was no specific professional expertise in disaster care.

This study largely concentrates on individuals and institutions based in New York City. I argue that lives and conditions have been altered by disasters in significant ways, leading to new forms of expert knowledge and global changes in subjectivity and self understanding, particularly in regards to ideas of trauma and conceptions of religious suffering. While this is true for many Americans, for those I studied, 9/11 and subsequent disasters revealed a niche for a novel emerging expertise that radically altered their lives and careers. While this expertise was not entirely new, the pervasive sense of societal risk, many of those I interviewed argue, created a forceful mandate and consolidated disparate efforts that were already underway. Most of my informants were from mainline religious groups and denominations and maintained affiliations with their religious groups. This was largely enforced by what seemed a tacit agreement among clergy involved in disaster response. Scientology and fundamentalists of various denominations were for the most part looked upon with criticism. This, of course, had to do partly with the religious composition of New York, where I conducted most of my research. However, despite the exclusion of fundamentalists, Mormons and other religious groups considered deviant, disaster work seemed to be characterized by eclecticism, encouraged by its interfaith collaborative nature—fundamentalists by definition are intolerant of difference and would not likely find a place in this atmosphere. Also, because disaster work entails interaction with bureaucratic organizations, like the Red Cross, the Office of Emergency Management, fire

departments and police departments, most of those I worked with maintained an awareness of the different contexts they worked in and were able to change registers to fit the situation. As I will show, this was not always the case.

Disasters encourage a re-examining and reorganization of relationships between clergy and mental health professionals on multiple levels—from the intimate encounters of the clinic and church to large government bureaucracies. I demonstrate how novel religious organizations have developed in response to perceived needs of disaster-related spiritual and religious distress. The expertise intertwined with the history of relationships between religion and mental health in the US since the Second World War, particularly scientific research on stress, which led to studies of the health benefits of prayer and meditation (Harrington 2008).

<u>Methods</u>

This project began as a case study commissioned by the Department of Health and Mental Hygiene in 2003 through the Nathan Kline Institute, a branch of the New York State Department of Mental health (DOHMH). Between January 2003 and February 2007 a team of researchers conducted 30 interviews with clergy involved with 9/11 recovery. These interviews have informed my research and, to a small degree, appear in this dissertation. Following the termination of that project in the spring of 2005, I continued the project in a revised form for my dissertation research. It is important to note that the City officials saw the role of clergy in disaster response as an increasingly important issue following September 11th. The fact that they commissioned this research supports one of the claims of this dissertation: that

distracters cause reorganization in relationships between religion and mental health professionals on multiple levels.

Following the end of my work with the Nathan Kline Institute in 2005, I received National Institute of Mental Health (NIMH) funding. Since then I have conducted 40 interviews focusing on emerging trends in religious and spiritual response to disaster, and with chaplains, administrators and mental health professionals involved in disaster work. Because many of my informants were interviewed in their professional capacities, they often spoke in a formal manner, providing information about the functioning of organizations.

Consequently, as is often the case, much of my more useful data was collected from informal conversations at conferences, and trainings. Since I have been acquainted with many of my subjects over the course of several years, seeing them repeatedly in different contexts, I was able to gain their perspectives over time. Several have become close friends and coeditors of a book titled, *Creating Spiritual and Psychological Resilience: Integrating Care in Disaster Relief,* expected to be released by Routledge Press in the fall of 2009.

A semi-structured interview guide was used, comprised of questions that emerged from preliminary interviews with clergy when I was working for the Nathan Kline Institute. About one third of the interviews were recorded. Following interviews, I took notes as soon as possible, writing extensive comments.

I attended eight conferences on religion, spirituality and disaster mostly in New York City, numerous meetings of local organizations involved in disaster planning, and 6 training courses on spiritual care and disasters ranging from 1 to 4 days, discussed in

chapters four and five. As part of this research I entered a training program in hospital chaplaincy that consisted of clinical time with patients and classes in chaplaincy with Beth Israel Hospital's Department of Spiritual Care. Because of ethical considerations[5], none of that material explicitly appears in this dissertation, but the experience has immeasurably informed my understanding of religious and spiritual care. Since many of the ideas that underlie disaster religious and spiritual care were developed in hospital settings, the time I spent with chaplains and patients provided me with an enriched sense of the development of chaplaincy as a field. I participated in group exercises on diagnosing spiritual problems, theory of chaplaincy work and role plays, as well as receiving direct supervision of my clinical hours with patients as a chaplain-in-training by a supervisor certified in Clinical Pastoral Education (CPE).

Over the course of the years that I have been involved with this project, the research questions have changed. Initially I was interested in interpretation of distress in a moral clinical sense—understanding the way clergy understood disaster-related suffering compared with that of mental health professionals. But as time went on it became clear that I was seeing a change in how the relationships between religion, spirituality and mental health were being framed and understood by those creating a new expertise— and that these changes were part of a much larger historical and cultural picture. I began to place greater focus on the history of the ideas and practices I was encountering in my research. It became increasingly clear that what I was seeing was embedded in a very complex history of ideas about the body, self, and suffering, as well

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[5] As part of chaplain training I had to assume the role of chaplain and see patients. This raised questions about authenticity, and ultimately I decided that it did not seem quite right to continue.

as cultural changes in how distress is treated. The broader context of this research is thus located in the institutions associated with disaster response, and the interpretive frames they hold regarding distress and healing.

Trauma and Disaster in the Social Science Literature

Tensions between religion and science, rationality and superstition, and the causes of suffering have long had a place in discussions of disaster. Rousseau and Voltaire's famous correspondence following the Lisbon earthquake of 1755, centered on whether or not the massive affliction caused by the quake was cause for despair over the lack of order and meaning in the cosmos (Kendrick 1956). Disasters tend "to cast doubt on the central Enlightenment idea that we are in charge of our own fate" (Taylor 2007: 638). By showing how the New Age of Anxiety has intensified the development and created a cultural niche for "disaster religious and spiritual" as an emerging expertise, I aim to contribute to a broader understanding of the literature on the anthropology of illness and healing (Lindenbaum and Lock 1993). More specifically, I situate this study within the anthropology of psychiatry (Young 1995; Luhrmann 2001); the literature on "idioms of distress" (Nichter 1981); and to a lesser extent the anthropology of religious healing (Frankenberg 2004; Obeyesekere 1984) and the anthropology of disaster (Oliver-Smith 2002; Petryna 2006). I base much of the historical background for this dissertation on the history of mind/body medicine (Harrington 2005, 2008; Johnston 2004) and the history of psychology (Herman1995) in America, particularly as it relates to questions of secularization (Swedin 2003).

Anthropologists have long been interested in trauma, going back at least to the work of physician/anthropologist W.H.R. Rivers in the 1920s. Rivers—in contrast to the

dominant view of the time—recognized "trauma" as a legitimate way for soldiers to suffer from combat experiences. Abraham Kardiner (1947), another key figure in early trauma studies and anthropology, wrote an important volume on combat stress (Shephard 2001), and had an association with one of the titans of American anthropology, Franz Boas, as well as with important psychoanalysts of the time.

It was not until the 1990's that medical anthropology began again to adopt trauma as a central area of study (Young 1995). Broadly, anthropologists have followed three avenues of inquiry: the social construction of Post Traumatic Stress Disorder (PTSD) and biomedical discourses on trauma; humanitarian interventions and disaster responses; and ethnographies of collective violence, cultural trauma, identity, and memory. Allan Young's (1995) work on the development of PTSD and its antecedents has become a key text, widely cited in both anthropological and psychiatric literature. Drawing on science studies and philosophy (Fleck 1935; Hacking 1995), his work both historicizes PTSD and critiques the idea that its 1980 entry into DSM was in fact based on a new scientific discovery. Rather, he argues, it was a reworking of previous symptoms into a new diagnosis, which had more to do with politics and disciplinary debates than with novel scientific study. Young, however, does not mention the interrelationship between religion and trauma discourse, which is particularly surprising given that the fieldwork for his highly influential *The Harmony of Illusions* was conducted in a veterans psychiatric clinic, an environment that would likely include conversations about religion.[6]

[6] There is a significant literature among veterans and veteran chaplains discussing the relationship between PTSD and religious experience. Much of it is written as first person narratives and memoirs (Mahey 1996).

A recent turn towards subjectivity (Biehl et al. 2007) aims at drawing connections between individual experiences of suffering and large scale social change that takes into account structural inequality, political violence and widespread upheaval. Subjectivity is said to explain the formation of the self in relationship with large-scale global change, relating individual will and desire and local moral worlds, to structural change (Biehl et al. 2007).

Following Wallace's (1956) study of the Worcester Tornado, a few anthropologists, including Oliver-Smith (1986), specialized in disaster studies, publishing several monographs and collections dealing with both applied and theoretical aspects of culture and disaster (Hoffman and Oliver-Smith 2002). Historically, however, anthropology's focus on the "timeless present" and on social cohesion deemphasized disruption in favor of the study of continuity (Hoffman 2002).

A recent flourishing of disaster studies in anthropology include Lakoff's work on logic of risk (2008), Barrett's study of the impact of the 1972 Yugoslavian smallpox epidemic on biosecurity policy (2006) and Schoch-Spana's (2004) work on bioterrorism as secular apocalypse, as well as Petryna's work on the nuclear catastrophe in Chernobyl (2002). These studies have in common historical and contextual analysis of disaster and see disasters not as discrete events, but instead as embedded in broad social and cultural processes. The elision of social dynamics of poverty and public health infrastructure leads, they argue, to a dangerously simplistic conception of disaster.

A more developed sociology literature on disaster dates back at least to the Halifax explosion of 1917 (Prince 1920). Kai Erikson's Buffalo creek monograph (1972), describing the long-term impact of a flooding on a community in West Virginia,

focuses on the malfeasance of government response. Other important recent contributions to the sociology of disaster include Dynes and Tierney (1994) and Quarantelli (1998).

While there is some overlap between anthropological and sociology literatures on disaster, for the most part they remain independent—the former focusing on construction of knowledge, culture differences in reaction to disaster, and psychological experience; the latter on larger-scale structural issues. Both literatures are rapidly growing, providing further evidence that disasters have become an increasingly central issue.

The psychology of religion, beginning with William James (James 1902), has a long history. While religion and psychology continued to be an early interest, the last twenty years has seen a flourishing of work in this area (Gorsuch 1988), including Milstein's work on collaboration between clergy and mental health professionals (2008). Milstein argues that the use of the term "faith-based" is ill fated, suggesting in its place the term "religion inclusive" to indicate the importance of religion in mental health provision, while not necessarily endorsing faith-based perspectives. Oman and Thoresen (2002) identify four causal pathways through which religion might impact health: behavior, support, psychological states and superempirical, or phenomena outside the realm of traditional scientific study. These sometimes overlapping pathways represent traditions of research on the health benefits that were evident in my fieldwork.

Kleinman (1988) and Mattingly (2000) have written about suffering, illness, and relationships between clinicians and patients. Their articulation of the cultural and narrative aspects of distress is important for this dissertation. Particularly in Kleinman's later work, the relationship between global, social and economic processes and ideas of

the self has been widely influential. “Quietly but ineluctably,” write Kleinman and Benson, “beneath the surface of events large and small, the self itself is changing. We are not the same people as our parents or grandparents, and our children will not be the same people we are.” In addition they observe, “Medicalization makes unhappiness, anxiety, and moral anguish things that should not happen, that are not normal, and pharmacology as an end in itself could end up undermining our human ability to cope with these very normal and serious conditions” (2006: 308). Highlighting the historical and cultural nature of subjectivity, this work argues that the very possibilities for experiencing distress—not just the categories—change over time.

Regarding subjectivity, Lear writes, “as it turns out, intending and hoping and wondering and desiring are not just up to me: They are not just a matter of exercising my will. And my inability to do so is not just a psychological issue: it is a question of the field in which psychological states are possible” (2006: 49). The self and subjectivity are culturally and historically contingent, and subject to mercurial forces with subtle implications for the kinds of psychological states that are possible in any given time and place. A move away from research on numbers of adherents to the *conditions of belief* deemphasizes the epistemological conflict model between religion and science (Evans 2008; Taylor 2007). A focus on the different expressions of lived experience of religion and science would provide a much-needed corrective to theoretical views of secularization and re-sacralization that view these processes as occurring in the ether, rather than in the day-to-day contingent patchwork of lives (Smith 2003; Taylor 2007).

Fassin and Recthman, describing the mental health response to the attacks of September 11th in a forthcoming volume on the global spread of the concept of trauma, write:

> No one seems astonished when mental health professionals leave their care centers and consulting rooms to attend to the 'psychically wounded' in debriefing spaces. The idea that tragic and painful events, whether individually or collectively experienced, leave marks in the mind which are then seen as 'scars' by analogy to those left on the body, is just as easily accepted (2009: 6).

I hope to clearly show that this peculiarly misguided statement is far from what happened following 9/11—or the widespread reverberations that continue. Instead of consensus, the mental health response to 9/11 was the site of contradiction and complexity, calling into question diagnostic categories, interpretation of suffering and how many Americans understand the relationship between resiliency, trauma, religion and spirituality, rationality and technological progress. As I will show, both the popular press and scholarly journals—along with my informants—raise profound and historic questions that we shall continue to reckon with. The attacks produced an unprecedented amount of mental health data, which has yet be fully debated and interpreted.

Organization of the Dissertation

Part I of Chapter Two describes the historical background of disaster religious and spiritual care, outlining the number of pathways through which it has been developing into a discrete expertise. Drawing on the increasing connection between religion and medicine in the past 30 years (Harrington 2005; Sloan 2006), made possible in part by studies conducted around WWII, I show the kinds of scientific knowledge that lend legitimacy to experts in disaster religious and spiritual care and their attempt to claim

jurisdiction. The chapter focuses on how relationships between mental health theory and religion have played out since shortly before WWII and more intensively since the 1980s. Building on the history outlined in Part I, Part II of this chapter focuses on changes that occurred in disaster mental health and "disaster religious and spiritual care" following the attacks of September 11th.

Chapter Three focuses on the development of organizations involved in "disaster religious and spiritual care" in New York City. These include New York Disaster Interfaith Services (NYDIS), Church World Service, Disaster Chaplaincy Services and the Red Cross. I show how individual lives intersect with the development of these organizations. I also show how conflicts over resources, credentialing and status were played out in the creation of these organizations. Lastly, this chapter looks at the role of interpretation of distress in the formation of "disaster religious and spiritual care organizations."

In Chapter Four, I show how Critical Incident Stress Management's (CISM)Pastoral Crisis Intervention (PCI) training, frames the concepts of trauma, religion and spirituality for clergy. CISM has strong ties with the military, fire departments and police departments, and has been at the center of debates over the efficacy of disaster debriefing methods. This chapter shows how a training philosophy designed to meet the needs of large bureaucracies incorporates different traditions of mental health practice, creating a model for clergy working in disasters. I examine tensions between mechanistic and holistic discourse in disaster mental health response.

Chapter 5 looks at 3 different trainings, which were in part developed from experiences following the attacks of September 11th, 2001. The trainings took place at

Princeton University, Eastern Mennonite University in Harrisburg, Virginia, and in Biloxi, Mississippi. The chapter shows how trainings develop ideas of expertise of disaster religious and spiritual care, incorporating psychology, neurosciences and religion and spirituality.

In Chapter 6, I focus on three informants, the Prophetess, Frank, and Rose, chosen because of the different ways they embody the expertise of "disaster religious and spiritual care." I show how their lives—career opportunities, theological perspective and understanding of trauma—were transformed by their experiences of disaster work. I argue that they represent "healers for a new age," incorporating science, religion and new age practice into disaster mental health. Their personal lives were significantly changed by 9/11, leading them to different perspectives on suffering, disaster, religion and spirituality. Frank sees no contradiction between religion and science, using both interchangeably, while for the Prophetess there is a greater tension between "the spirit" and modern therapeutic practices. Rose, while not religious, exemplifies a form of modern "spiritual healing" that draws on a variety of traditions, incorporating energy healing and scientific perspectives. In this chapter, I also examine the effect that these subjects had on me and discuss the role of personal and existential perspectives in fieldwork.

Lastly, Chapter 7 draws together the central arguments of the dissertation: 9/11 and subsequent disasters have resulted in the expansion of the expertise, disaster religious and spiritual care. This expertise was consolidated by an increased perception of risk in contemporary America, consolidating disparate historical narratives about distress, religion, mental health, science, therapeutic culture, trauma, and more generally

suffering. By studying the lives of those involved with the creation of the expertise, I show how current debates about rationality and religion are lived through the practice of disaster religious and spiritual care, the ways those I studied come to understand their own suffering in relationship to others and to cosmologies of science, religion and spirituality. I offer some policy recommendations and make some speculations about how "disaster religious and spiritual care" might continue to develop in the face of future catastrophes.

Chapter Two

The Patchwork of Disaster Expertise: History and Background

A new science of disaster relief must include treatments that go beyond the current models pitting one set of needs against another. Instead, new models must link the mind and body, recognizing that the resilience of one affects and depends on the resilience of the other.

--M.Laurie Leitch, *New York Times*, May 31, 2005

Introduction

The first section of this chapter charts the history that laid the groundwork for the expertise of "disaster religious and spiritual care." I outline the kinds of expert knowledge, including neurosciences, biopsychiatry, and psychodynamic therapies being employed to make claims to establish "disaster religious and spiritual care" as a legitimate expertise. An important part of this history includes the clergy's loss of jurisdiction to the emerging mental health professions over particular kinds of suffering. This historical trail reaches back to narratives that help frame ideas of self, suffering and distress, secularization and re-sacrilization, providing a way to fit their own life stories into larger frameworks of meaning (Harrington 2008).

In what may at times appear to be a circuitous route, this chapter shows the complexity involved in the inclusion of spiritual care in disaster response. I present the different historical narratives that give the men and women that I worked with the historical narratives (Harrington 2008) they use to make sense of events and to craft the expertise of religious and spiritual disaster care.

The second section of this chapter examines a much narrower timeframe for a more fine-grained analysis of the history of "disaster religious and spiritual care" from

the mid-90's, when one of the first formal organizations was established, focusing on responses to the attacks of September 11th.

Secularization and Re-enchantment

In 19th century America, a person experiencing difficulties in work, marriage or other life crises in general had few other options for advice than to turn to their clergy person. What today we might label psychological distress of various kinds was almost exclusively described in religious terms (Abbott 1988). By the early 20th century, this situation had changed. Urbanization and industrialization gave rise to novel problems that became defined by the newly emerging mental health professions. Clergy began to lose jurisdiction over the problems of everyday life to neurologists and psychiatrists, who were originally called alienists (Kirschner 1996). Problems once associated with the everyday work of clergy—including listlessness and mental distress of various kinds—rapidly became defined as pathologies to be dealt with by professional authorities. As the century continued, mental health professions fractured into a multitude of factions, spawning recondite debates over diagnoses, filling journals and the popular press. By the end of WWII, the mental health professions had rapidly expanded outside the walls of mental institutions, pushing clergy further to the sidelines, and claiming jurisdiction over a much broader range of the problems of daily life[7] –difficulties hitherto not seen as under the purview of mental health professionals (Herman 1995). The army of mental health professionals had solidified their control over the interpretation of problems of everyday life.

[7] Much of my discussion of secularization of distress draws on Harrington (2007) and Abbott (1988).

A popular narrative about the evils of modernity suggests that humans once lived harmoniously with nature and spirits and Gods. Then came the revolutions and reformations: secular, industrial, scientific and political. As part of these transformations, our understanding of health and healing, suffering and solace were radically altered. The secularization of health and healing led to the creation of the mental health professions, and transformation of professional responsibilities—from "cure of souls", once the province of religion, to the cure of the psyche, the province of psychology (Ellenberger 1970; Hacking 1995).

Weber discussed the potentially alienating dynamics of modern medicine (1946), and many 20th century secular critiques from proponents of the New Age world and the religion and health movement resonate with his work (Harrington 2005; Koenig 2005), casting the routinization and rationalization of medical care as a pernicious force of modernity. He argued that rationalization—the process by which human action comes to be dominated by efficiency and means-end calculations—would result in a loss of meaning.

> Whether life is worthwhile living and when—this question is not asked by medicine. Natural science gives us an answer to the question of what we must do if we wish to master life. This means the medical man preserves the life of the mortally ill man, even if the patient implores us to relieve him of life, even if his relatives, to whom his life is worthless and to whom the costs of maintaining his worthless life grow unbearable, grant his redemption from suffering (Weber 1946:144).

The echo of this sensibility has been a defining feature of the modern Western experience, reflected in the literary works of Tolstoy, Beckett and T.S. Eliot.

At the same time, we have recently experienced the re-enchantment of health care discussed in media and medical journals. Bill Moyer's 1993 PBS series, *Healing and the*

Mind, documented the impacts of eastern meditative practices—many shorn of religious ritual—providing a turning point in the history of mind/body medicine in America (Harrington 2008). Numerous articles in the press, as well as scholarly works, have helped popularize ideas about the relationship between spirituality and health. The current view suggests that earlier theorists were mistaken—social evolutionary visions had misread the signs. Religion is said to be back, and not only is it back, some believe, but now it is shorn of conflict with medicine and science.

As part of this rapprochement, spirituality, generally defined as the human need for *meaning*, has often come to take the place of religion in public discourse (Wuthnow 1998). Disaster religious and spiritual care claims its ability to provide *meaning* as one component of its expertise: psychology, psychiatry and allied professions are associated with a medical model that does not, for the most part, deal with questions of meaning. This model needs to be respected, the argument follows, because of the biological and cognitive nature of traumatic experience—but they are not enough, according to those who advocate for giving religion and spirituality a greater role in medicine and mental health settings (Sloan 2006). If psychiatrists in the biopsychiatric model are able to restore the brain to healthy functioning, then clergy can provide meaning, which has been shown, advocates suggest, through scientific study to be a protective factor: spirituality becomes another component of healthy functioning. In the new configuration of spiritual care, meaning is what chaplains are said to provide, and which comprises one of their strongest claims to expertise[8].

[8] Charles Taylor criticizes the idea that the universal primary motivation for religious practice is the search for meaning. The claim that *meaning* falls under jurisdiction of "spiritual care" is part of larger-scale cultural shifts associated with modernity. By

The Discourse of Holism and Anti-Modernism

At a conference on disaster for clergy in the spring of 2006, the director of a large religious organization opened the proceedings in a room full of clergy, government officials and representatives from social service agencies, by observing

> Wholeness and hope need to be present for people we serve. 9/11 impacts humanity. We are in the business of redelivering that humanity and *wholeness* and calling it back to being. Not just for ourselves but for Israel, Madrid and other places around the world.

As Rosenberg (2007) writes, ideas of holism are part of an intellectual tradition and sensibility that sees the success of reductionistic/physicalist medicine as partial (Harrington 2008), reflecting unfounded confidence in technology, while ignoring the price paid for placing the needs of "humanity" in a subordinate position. "Because ideas of holism are elastic, they can be deployed by the left as well as right, the defender of status quo as well as its would-be antagonist" (Rosenberg 1998: 349), tapping into an aspect of anti-modernism that runs deep in Western thought, and can be found in the rhetoric from Nazi Germany's *Volkgeist* to the hippies of the 1960's when calls for holism became a mass movement, linking a wide variety of

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showing the search for meaning itself—something widely taken for granted as a fundamental human trait (Frankl 1984)—to be contingent, Taylor profoundly questions the underpinnings of many schools of modern psychology, and spirituality/psychology hybrids. "It is easy to understand why, after religious views have been challenged, and even rendered for many people ineligible, the sense of what has been *lost* may center on the issues of meaning. The "disenchanted" world does indeed seem a world without meaning. But this doesn't mean that through all the ages of religious life in all its variety, this was the driving factor in the constitution and preservation of religious form. There is a fallacious inference behind the untroubled adoption of this theory of religious motivation. Just because this looms as a big issue for *us* in a secular age, it is all too easy to project it on all times and places. There is in the end something incoherent in this move. It will certainly not help us at all to understand why, for instance, certain kinds of shamanism in Paleolithic times, nor why Europe was torn apart over the issue of salvation by faith in the sixteenth century" (2007: 680).

practitioners together under the "banner of holism"[9] (Harrington 1999;Whorton 2002). As part of the "master narrative of anti-modernism" (Rosenberg 2007), religion and spirituality play a key role in critiquing what have been seen as the alienating forces of modernism. I suggest that many of the criticisms leveled by those advocating for disaster religious and spiritual care draw from the discourse of holism, and that one of the reasons these arguments resonate stems from their ability to tap into a "structure of feeling," internalized experiences often understood as isolated affect at the core of modern anxieties that create and simultaneously interpret social worlds (Williams 1977). In this sense, the case I am analyzing can be seen as an instance in the long ebb and flow of tensions between holism and mechanization.

Many recent critiques of medicine draw on tropes of holism (Rosenberg 2007; Harrington 2008). Characterized by a reaction against the dehumanizing forces of technology dominated modern medicine, invoking ideas of holism provides a critique that resonates with spirituality and religion—playing on their shared dissatisfaction with strictly material or biological views of the human self. The stakes of conflicts over meaning are dramatically amplified in the context of disaster where some of the most highly valued tools of modernity—the ability to manage risk and predict and prevent calamity—seem to falter (Rozario 2007). What better place for the holistic sensibility to flourish and find new allies than when people see levees break or planes crash into buildings? "Disaster religious and spiritual care" often stakes its claim to professional jurisdiction on these premises: the idea that disasters inherently raise

[9] Over the past 30 years or so the dominant terminology used within the medical community has changed from "holistic medicine" to "alternative medicine", to "complementary and alternative medicine" (CAM), and its current form, "integrative medicine".

questions about meaning, and that questions of meaning are innately spiritual, the province of clergy, rather than mental health professionals.

The Birth of Stress

As suffering of various kinds became increasingly divorced from religion, novel ways of framing distress began to fill the opening niche. In the post World War II United States, "stress" has become one of the key "idioms of distress[10]." A concept with vast explanatory power, stress has been used to describe everything from mild states of dis-ease to incapacitating emotional and physiological shock. Concepts like stress become popular in part because they expand and morph, capturing a vast array of experience, providing a narrative framework. Perhaps more than any single concept, stress has allowed for the secularization of distress and the construction of "personal problems" that began in the late 19th century and following WWII dominated American culture (Abbott 1988).

In 1942 the physiologist Walter Cannon was trying to determine whether or not it was possible to die from a voodoo curse and a belief in the power of sorcery (2002). While his colleagues thought that he might have gone mad, his conclusions on human stress, born of this seemingly far-fetched research, have had widespread influence on ideas of health over the past sixty years. His concept of homeostasis, the return of physiology to a pre-arousal state after a stressful incident, spawned volumes of physiological research (Harrington 2008).

[10] March Nichter (1981) coined the term "idioms of distress" as way to describe experiences of distress without reliance on culture specific diagnoses. I use it as a generic term for distress under which it is possible to group what appear to be similar kinds of experiences across cultures.

The "stress of modern life," as Hans Selye (1956), one of Cannon's most important successors, called it in his popular book of the same name, has become a common refrain in contemporary America. In the first half of the 20th, however, a scientific concept of stress was not a term widely used in mental health theory or practice. Though much criticized within the scientific community for its weak scientific basis, Selye's work became admired by many social conservatives for its neo-Darwinian perspective on competition (Viner 1999; Sternberg 2000). What then were the influences that allowed this idea to become a scientific "fact"[11] and how does this illuminate our understanding of the interactions between religion, spirituality and disasters in what I call our "New Age of Anxiety?"

Over 70 years after Cannon's work on voodoo death (1942), I was attending a conference entitled, *Five years after September 11th*. Designed to bring together an array of clergy and mental health workers who participated in recovery work, the conference had a wide range of speakers—and for conference participants, massage, acupuncture and other forms of stress reducing practices. The speakers included Imams, Rabbis, psychiatrists and other therapists. The common theme was disaster response and the lessons learned since 9/11. But what do Christianity, acupuncture, massage therapy, Buddhism, psychiatry, social work and trauma therapy have in common? What made it possible to link these disparate beliefs and practices in the same conference?

In second half of the 20th century, scientists studied the ways in which religion and spiritual practices might be associated with stress reduction, creating a new way to

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[11] This use of the term "scientific fact" is derived from Ludwik Fleck's *Genesis and Development of the Scientific Fact* (1935). Here he describes the way scientific phenomena come to be seen as facts.

understand the supposed benefits of belief. As many have pointed out, religion became not only good in itself but also good for you. The links between mental and physiological states that Cannon and Selye proposed allowed scientific studies to draw connections between health and religion. I argue that, in part, it was this conception of mind/body medicine that allowed for increased relationships to develop between religion and medicine (Harrington 2008).

Cannon and Selye's work set the stage for some of the sciences of mind/body medicine, opening the door to scientific studies of religion and spirituality. It was, however, not until the 1950's that stress became a household idea, and not until the 70's that connections between prayer, meditation and stress were made popular, with the publication of Herbert Benson's and Norman Cousins' widely read work (Fuller 2001; Harrington 2008). These publications led the way in popularizing the connection between mind and body and in creating new understandings of the role of religion in dealing with the stress of modern life. What had once been questions of meaning, morality and theology became also questions of physiology, inscribing aspects of belief, healing and suffering in the workings of neurological and hormonal systems. During the 1960s these ideas were incorporated in the rhetoric of mind/body medicine, which had great cultural resonance.

> In important and novel ways, the language of faith interwove with the language of science. What might have once been considered heretical—to think of belief as merely a "pill" to cure ills—has become increasingly accepted, as in the following quote, which "biologizes" prayer and meditation. The missing link to complete this circle is an understanding of what controls the hormones and nerve chemicals of our brain's stress and relaxation pathways. If learning, conditioning, ritual, prayer, and meditation downshift the stress response, decrease stress hormones, and allow enkepahlins, endorphins, and other immunosuppressive molecules to play a greater role, then such molecules might also shift (Sternberg 2001: 87).

The fact that prayer can be said to “downshift the stress response, decrease stress hormones and allow ekepahilins” is a radical statement, and would have once been considered heresy. These ways of thinking about the physiological connections between mental states and physiological states, following Cannon and Selye, provided scientific evidence for those wishing to connect belief and prayer to ideas of health. Psychoneuroimmunology, a field of study that has its roots in Walter Cannon’s work, deals with interactions between psychological states and the immune and nervous systems (Sternberg 2000). This body of work has increasingly included the studies on the impact of religion and spirituality on physiological processes (Koenig and Cohen 2002).

The Varieties of Therapeutic Culture

A concept that has received extensive treatment in the social history and social science literature, *therapeutic culture*, refers to the pervasive shift that took place largely after World War II, where much of our understandings of the problems of life became framed in therapeutic terms. Importantly, this shift made self-fulfillment the apogee of human experience, raising the ire of many religious, conservatives and moral philosophers. Many theologians (Shuman and Meador 2003) and social critics (Lasch 1984) have criticized the impact of therapeutic culture on religion, how it leads to a relationship with God—and hence society and life in general—with an impoverished sense of morality and diminished, or eclipsed, conception of the collective good. Therapeutic culture has had different manifestations over the past roughly 70 years, but

the simplified version of these often complex debates—which transcend superficial left/right political distinctions— often gets framed as a tension between those who argue for a "transcendent" view of collective social good (often associated with adherence to traditional religion) and those who do not conceive of human ends beyond self-fulfillment (MacIntyre 1984; Lears 1994). As one aspect of this I will examine the way distress has been framed by neuroscience, the proliferation of PTSD, and how they relate to "disaster religious and spiritual care."

The primacy of psychology for understanding and solving human problems is one of the defining features of therapeutic culture, or what Moskowitz (2001) calls the "therapeutic gospel"—a nod to the religious origins of the therapeutic in America. The fact that these problems can be treated and cured provides a corollary to this argument. Happiness and personal fulfillment become ultimate goals, and though Freud never conceived of psychoanalysis as a road to happiness, America optimistically grafted Germanic stoicism onto idioms of positive thinking with religious roots that run deep in American culture (Fuller 2001**.** Unlike behavioral therapies, psychoanalysis attempts to discern meaning in distress, but it ultimately diverges from religion and spirituality because it does not seek moral lessons: there is nothing to be learned in any larger spiritual or moral sense from suffering (Taylor 2007). And in this, the distinction between therapeutic and spiritual ends is stark, if taken to their logical conclusion. The relevance of this distinction for "disaster religious and spiritual care" is crucial—those wishing to broker a commodious relationship between spirituality and therapeutic culture will find themselves in the position of creating a patchwork of *seemingly*

contradictory discourses—though the way these discourses are lived, as I will show, may belie the conflict narrative of religion and psychology.

Post-Traumatic Stress Disorder

Discussion of disaster-related distress often centered on how to diagnose post-traumatic stress disorder (PTSD). Many of the trainings I attended spent a great deal of time defining the difference between spiritual and religious distress and PTSD. As one priest said, "It is our job to figure out when someone needs to be sent on to a mental health person. But I think PTSD has been far over-diagnosed, sometimes people are still just in shock, and that doesn't mean that they need shrinks." The ability to understand PTSD was considered essential to both clergy working in disasters and mental health professionals. The interpretation of distress by these professional groups, defines, to a large degree, their professional jurisdiction.

It was the inclusion of PTSD in the third edition of the Diagnostic and Statistical Manual (DSM III) of the American Psychiatric Association in 1980 that lay the groundwork for a number of trauma-associated expertises, including disaster mental health. PTSD has entered the *lingua franca* of distress in the late 20th and early 21st century, providing a powerful way to understand many of life's difficulties for many people. The symptoms have morphed, responding to the catastrophes of the 20th century, including WWI, the holocaust and the Vietnam War, 9/11, the war on terror and, more generally, "the New Age of Anxiety," have created the context for the emerging new manifestation of this mercurial diagnoses (Young 2007).

Clergy working in disaster settings are required to develop at least a cursory knowledge of PTSD because of its central place in disaster mental health discourse and

relief work. As part of developing the expertise of disaster religious and spiritual care, clergy are expected to distinguish religious and spiritual distress from other forms of psychiatric distress.

While the symptoms have been around since at least WWI, the current nosology entered the biopsychiatric revamped DSMII in 1980. Disaster mental health, along with modern psy disciplines has its origins in the formal recognition of PTSD (Halpern and Tramontin 2007: 73). Trauma has quickly grown to be a major industry, and heatedly debated. After 9/11—following the historical pattern of intensified interest in theories of distress after wars and disasters—PTSD became a major national issue. In the days after the attacks, hordes of researchers mobilized to study the psychological impacts, and therapists descended from all parts of the country. New York City was inundated with brochures and public service announcements on how to identify PTSD. Many of the debates around mental health following September 11th centered on the prevalence rates of PTSD and how to treat the disorder. In a secular society where science often has the weight of cultural authority, trauma becomes one way to create a sense of coherence in the face of catastrophic events that often threaten to undermine the foundations of security—morally, psychologically and politically (Micale and Lerner 2001). In this view, PTSD was a near inevitable outcome of the twentieth century because of both the collective large-scale tragedies and the need for a widely applicable secular idiom of distress.

To show that they have the expertise to work in disaster settings, chaplains were expected to demonstrate that they could distinguish PTSD from other forms of distress. At the same time they were often critical of the perceived over-diagnosis of PTSD, the

tendency to pathologize what previously would have been seen as normal suffering or a condition more closely associated with religious and spiritual distress. This was a fine line. If they pushed their criticisms too far, they ran the risk of confirming many of the suspicions that mental health professionals already have of clergy, that they do not have adequate knowledge of mental health issues and may in fact be dangerous to those seeking help.

As research on PTSD has become dominated by questions of biology, the questions of where we place the locus of suffering and how we understand the needs of distressed bodies and minds have increasingly been removed from the clinical context. Biopsychiatry, in contrast to the psychiatry that dominated the first two thirds of the 20th century, has little interest in how people create meaning, unless they can measure the hormones associated with memory and meaning. Young asks, "Will the hypothalamic-pituitary-adrenal axis and hippocampus replace mind and memory in efforts to explain the pathogenesis of this syndrome?" (2007: 173). Young's question points to the very real issue of how we understand suffering, where we place our emphasis in the kinds of treatments we develop for people in distress, and in what kind of self we envision.

Neurosciences

The recent rise of neurosciences is the latest development in therapeutic culture, subsuming everything from psychoanalysis to religion under its aegis (Rose 2003)**.** The adoption of neuro-scientific research strategies over the last 30 years has allowed psychiatry to regain its place within the medical profession and research sciences. Psychopathology is seen as the product of neuronal activity and hormones rather than psychodynamic or development. Much of the current research on PTSD, and mental

illness in general, has moved towards explanations of disorders that rely on brain scans and the measurement of chemicals like serotonin and dopamine. It is not surprising, then, that clergy would also take advantage of the status of these scientific theories in order to bolster its own claims, by trying to understand how religion impacts the brain and may act as a protective factor against psychopathology.

This was evidenced in many of the workshops and trainings that I attended. What would have been, in a previous generation, questions phrased in psychoanalytic language, were often phrased in terms of neuroscience and biochemistry (Luhrmann 2001). The concept of the unconscious has been replaced, by-and-large, by neuro-anatomy and biochemistry (Harrington 2005). The explanations for human "malfunctioning" would previously have been based on finding out family history and uncovering the impact of repressed memories rather than in brain imaging and laboratory tests.

A rapidly growing body of work trying to locate God (Newberg and Waldman 2007; Newberg and Waldman 2009) has been given great attention in the popular media. The primacy of brain sciences has given rise to a vision of "neurochemical selves," a reshaping of personhood that places the locus of experience and intervention in the brain (Rose 2003). In trainings I attended, therapeutic interventions were often framed in terms of their impact on the brain.

The neurosciences also presuppose a very different kind of therapeutic culture, one that, as I have been arguing, paradoxically opens up a larger space for religion and spirituality of a *particular* kind—the religion of health (Schumann and Meador 2003). Unlike psychoanalytic theory, the neurosciences largely leave questions of *meaning*

alone, which provide an opening for religious and spiritually based therapies to fill. Neuroscientists (Jeeves 2005) do not typically get involved with whether or not God exists, or with how one ought to live, but focus instead on the impacts of belief on the brain, or the parts of the brain that become engaged in religious practice**.** The traditional goals of religion are transformed from that of salvation to physical and mental health.

Religion and Health Today

In order for disaster religious and spiritual care to have taken root, many forces coalesced. A variety of actors were required, including the early work of Cannon and Selye, to organize and legitimate practices. That religion and health have become so connected at the end of the 20th century and beginning of the 21st century in the popular imagination, among research scientists at prestigious universities, and important religious figures (including the Dalai Lama), owes much to the broad cultural shifts I have been describing, as well as a specific scientific research agenda (Harrington 2003). But just as secularization was not an inevitable uniform process, the so called re-sacrilization that we are seeing today (Csordas 2009) is also the product of a diverse set of actors in institutional settings often working, unbeknownst to one another, towards ends that are dissimilar on the surface but end up reinforcing each other's agendas (Smith 2003).

Integrating various academic disciplines, including the body of research on the relaxation response that was spawned by the work of Cannon and Selye, the religion and health movement has received a great deal of attention in the popular media—in part because of controversial studies of intercessory prayer. The movement encompasses a number of sites and agendas with the broad program of bringing religion into medicine,

taking the latter closer to its roots under the general banner of proving the health-inducing impacts of religion and spirituality (Koenig 2002; Sloan 2006). Important because of its ability to garner funding for research on the health benefits of religion and to successfully publicize the results, figures like Harold Koenig have been key in building up the movement. One of the central sites for research has been Duke University's Center for Religion and Health, headed by Koenig. For the purposes of this dissertation, the religion and health movement helps to set the stage for the formation of disaster religious and spiritual care. The John Templeton Foundation, founded by the wealthy philanthropist John T. Templeton, has also been one of the key supporters of research on religion and health, supporting much of Koenig's research.

Spirituality, it is said by many disaster spiritual care providers, is different from religion because everyone has it: While religion is concerned with institutions and specific beliefs, spirituality simply refers to the search for meaning. And since everyone searches for meaning, it follows that everyone is spiritual—in one way or another. This provides an important justification for spiritual care. In fact, as a director of a large New York hospital's pastoral care department told me, hospital "pastoral care" departments in recent years have been changing their names to "spiritual care" departments, illustrating the move towards *spirituality* and away from *pastoral,* which has specific Christian origins. Combine this with a powerful scientific discourse that ties spirituality to better health outcomes, and the arguments for disaster religious and spiritual care being given a place at the disaster response table become stronger. It is into this thicket of mercurial discourse and practices that the response to the attacks of September 11th took place.

Part II

The Attacks of September 11th and the Consolidation of "Disaster Religious and Spiritual Care"

This section focuses on events that took place shortly before and after the attacks of 9/11, placing them in the context of the issues raised in the previous section. I look at different idioms that supply narratives for how to manage and interpret distress. Again, I show how the response took place within a network of historical narratives that have been reworked in different ways to construct the expertise of "disaster religious and spiritual care" (Harrington 2008).

Despite that the cultural trend in America has throughout the late 19th and most of the 20th century been towards an exclusion of religion from public institutions (a move towards "secularization" and an "exclusive humanism" (Taylor 2007)—the belief that human goals do not extend beyond a secular concept of the good), more recent movements indicate a resurgence in the force of religion in public arenas (Allitt 2003). Before 9/11 there had already been a shift towards the inclusion of religion in public culture, as evidenced by President Bush's Faith-Based Initiative (Daly 2006). Also in medicine and in mental health theory and practice, as indicated earlier, there has been a move towards integrating religion and spirituality (Harrington 2005; Sloan 2006).

As part of the research I conducted, I learned about a number of different informal arrangements between clergy and MH professionals that were in place before September 11th. One psychiatrist, for example, told me about how the local mental health clinic had a working relationship with a parish priest and the *Santeria* storefront. When a known neighborhood schizophrenic man showed up at either place acting in a disordered way—buying more candles from the Santeria store, for example, than he could possibly

use—they would call the clinic and someone would come to get him admitted to the emergency room, where attendants could then make sure he was properly taking his medications. Other examples include accounts of long-term relationships between clergy and therapists.

As one Methodist minister said when asked about referring people to MH professionals, "I just tell them that Jesus is a mental health professional." This simple sentence encapsulates much of the fusion occurring between religion and mental health. What may have in previous times been considered irreconcilable differences have, at least in this example, become reconciled.

Clergy have long been an integral part of the so-called de facto[12] mental health system; during times of personal distress Americans rely on clergy more than all mental health professionals combined (Wang et al. 2001). Many clergy that I spoke with reported taking congregants to emergency mental wards or to substance abuse rehabilitation centers. The disaster chaplains who I interviewed had hospital experience and many worked with the fire and police departments, and some had military experience. Fire and police departments have a long history of using chaplains, and I was often told that one of the reasons that chaplains were more important than mental health professionals in these professions was because those visiting the latter are stigmatized by their colleagues, raising worries about confidentiality. After 9/11 a great deal of attention was paid to the mental health of firemen and rescue workers, resulting in the Fire Department of New York City (FDNYC) opening up a counseling department

[12] I use this term to describe mental health services that fall outside the formal structure of mental health services. However, some members of the clergy that I spoke with took taken offense, suggesting that the term does not show adequate respect for their work.

to respond the mental health needs among their ranks. As one of the commissioners of the fire department told me, 9/11 made clear the mental health needs of firemen. "While they have often relied on chaplains," he said, "9/11 showed the need for integrating chaplains and mental health, and took away some of the stigma associated with firemen using mental health services."

On the mental health side, a group of disparate professionals have been responding to disasters in ways that parallel spiritual response. Military psychiatry and psychology has long provided a training ground and laboratory for theories of stress and trauma (Shepherd 2001). However, despite the long history of military psychiatry, a unified field of disaster mental health has only recently emerged, following 9/11, with significant force (Halpern and Tramontin 2007). As with their religious counterparts, they comprise a number of different, often conflicting, mental health professions[13]. In both cases, housing historically antagonistic professions under one canopy has helped to reframe jurisdiction: biopsychiatrists and psychodynamic therapists who might otherwise be at professional odds, become advocates of a new field of disaster mental health. It took September 11th and the inter-professional collaboration engendered by the disasters and the Homeland Security Act, which garnered funding for graduate programs and professional training in disaster mental health to consolidate this budding expertise.

The key difference in the way things were conducted before 9/11 and the way things are being conducted after 9/11 lies in the level of organization and attempts at

[13] Professional journals include *The American Journal of Disaster Medicine, The Journal of Homeland Security and Emergency Management, The Journal of Disaster Studies, Policy and Management,* and *The Journal of Emergency Mental Health.*

bureaucratic control. Clergy (and religious organizations), as already noted, have been involved in disaster response throughout American history (Rozario 2007)[14], and religion has long helped to frame response to disaster. In the twentieth century, the response of the churches predates concerted government response. But what happened after 9/11 does not have a precedent: the emergence of mental health professionals and clergy who sought to combine secular modern psychological techniques with religion and spirituality in a systematic way. One could always have gone to a church for counseling following a disaster, and many organizations had chaplains associated with them—including the Red Cross and fire and police departments—but they would not have been considered experts in disaster, and would have been able to offer few, if any, trainings that dealt specifically with the needs of clergy working in disaster settings.

In short, the relationships that existed were idiosyncratic, and not easily tracked by government and social service agencies. Nor were they monitored by a professional body, or identified as professional disaster experts. Ministers tended to know who in their community were in need of special care and could reach out to them accordingly during a disaster, or could send community members to visit them when in the hospital. But agencies were by-and-large not particularly interested or able to track these relationships in a comprehensive manner. After 9/11 this was increasingly seen as a

[14] Rozario writes, "Disasters (real or imagined) have from the first days of settlement played a vital role in shaping American religious beliefs and practices, political and economic systems, social relations, environmental outlooks, and identities. Despite the profound heartbreak, misery, anxiety, and terror occasioned by calamities, European colonists converted a troubled sense of themselves as a people of calamity into a comforting sense of themselves as a people of progress. They did so by imagining disasters as "blessings," as instruments of religious salvation, moral reformation, and (ultimately) material improvement" (2007: 32).

priority by government agencies and religious NGOs. A large mapping project was initiated to take stock of the NYC's houses of worship and their potential for playing a role in disaster preparedness plans[15]. Also, many clergy were trained in psychotherapy, had degrees in psychology or social work, or pastoral counseling (a profession that attempts to wrest help-seekers from secular mental health professionals). But there was no viable organized attempt to carve out a profession that reached across religions and denominational boundaries, providing religious and spiritual care in disaster settings. This marks a significant departure from how these problems were framed prior to the attacks of September 11th 2001.

The Attacks of September 11th 2001 and Responses

The attacks impacted both how we understand distress and the institutions responsible for responding to distress. These include federal, state, local and non-governmental relationships. These institutional structures are, of course, not separate from the concepts I have been describing, but rather embody and shape cultural idioms. Changes include: the creation of departments designed explicitly to respond to disaster on the federal, state and local levels; community based efforts at disaster preparedness; new partnerships between religious groups and government; and a widespread

[15] In 2007 New York Disaster Interfaith Services (NYDIS), one of organizations involved in preparing religious communities for disasters sponsored a project to map out all of the houses of worship in New York. "We've needed HOWCALM for 35 years," said Ken Curtin, a FEMA voluntary agency liaison, in a news release from NYDIS. "For disasters small or large, involving the faith communities is essential. They hold valuable information...Local faith organizations - churches, synagogues, mosques and temples - are an indispensable element in relieving peoples' disaster distress. HOWCALM will bring practical information to people, through their houses of worship, both before and after disaster" (Moyer 2007).

perception that the United States had entered a world of greater peril (Ursano et al. 2003).

While the development of a comprehensive federal disaster relief plan dates back to the Disaster Relief Act of 1950, 9/11 and Hurricane Katrina have contributed to the creation of a "culture of calamity" (Rozario 2007), a world where the possibility of large-scale calamity has become an increasingly prominent component of American life. On the local level, security has become a dominant discourse and an increasing fact of everyday life in NYC—baggage checks in the subway, and bomb-sniffing dogs in trains are only the most obvious manifestations of increased attempts at security and surveillance. The New York City Office of Emergency Management, a complex organization that includes everything from paramilitary to social work components, received increasing press coverage, moving from relative obscurity on to the front page of the *New York Times*. The merging of natural disasters and "man-made" disasters, together with military and intelligence response, increasingly punctuates a new disaster model. One impact of 9/11 was that it helped to consolidated federal power, leading to large government allocations for disaster preparedness and response, helping to form an age of "permanent disaster" (Rozario 2007: 25). The transformation of national security into a "disaster-security state" where both official and more secretive agencies have been granted a remarkable degree of power (often under the aegis of disaster relief and prevention), has widespread implications for governance and delivery of services, both for disaster recovery, as well as in times of relative calm (ibid. 25). These changes in American culture, as I have been arguing,

have helped to create an opening for new expertise, including “disaster religious and spiritual care.”

The anxiety produced by the governmental emphasis on disaster (Schoch-Spana 2004) provides some of the impetus, as well as funding and official governmental recognition, for “disaster religious and spiritual care.” The “disaster security state” provides the structural openings for new forms of governmental relationships with religious communities. The faith-based initiative sets the stage for an increased government emphasis on the role of religious groups in social service provision, and the disasters, as I have been arguing, only increase the perception that religion is needed to deal with the crises at hand. The tropes of holism, described above, and anti-government rhetoric that jibes so well with psychological theories of resilience, thereby lend increased support to the ideological underpinnings of the recent governmental intensification of the security state.

Disaster response has a long history in the United States, with much of the burden born by religious groups, as the federal government did not develop a concerted response until the middle of the last century (Rozario 2007). The American Red Cross (ARC) was given a charter in 1905 by congress to respond to disaster, providing shelter during famines, fires, and other catastrophes. ARC was designed as a neutral organization, remaining independent of religious groups and politics. While faith-based organizations have long supplied material resources, prior to the mid-nineties there was no specific organization mandated with providing spiritual care in disaster settings. This changed after several airline crashes in the 1980s and 1990s led to congressional hearings over the response of the National Transportation Safety

Board and ARC. Chaplains from several accrediting organizations were called upon to create the Spiritual Care Aviation Incident Response (SAIR) team, marking the novel creation of a dedicated spiritual response effort to disaster (Sutton 2004). The SAIR team, though, was designed solely to respond to airline and transportation disasters. Moreover, the original legislation indicated that families had been disapproving of the way airlines had handled the remains of victims and of perceived insensitivities to families of survivors. It did not explicitly mandate religious and spiritual care. This is important because many of the clergy I interviewed claimed that this legislation did, in fact, provide them with a legal and moral mandate[16]. Following the attacks of September 11th, the SAIR team was mobilized and chaplains from around the country arrived in New York City to oversee the provision of spiritual care. They screened over 500 chaplains between September and December of 2001, at which time the region Red Cross office took over. Many of those involved with the original SAIR team have become local and national figures in "disaster religious and spiritual care," authoring books, heading organizations and departments, as well as providing training for clergy around the United States and beyond.

The clamorous debates within academia and the popular media over the mental health response to the attacks of September 11th (Satel 2003) point to some of the perceived inadequacies of how mental health professions have responded. The massive influx of therapists and crisis counselors, as well as the often-mandated therapeutic processes, led to an important cultural backlash against mental health professions, in turn providing an opportunity for enhanced cultural legitimacy of

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[16] Sutton (2002), who conducted dissertation research shortly after the attacks of September 11th, had similar findings.

religious response. Theories of debriefing that previously had wide appeal were jettisoned, and even ridiculed, by the psychiatric establishment following 9/11(Groopman 2004). Importantly, the attacks led to the largest single financial output for mental health services in history (Seeley 2008: 13), creating a network of mental health organizations—including Project Liberty—with widely advertised services.

"Not only were the events of 9/11 beyond the reach of everyday language," writes Karen Seeley, "but their psychological consequences also defied classification in the specialized categories of the mental health professions" (2008: 12). If they could not be categorized by the supposed experts on distress, who then could be trusted, who might have the ability to understand and heal? The religious community was poised to seize the cultural moment and assert their historical claims to jurisdiction.

Disasters and American Optimism

As an example of the way deeply ingrained idioms shift over time, providing the scaffolding for a variety of religious and psychological ideas, American optimism has played an important role. Since the colonial days, Americans have seen in catastrophe and suffering a road towards salvation. The idioms that frame our range of experience reach back to times when religion was the dominant matrix in which suffering was experienced, working their way into secular settings as well as influencing religious narratives of disaster-related suffering and redemption. Phrases like "this is God's will" or "a blessing in disguise (Rozario 33),"though perfunctory and clichéd, point to important psychological and religious themes. Contemporary views of disaster as a chance for emotional growth have strong connections to biblical themes that find their

way into self-help literature, and have shaped 19th century American religious movements such as New Thought and Christian Science. Positive thinking has a peculiarly American history, one that has roots in Colonial American religion and is intimately connected to conceptions of virtue and worth, as well as moral, spiritual and economic growth. The contemporary interweaving of biology, religion and positive thinking makes for a powerful combination when ignited by disaster. The compelling American vision of disaster as chance for growth— be it religious, psychological or economic—has many adherents.

The bestselling *Power of Now* (Tolle 1999) is just one example in a seemingly endless tide of publications on the power of positive thinking, an American genre that has widespread influence in health settings, and has become associated with research intent on proving the positive correlations between positive attitude and health outcomes. The social critic, Barbara Ehrenreich (2007), in a recent piece on her struggles with breast cancer, was so frustrated with American versions of positive thinking that she began an essay with the words "I hate hope…" in reaction to American breast cancer groups admonishing her to maintain positive thinking. A great deal of research in positive psychology (Seligman 2002), which has some theoretical similarities to studies on resilience, seeks to correlate positive attitude with improved health outcomes.

Herb Trimpe, a chaplain who worked at Ground Zero and who I interviewed, wrote a book about his experiences called *The Power of Angels: Reflections from a Ground Zero Chaplain* (2006). An example of the kinds of religious and spiritual transformation that emerge from disaster setting, this book charts his journey,

Dantesque, as a ground Zero Chaplain. Trimpe, a former comic book writer, developed a new relationship to his Christian faith and points to how people might view the "positive" side of disaster. What's more, the idea of seeing the Earth as a larger Ground Zero is a compelling religious and ethical statement. "What if people addressed all of our current social problems with the urgency that they addressed Ground Zero?" He writes

> I think I saw religion at its best at Ground Zero, doing the thing it knows how to do best, working in total cooperation across theological lines. There were no programs or committees, just people for people. If we could only see our Earth as a larger Ground Zero, where tragedy happens daily, where the pieces of broken lives have to be put back together again, we might go a long way toward understanding and peace in the world. We are here on Earth for one another (2006: 18).

Chaplains I interviewed echoed this kind of positive statement. Also, as Rozario (2007) describes, this sensibility is part of the history of American reactions to disaster, which frames them in a positive light as a way to grow personally and often economically. The religious are often prone to see disasters in light of what can be learned, and how people grow morally and spiritually. While Trimpe poses a particularly progressive understanding of Ground Zero, the tendency to view events in a light of positive growth seems embedded in a style of American spiritual reasoning (Fuller 2001). This style of reasoning has long been characteristic of an American version of therapeutic religion.   Norman Vincent Peale, minister and popular author of the *The Power of Positive Thinking* (1952), is one of the most famous exemplars of this tradition.

The Concept of Resilience

Resilience is defined as the "ability of adults in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event, such as the death of a close relation or a violent life-threatening situation, to maintain relatively stable, healthy levels of psychological and physical functioning" (Bonanno 2004). Recent years have seen a growth in research on resilience (Pargament 1997), in part as a corrective to what many have seen as the over pathologization of reactions to trauma and loss by psychologists. More recently, research on the relationship between resilience and religion and spirituality has increased. During the course of my fieldwork, resilience was often invoked to argue for the positive impacts of religion as a way of coping with disaster or as a "protective factor." Religion and spirituality easily merge with research on resilience because of the ways that resilience scientizes what were historically valued religious or moral characteristics: courage, hope, positive thinking, and belief in something greater than one's self can all be studied under the banner of resilience. Also highly political and important for developing policy, the concept of resilience, as opposed to deficit models of human behavior, suggests a self that can recover—or even grow and become stronger—after disaster or loss without the aid of experts. Clergy often use the term resilience to point to the utility of religion and spirituality in preventing psychological problems, and allowing people to get through trying times.

The politics surrounding PTSD, resilience, and experts, link concepts such as distress to nationalism, and concerns over the health of the national body. This has been the case in various times throughout the 20th Century (Orr 2006). The politics of the mind and body, post 9/11, attest to the complex and deep relationships between the individual suffering body and the social body (Satel 2001). The emphasis on resilience is

part of an historical discourse that centers on the needs of suffering bodies and minds, which marks an opposition to perceived over-pathologization of disaster-related distress by mental health professionals. As a manifestation of American optimism, resilience, along with "post-traumatic growth" and positive psychology, taps into a powerful and compelling discourse, giving it widespread appeal in the "disaster religious and spiritual care" world.

As one disaster chaplain said, "Prayer creates resilience, it centers people and calms the stress response. When the body is stressed it loses equilibrium—prayer and meditation can bring back homeostasis." If extreme life events cause stress, and religion or spirituality reduce stress, then someone who wants to reduce their stress would do well to find a home in a religion or spiritual practice.

Conclusion

To conclude, the expertise of "disaster religious and spiritual care" finds its niche amidst intersecting discourses and practices of religion, science, mental health theory, and American tropes of optimism, which significantly impact how distress is understood and treated today. Scientific discoveries have allowed for the coupling of religion and stress studies, and more recently the connections among resilienc, opitimism and spirituality.

The combining of religion and secular psychological models into a specific expertise on disaster marks an attempt by clergy to reclaim their erstwhile historic jurisdiction over disaster-caused distress. Having lost its cultural authority to the ever-growing ranks of mental health professionals beginning in the late 19th century, religion

had been in retreat, relinquishing the "diagnosis" and treatment of personal problems to mental health experts. Scientific attempts to prove the health benefits of religion are a way for religion to regain some authority, ironically by adopting the very tools that played a critical role in putting religion on the defensive. As I have shown, however, lines are not so easily drawn—what were once considered to be competing frameworks of religion and science now coexist in seemingly commodious ways.

As part of understanding how an expertise like disaster and spiritual care has been able to get a foothold and find its niche in the contemporary thicket of expertise, it was necessary to trace some of the history of secularization of suffering. Stress, as I have shown, plays a central role in this story because of its ability to connect many different kinds of experiences, including subjective psychological states and physical ailments, as well as providing the framework for incorporating ideas of optimism and resilience into thinking about health. It is by understanding the complexity of cultural processes, the layering of concepts like spirituality and mental health—he lifting and folding and sedimentation of beliefs and practices over time—that allows for a deeper understanding of what is at stake in the chapters that follow.

Summing up much of what I have been describing as the goals of "disaster relgious and spiritual care," one male chaplain and director of a religiously-based disaster response organization said,

> The most important thing is understanding that as shepherds, that parental relationship we have with our communities, is about safety wellness, resilience and wholeness of their created being. We represent the hope of the people of God in times of crisis, and the leadership, moral and ethical, that the community must live under in times of disaster.

Wholeness and hope, safety, resilience and wellness set against the imposing forces of anxiety-inducing disaster may, he is suggesting, provide the only possible ballast in the face of calamity. Like Herbert Trimpe, the author of *The Power of Angels Reflections from a Ground Zero Chaplain (2006),* the above quote shows how the connections among fear for safety, the search for spiritual wholeness, religion and crisis, merge in this "New Age of Anxiety."

In the next chapter, I turn to organizations that have been key players in the formation of disaster religious and spiritual care in New York City.

Chapter Three

From Individuals to Disaster Organizations

Introduction

This chapter focuses on key organizations involved in disaster religious and spiritual care in New York City. It examines the way individuals interact with these organizations, and how personal experiences in disaster work shape career trajectories, which in turn influence the development of the organizations themselves. It focuses on several key players: New York Disaster Interfaith Services, Disaster Chaplaincy Services and its former incarnation, the Center for Disaster Spirituality. Because disaster recovery spans a wide range of organizations, particularly after an event with an impact as widespread as the attacks of September 11th 2001, I also include representatives from several other organizations that played important roles in disaster religious and spiritual care recovery work. These include the Red Cross, The New York City Council of Churches, and The Board of Rabbis.

As mentioned in chapter one, religious disaster response has often been rife with conflict played out across religious and sometime racial lines. In my interviews and meetings attended, I observed conflicts over jurisdiction, prestige and resources. One of the most contentious issues in the disaster religious and spiritual care world—nationally, locally, and to some extent between government bodies like the Office of Emergency Management (OEM) and NYC Department of Health and Mental Hygiene (DOHMH)—concerns the power to credential. Because developing relationships with government organizations allows religious organizations to garner greater funding and prestige,

competition over recognition among organizations was often contentious. And because these organizations are religious, issues of theology, funding, mental health practice and governance get played out in credentialing debates.

I will show how those arguing for the inclusion of "disaster religious and spiritual" care marshal an array of scientific and moral justifications. Organizations that have been active in developing "disaster religious and spiritual care" base their arguments on a set of assumptions that have their basis in the discourses that I described in chapter II. Spirituality, many argue, has a unique role to play in alleviating disaster-related distress. Clergy aim for exclusive jurisdiction over the domain of *meaning*. Their expertise is distinguished from mental health professionals by virtue of the fact that they represent a higher power, and a different way to heal trauma. Strategies for justifying the role of religion and spirituality in organizational settings centering on how to define this expertise in a way that maintains some sense of religion but does not alienate those who may be less than friendly towards religion.

Organizations and Their Dynamics

In November 2007, I had been working in the disaster and spiritual care world for three years, and could recognize a fair number of faces. When I arrived at The Goldman Center of New York University, the elevators were filled with Rabbis, Imams, Buddhists, Russian orthodox and Catholic priests. Two screens in the large conference projected multi-faith, multi-ethnic photographs—Ground Zero, policemen with clergy and firemen. The room was partially filled with nearly 200 people, including the Commissioner of the New York City Office of Emergency Management, and the Deputy

commissioner of the Department of Health and Mental Hygiene, who gave a peculiar speech about his experiences in Rwanda as the head of the Red Cross. "This country needs to develop a culture of preparedness," he repeatedly said to what appeared to be an approving audience of technocrats and clergy. A meeting like this in NYC would have been nearly impossible before September 11th 2001. An organization like NYDIS would not have developed a 4 million dollar budget and attract attention from Mayor Bloomberg. Religious organizations like NYDIS were able to take advantage of several developments: the faith-based initiative, and post-9/11 disaster funding and the general fear of future disasters.

Prior to the attacks of 9/1, there was one organization in New York City attempting to represent religious groups during disasters. The Center for Catastrophe and Spirituality (CCS) had begun meeting a year before 9/11 to design training for clergy providing care in disaster settings. Many of those in the organization had been involved with the Spiritual Aviation Incidence Response (SAIR) team. A year or so before September 11th, they had developed a curriculum for training clergy on mental health issues.

There are currently two main religious organizations involved in providing training and disaster relief services in New York City. The New York branch of the Red Cross, which initially housed the Center for Catastrophe and Spirituality, has long maintained collaboration with clergy. Following 9/11, they provided office space for CCS but because of their mandate to remain secular, about a year and half later the CCS asked them to leave. Despite their "neutral" status and their avoidance of intra-religious politics, their willingness to work with religious organizations has been an important

way for disaster religious and spiritual care to claim legitimacy. Because the Red Cross is the oldest and most established disaster relief organization and one of the first to make emotional and mental health problems a prominent part of their work, religious organizations that partner with them see themselves as gaining greater credibility (Halpern and Tramontin 2007). The CCS tried to maintain a close affiliation with the Red Cross after they were asked to move. But the Red Cross felt that housing a religious organization could compromise them. The Rabbi who was directing CCS at the time said, "We have had good working relationships with the Red Cross but we had to move because they didn't think it was a good idea to house us. It was potentially problematic, compromising their mission."

New York Disaster Interfaith Service (NYDIS), an umbrella organization that coordinates the local religious response to disaster, arose shortly after the attacks and has become the most well-funded and connected religious disaster organizations operating in New York City. They offer a wide array of direct services, outreach and training activities for New York congregations. Their main goals as stated on their website are to facilitate the delivery of services, resources, and information to religious communities, as well as to under-served individuals, populations and impacted communities, and to provide a coordinating function for disaster-related planning and preparation for religious organizations. They continue to provide an unmet needs table—a meeting of social service agencies that review requests for assistance—for those in need that have fallen through the cracks of 9/11 related services. NYDIS has an active engagement also with National Voluntary Organizations Active in Disaster (NVOAD), a member organization that coordinates disaster organizations nationwide.

As Gary, a director of a faith-based disaster organization pointed out, recent disasters have been bringing about novel forms of government alignment with religious organizations, with memorandums of understanding between governmental organizations like the New York City Office of Emergency Management and religious organizations, for instance. Again, it is clear that while the faith-based initiative was underway before 9/11, processes already started have been intensified. The attacks further supported the preexisting niche for spiritual care, causing forces to realign in unforeseen and perhaps unprecedented ways have built on cultural momentum.

For example, efforts of clergy to create training programs for disaster religious and spiritual care following the Oklahoma City bombing of 1995 became an important resource for 9/11 recovery workers, and perhaps more importantly the work of the SAIR team (described in chapter II) providing the prototype for the disaster chaplain. Disaster experts move across the globe, altering their methods based on new experiences and disseminating knowledge to emerging would-be disaster professionals. By nature, disaster professionals are itinerant and the various subfields build on both the individual experiences of those working in disaster, and the research from different disasters, which results in novel theories. Conferences I attended in New York City often had chaplains coming from the Gulf or returning from Indian Ocean Tsunami recovery work. I observed an emerging culture of global spiritual care workers—people who knew each other from multiple disasters around the world. A fellowship of suffering characterized some of their interactions—the extremity of destruction and the kinds of emotional and spiritual problems they encountered.

Credentialing: Rationales and Conflicts

“All kinds of clergy were flocking to New York and many of them didn’t know what they were doing. We had high level people, like bishops, that we had to ask to leave. This created problems—and resentment.” “Training [mental health] is necessary,” recounted Rabbi Feinstein, describing the problems she saw at Ground Zero. The request trainings for clergy on disaster mental health have multiplied over the last seven years.

When I began this research, I had not worked with the religious community before, and was startled by the high degree of animosity between organizations involved in disaster work. What I encountered was a maelstrom of difficulty. From my first interview in the winter of 2003, I found myself in the middle of personal difficulties, organizations vying for control of resources, and status. It was clear from the start that the conflicts were not strictly of a professional nature, and had much to do with the emotional nature of the work: people who spent days working in Ground Zero counseling families and rescue workers, were not necessarily in a frame of mind to take a step back and see what was going on. There was a high degree of mutual suspicion. Some refused to speak with me because they thought I was associated with rival organizations. Others seemed to think they could use me to represent their organizations by describing them in a good light, or helping them find funding. In one of my first conversations with one male rabbi who was part of a disaster mental team, I was told, “You may hear some bad stuff about me from others. But don’t pay attention to it.”

Since that time the infighting and difficulties have often been commented upon by those working in disaster fields in NYC. One minister even called the competitive bad

feelings, "9/11 syndrome," referring to the pervasive backbiting and bad feeling. "We must stop this," she said in a sermon-like cadence.

> We can't let ourselves be petty and backbiting. We need to work through our traumas and learn to really love each other. All of this gossip and fighting and competition, it's like a 9/11 syndrome, and we need to stop it. Egos get in the way. Everyone's busy keeping their own turf. As nasty as it sounds, it's true. As humans we want to protect ourselves, where we work, our families.

This was a frequently talked about issue—the infighting, gossip and badmouthing that took place after September 11th. I was constantly told that different people involved in disaster spiritual care were incompetent, selfish or even corrupt. Many felt, in particular, that NYDIS was using strong-arm tactics, trying to bully religious groups into signing on with them. Even now, 7 years later, at conferences and meetings, there are leaders of organizations that refuse to talk to each other because of perceived sleights. As one white male psychiatrist who was involved in 9/11 recovery and has maintained an active role in disaster relief said, "People are traumatized and continue to traumatize each other."

Religious groups, of course, have long histories of conflict and mistrust, internal to denominations, between denominations and among different religions. The Jewish community, for example, has no central authority. The New York Board of Rabbis, for example, has no power to make decisions for congregations, and only represents a small number of largely conservative synagogues. Catholics, in contrast, have a very hierarchical system of governance, and have a great degree of power in New York City.

The problems of credentialing then touch on many thorny issues including theological differences, competition over congregants, personal grudges, and long-standing political affiliations between different religious groups and New York City

government offices. Compounded by the contentious Jewish-Muslim situation and the heightened sensitivities following the attacks of 9/11, a highly emotional and potentially volatile set of challenges characterized efforts to organize these groups to work together. I was told on several occasions that New York Board of Rabbis would not sign on to NYDIS unless the Muslim affiliate group signed an agreement denouncing terrorism. While I was unable to confirm that this was in fact the case, the story was told in a manner that was meant to paint the Jewish community as unreasonably difficult because they did not want to cooperate—though their lack of cooperation could have been for any number of other reasons.

After the attacks, clergy and mental health professionals were forced to work together to care for wounded bodies and souls. For the most part, relationships between mental health workers and faith leaders have been amicable, though faith leaders have reported some inappropriate responses by other faith leaders: the irresponsible use of theology, a deviation from what can be considered the norms of therapeutic intervention as adapted to pastoral care from secular psychological counseling techniques. These include proselytizing, judgments of sin, comments about retribution or "will of God" statements, which are forbidden by mainstream disaster response organizations, and continually restated in the "disaster religious and spiritual care" literature as examples of poor practice. In order for clergy to find a place in disaster work, they have to jettison much of their traditional role as religious shepherds. An adherence to the division between mental health theories and theology is, at least on the surface, required. This idea was oft repeated in interviews and training documents. Clergy must not proselytize and should not even introduce the topic of God unless the person they are talking with

mentions it first. It is difficult from our current historical position to understand how radically different this perspective is from the role of clergy in the previous century, when it would be assumed that they would talk about God and that their work was not beholden to the needs of another group of professionals (Taylor 2007). The question then becomes what kinds of expertise are they offering if not a connection to the divine, and what criteria can be used to judge the qualifications of clergy working in disaster settings? The contested arena of professional credentialing illustrates some of the conundrums inherent in the creation of "religious expertise."

"Credentialism," writes Freidson, "works to produce an occupational cartel, which gains and preserves monopolistic control over the supply of a good or service in order to enhance the income of its members by protecting them from competition systems" (1970: 63). Religious credentialing, however, poses unique problems because of the reluctance of government entities—because of America's stance on separation of church and state— to regulate their activities and because of the lack of cohesion among religions. This mutual obligation of religion and government to maintain their separate spheres of influence has been a defining feature of American politics, which has recently been challenged by the successful entrance of Christian groups into public debate (Allitt 2003). The division among religious groups are, of course, complex and varied with histories stretching back thousands of years, and any attempt at inter religious dialogue becomes hazardous, as I was often told, and witnessed at some meetings.

In order to understand some of the problems of credentialing associated with "disaster religious and spiritual care," it is necessary to look at their legitimating rationales. These arguments provide the parameters for credentialing—who should be

included, why and what kinds of work are appropriate for disaster spiritual care provider, and defining the skill set necessary to work in disaster settings. It has been crucial for disaster religious and spiritual care to distinguish itself as an expertise from mental health professions, while at the same time not appearing too far from the norms of psychological intervention.

Professions and expertise rely on credentialing to ensure control over a particular arena to define and monitor competency. According to a recently published manual,

> Spiritual Care also has the capacity to damage vulnerable persons if performed in an inappropriate way. Because of this delicate reality, it is crucial that agencies and groups providing Spiritual Care adhere to common Ethical Standards and Codes of Behavior (Light our Way 2006: 15).

As one head of a religious organization said, “We need national certifications but there’s no way we are going to get people to agree on these. We can’t even get people in our own city to agree.”

Credentialing then becomes an arena where many conflicts come into play. There are issues of funding, politics and control over how to interpret distress, as well as turf wars on individual, local and even national levels. In the end, the government bodies have, by and large, waited for the religious groups to sort things out on their own, not wanting to enter the thicket of religious conflicts, even though they have readily seen clergy as a potential asset in disaster response, and have developed trainings and liaisons through several NYC agencies.

As one government official said, “We want to include the faith community in disaster response. But we can’t get overly involved. We need to wait for them to work things out and come up with their own standards. It’s the separation of church and state. People would be outraged if we started telling church groups what to do. But on the

other hand, we can't just have anybody getting badged and coming into disaster situations."

The Role of Government

At a large conference for clergy on disaster preparedness held in 2004 at New York University's Kimmel Center, the director of a disaster relief organization spoke passionately about the need to support the work of clergy in disaster setting. "The city needs the churches to be involved," he said. "Disasters occur locally and people recover locally. We cannot depend on the federal government to intervene. We need to be prepared." Questions about the role of houses of worship and the extent to which government should be involved in keeping information on them repeatedly came up. There were those that I interviewed who had a great deal of suspicion about government's intentions. Reverend Green, an African American minster in a large New York City Church did not trust efforts to bring clergy into government disaster response plans. "We have been terrorized for years and that's not going to change. Now we are doubly terrorized—by the terrorists and our own government and police."

One informant, a middle-aged man from the Middle East, who works for a large government organization in NYC, said we are not the "emotional sheriffs." What he was referring to was the ways in which reactions to disasters have been made into "emotional" problems rather than material problems. Instead of providing resources in the form of information and adequate services, organizations like the OEM bring in mental health professionals to deal with angry crowds. After the explosion of the water main in Manhattan, he explained, the disaster mental health division received a call from the office of emergency management saying that they needed mental health workers to

deal with angry crowds. My informant told them that they didn't need mental health, but needed to give them some information about how to get home and about what was going on. "Of course they are angry," he said. "They want to get home and can't." Like some of the clergy I interviewed, this government official was suggesting that the emphasis on mental health professionals was overkill: people do not necessarily require counseling or mental health interventions after a disaster. This official had also been the disaster liaison to the religious community in the DOHMH. He had spent a great deal of time educating clergy about disaster and conducted his own research on the role of clergy in the mental health system. The deemphasizing of mental health needs also resonates with the resilience concept, which sees itself as countering the pathologizing tendencies of mental health theory. As discussed in chapter 2, this increasingly popular perspective, marks a widespread shift in psychology (Pargament 1997) that has important policy implications for how we understand the needs of those suffering from what might be considered traumatic events.

One head of a religious disaster relief organization, when asked about the changing role of government in disaster response, told me that after Hurricane Katrina, FEMA hired clergy to identify bodies. "This might be the first instance of a direct hire by the federal government of clergy in disaster response." While I was unable to confirm this story, there was a clear perception that government on multiple levels was interested in working with clergy in novel ways, and that clergy themselves felt there was a great deal that they could offer.

Creating the Super Chaplain

While it is difficult to pinpoint the source of institutional acrimony in individual psychology, it was clear from my observations that disaster work tends to draw particular kinds of people--not surprisingly, those who are for various reasons attracted to intense experience. Many I spoke with expressed frustration over difficult and emotional group dynamics at meetings and within organizations. As I mention above, one minister described the high levels of tension and disagreement among religious groups involved with disaster recovery as "the 9/11 syndrome."

"Disaster work," as one of the directors of a disaster religious response organization said, "has a tendency to create the Super Chaplain." While some have argued that disaster can bring out the best in people and cause "post-traumatic growth," when I asked what he thought about the idea, he replied,

> That's bullshit, there's no such thing. Those people are fucked up, the ones who say they are growing from disaster. Those are the ones who you have to watch out for, the super chaplains who have found new meaning in life in disaster work.

The "Super Chaplain," he went on to explain, consists of an emerging group of religious leaders who have found new meaning to their lives in disaster. "They go to all the trainings and conferences and have become self-styled gods of chaplaincy." This description of the super chaplain, while perhaps exaggerated, shows awareness within the disaster world of a professional culture that attracts people who are working through individual level problems by taking on the role of a disaster caregiver, though of course the person describing the super chaplain exempted himself from this description. But the level of emotional intensity among disaster workers is something I witnessed numerous times, which surely played a determining role in creating organizations.

Justifications for Including Religious and Spiritual Care in Disaster Response

Spiritual Labor

The National Voluntary Organizations Active in Disaster's handbook on disaster defines spiritual care as:

> Anything that assists an individual, family or community in drawing upon their own spiritual perspective as a source of strength, hope and healing. In disaster, anything that nurtures the human spirit in coping with the crisis is Spiritual Care. Religious Leaders naturally provide care for their own congregants, members, and parishioners in a manner imbued with the symbolism, meaning and resources of their own faith traditions. In fact, for individuals who belong to particular communities of faith, their own clergy and religious leaders are usually the best persons to offer them Spiritual Care in times of trouble. Disaster Spiritual Care, however, can be quite different. In Disaster Spiritual Care, Spiritual Care Providers may not share a religious or faith tradition with the individuals, families and communities for which they care. Indeed, the recipients of the care may not belong to any religious community at all. Thus, Disaster Spiritual Care endeavors to provide sensitive, appropriate care for all persons and to celebrate and respect every spiritual perspective (Light our Way 2006).

This broad mandate universalizes the need for spirituality creating a potentially endless demand for spiritual care. *Anything* that assists families in recovering can be considered spiritual—and, also, the actual faith of the care provider is largely irrelevant. Instead, it is the quest for meaning that defines spiritual work, rather than belief in a specific deity or adherence to a religious doctrine.

Spiritual "work" may be done for many reasons, including prestige, money and even salvation. But many clergy do not get paid at all for disaster work, and unlike most other professions, clergy are motivated in large part by something other than conventional economic incentives. The dynamics underlying motivation are not necessarily the same as those of secular motivation. Like Hochschild's (1983) concept of emotional labor, spiritual labor is built around creating a perception of religious altruism and caring for those suffering that differs from labor that focuses strictly on

economic gain. Many I interviewed spoke of this religious and psychological sense of mission. "We all carry tears, and part of our work is to help others carry their tears—we all have our traumas," said a Baptist minister whom I interviewed. Statements like this describe a universal sense of suffering and a conception of care that differs from secular views of care. The valuation of suffering (Bowker 1970) lends to disaster work a meaningfulness that can be seen as payment in itself. The tendency of anthropologists to interpret actions in terms of rational economic models obscures the possibility that clergy may genuinely have other motivations, and may have subjectivities formed differently than non-believers (Proudfoot 1985). This is not to say that religious people are more altruistic, but rather that their actions take place in a social field that may differ from those who do not believe. While they may be looking for "payoff," the kinds of social rewards garnered in spiritual labor have more to do with appearing to be selfless than in climbing organizational ladders or financial reward. The kinds of suffering one witnesses, the extremity of destruction and the symbolic nature of the disaster itself, plays an important role as well.

As one white male minister said, "We step into the burning pit in order to fulfill our missions." The burning pit he referred to as disaster work could also be a reference to hell or the apocalypse. Many disaster religious and spiritual care workers are volunteers, even at higher levels. Reverend Simpson, a white female Episcopalian in her 40s, whom I met at a conference, said her motivation for the long hours and difficult work stems from her own sense of connection between the traumas she witnessed as a child and a spiritual view of injustice, a calling to do God's work. "I work in disasters," she said, "not because I have interest in financial reward but in part because it is a

calling. I know what it feels like and I know I can help others walk through it." Referencing a deeply held Protestant belief in the importance of following ones Godly mandate, she finds a sense of order in flaming buildings and flooded streets.

Spiritual labor, however, also has an economic component, which often went unmentioned by those I interviewed. Clergy often provide free volunteer labor during disasters, as I mentioned, absorbing some of the burden of care. Also, rhetoric of volunteerism appeals to the American sensibility, and as some clergy argues, is a more genuine form of care than paid labor. This conception of care coming from a deeper spiritual source constitutes a powerful rhetorical claim.

Emotional Rationale

A minister who I interviewed spoke of the tension between clergy and mental health professionals that resulted from 9/11:

> During 9/11 psychologists came out of the woodwork to help but were not prepared for acute psychological trauma. They were used to providing long-term care. Many burnt out. People wanted to talk to clergy. If mental health is going to be involved in acute care they need to learn.

This kind of statement was often made, indicating the general perception among clergy that they were in fact needed—not only needed, but that there was a special demand for their services by those suffering from the disaster. The view that families demanded that religious and spiritual care be provided after plane crashes (Sutton 2004), provides organizations with a claim to moral authority with great emotional appeal. Families of those who were killed in the plane crashes were seen as victims of heartless experts who were unable to address the *real* needs of those suffering. The notion that

religious leaders, on their account, are better able to understand those needs specifically because they do not pathologize, was an oft-echoed sentiment oft-echoed.

Rabbi Solomon Singer, an active presence in the New York City and the national religious disaster relief community, as well as the founder of an organization for training clergy in disaster response, defined good religious and spiritual care as follows:

> Lots of listening very little talking. Appropriate questions that get people to really talk about what they are experiencing. What they are feeling so that they are not going through it alone. Somebody that's been through let's say a 9/11 experience. It's helping as quickly as possible relive their experiences so that they don't end up with PTSD or other things. Research has shown that people who cannot articulate for whatever reason they experience they have gone through are at much greater risk for having PTSD because they can't make meaning of it. The person who saw people fall from the Trade Center and can't talk about it is at a much greater risk than the person that can talk about it. And some of the meaning that we help people come to is that sometimes there is no meaning in what people see, but that meaning if you can't even touch it begins to overwhelm the psyche, and that's good spiritual care helping people early on. And also good spiritual care is helping people understand what common reactions to uncommon situations are. I intensely dislike the word normal because normal implies that there is a psychological and mental health component to it. There is no normal experience. There are common and healthy and unhealthy reactions to an uncommon situation, and good spiritual care helps people understand what common experiences are and when they are no longer uncommon. What are common unhealthy experiences and helping people understand that certain things they do are common but unhealthy.

Singer sees spiritual care as providing an antidote to the tendency of mental health professionals to pathologize reactions to disaster. But this perspective on healing still mimics a conventional psychological belief in the need to speak about an event and to articulate a narrative—create coherence in the face of maelstrom— in order to prevent normal reactions from becoming PTSD. Far from a religious or spiritual argument, the Rabbi's statement upholds one of the dominant religious/psychological dogmas.

A female minister explained the key differences between religion and mental health, "Unlike mental health, we can walk next to them, cry with you."   Defining religious and spiritual care as emotional rather than mechanistic, as addressing the whole person as opposed to pathology, goes to the heart of the argument. Her speech links pathologizing, and mechanistic views to dehumanizing practices. Spiritual care is associated by clergy with the expression of authentic emotion, whereas mental health care is associated with mechanistic fixes. In the logic of the argument, this can be seen as an entirely different model, connected to the divine, *or*, importantly, a psychological impact that clergy can have that differs from mental health professionals.

Psychiatric and Spiritual Diagnostics

Underlying the claims to expertise are particular ideas of distress and suffering—that one's "spirit" or "soul" can be affected by suffering, and that mental health professionals are not equipped to treat the soul or spirit. This assumes that it is possible, at least on some level, to distinguish psychological pain from spiritual or religious forms of distress.

Religious and spiritual care providers often argue that there is an over-diagnosis of PTSD, the pathologization of distress, which some claim undermines the natural resilience and healing of those in distress. Since religion and spirituality do not pathologize distress, the argument follows that clergy can address suffering in a way that does not pathologize, tapping into the spiritual resilience that they see in everyone. Rather than seeking to label, they say that they address the whole person. Just "being present with the suffering and pain" was a phrase frequently used.

Harry, a young male Methodist minister, illustrated the pervasive belief that people are intrinsically spiritual, and disasters bring out that spirituality.

> People are more likely to go to clergy in the wake of a disaster because they are readily accessible within a tangible, solid structure within every community. In times of crisis, people naturally seek spiritual guidance due to the deep human need for ritual and community among the living and the dead. The shrines people spontaneously erected at Washington Square Park and the various firehouses after 9/11 complete with candles and offerings. These shrines were set up as places where people could commune with each other and pay their respects to the dead. Even without church, people will become spiritual leaders to each other in times of disaster.

Many of the debates around the role of religious and spiritual care center on how to interpret distress. The fears of clinicians and mental health professionals about the ability of clergy to both put religious beliefs aside and to understand the nature of mental distress lies at the center of how the expertise of disaster religious and spiritual care has been created. Manuals and trainings are often at pains to describe what exactly comprises religious and spiritual distress, distinguishing it from psychological distress[17]. This both serves to allay the fears of secular professionals and to carve out the jurisdiction of religious and spiritual care providers.

Below are the symptoms of spiritual "dis-ease" taken from a recently published manual of spiritual care, *Light our Way* (2006), which was developed by a national team of clergy who have been involved with disaster relief for some time, organized with NVOAD. Because disaster religious and spiritual care defines itself as a clinical discipline, part of their claims to legitimacy make clear how they differ from mental

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[17] The DSM-IV v-code includes a diagnosis for religious and spiritual distress, which, surprising was not mentioned in my interviews or the trainings and conferences I attended. See Milstein et al. (2000) for an empirical study of the use of this diagnosis among rabbis.

health workers. Also, making clear that they know the limits of the expertise is one way to allay concerns of mental health professionals and secular organizations. The criterion for spiritual “dis-ease” largely stays within the domain of traditional religious themes, though they could easily be translated into psychological problems.

Symptoms of spiritual dis-ease that may be exhibited during disaster include

- Reconsidering core tenets of religious beliefs
- Asking questions like “why did God do this?”
- Questioning justice and meaning
- Feeling far from previously held beliefs
- Feeling a need to be cleansed
- Closing oneself off from loved ones
- Feeling despair and hopelessness
- Feeling guilty
- Wondering about life and death
- Feeling shame

The term “dis-ease” is used to make it clear that a medical diagnosis of a *disease* is not the goal of spiritual care. Instead spiritual distress can lead to diminished spirituality, not a circumscribed pathology. A loss of spirituality, in this perspective, is normatively undesirable. Yet the idea that there is a set of “symptoms” that constitutes a kind of spiritual disorder imitates the very language of the mental health professionals that many spiritual care providers criticize, exemplifying the move towards efficiency and codification demanded by the requirements of modern expertise. The kinds of

“spiritual assessment” advocated by some disaster spiritual care practitioners mimic the language of psychiatric diagnosis. Theological problems become lists of possibilities for suffering similar to the psychiatric nosology. In other words, spiritual care ends up looking much like psychiatric diagnosis, at least in the manuals. Where psychiatric diagnostics are seen as pathologizing, religious and spiritual care allies itself with a tradition of holism, treating “mind, body and spirit,” a phrase often repeated. The shift from disease to dis-ease—while only a hyphen away—attempts to make a clear distinction between mental health care and spiritual care. As one Russian Orthodox minister, seemingly in an effort to show me that he was educated about mental health problems, said, “It’s very clear when something is PTSD—and that’s a disease and I need to refer them to a mental health professional. It’s not my job. But the differences are very clear between religious problems and the disease of PTSD, which requires a diagnosis, that I’m not qualified to make.”

Another way that spiritual care models itself after mental health care can be seen in the language of spiritual growth. Religious caregivers facilitate the transformation of disaster from a traumatizing experience to a growth-oriented experience. As with concepts like resilience and post-traumatic growth, such a view turns the common view of disaster as irreparably damaging on its head and instead sees suffering as potentially valuable. Much of the trauma literature simply ignores this historically widespread ideal, the view that the “spiritually injured" are transformed into “more mature, better human beings.”

> Pastors and pastoral counselors need to provide trauma victims with the kind of spiritual resources that will enable psychological and spiritual growth to take place. Addressing spiritual needs can help victims emerge from these circumstances as more mature, better human beings—rather than as wounded

> individuals struggling for years or decades from psychological and/or spiritual traumas that have not been adequately addressed (Koenig 1996: 11).

Rabbi Berkowitz, a woman who had been active in disaster response, succinctly summed up her view of differences between clergy and mental health professions: "If they are angry with god, send them to a pastor, if they think they are God send them to a mental health professional." Statements like this were made to define the professional boundaries and to show that clergy were not in fact "poaching" from mental health professionals but were well aware of the differences in their roles.

These questions of diagnostics and interpretation have a determining impact on how organizations form and the direction they take. Organizations embody values, translating concepts like religion and spirituality into practice, reinforcing collective experience. These include debates about government funding for social services, and benefits for survivors of disasters and/or their families. In the case of disaster response organizations, conceptions of what it means to be healthy, wounded, distressed or disabled are made explicit through the kinds of care given—the ways in which organizations operationalize their theories through trainings and direct care. Behind some of the seemingly anonymous manuals are, of course, individual authors with real life experiences that influence how they create the documents and run organizations. When dealing with mental health issues, cultural conceptions of health become filtered through individual and organizational dynamics. Trade manuals, like the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM), can be read as narratives on what it means to be a healthy functioning human rather than an "unwhole" dysfunctional being. The individual biographies of care providers become entwined

with the language of diagnostics. The notion that "traumatic" experience gives meaning and transforms lives translates well for the creation of new organizations, suggesting an interweaving relationship between selfhood, and larger social structural dynamics. The transformation of individual experience resonates with organizations wishing to change the individuals who become part of their organizations. The way in which cultural symbols transmute from private experience and then back again into the public realm has much to do with the way organizations are formed and define themselves.   This can be seen in the way the informants below narrate their personal lives in relationship to the organizations they work for and have helped to found.

Much like military chaplains at the beginning of the 20th century who had to conform to an increasingly secularized bureaucracy in order to work with government and large recovery organizations, "disaster religious and spiritual care" required a professional model that would allow them to work within bureaucratic structures[18]. I observed the complex difficulties of disaster spiritual care as it has sought to find its place in a city bureaucracy which itself is still trying to figure out how to integrate preparedness, as well as how to deal with federal bodies, like the Federal Emergency Management Agency (FEMA) and larger organization like the Red Cross.

Rabbi Naomi Peretz explained to me early on, "after 9/11 we started screening clergy who wanted to provide care at Ground Zero and at the rest stations and found many people were not appropriate.   We found their knowledge of mental health problems to be inadequate. We even screened out Bishops, which became very

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[18] Budd's aptly titled, *Serving Two Masters* (Budd 2002), outlines conflicts between the military and chaplains, as the latter sought to define their role within a system of professionalization that was not suited to the organizational structure of religious groups.

unpopular." This incident illustrates what has become a long drawn out, and often acrimonious conflict among religious groups.

She went on to say:

> Spiritual care deals with issues of meaning that everyone has. If people were not spiritual, they would have killed themselves a long time ago. This is a very exciting time and there are a lot of changes in how things are being done. Faiths are working together in ways they never have before. While this may have started before 9/11 it has drastically increased since.

Reverend Simpson

Sitting in a small midtown office, Rev. Mary Simpson, the voluntary director of Disaster Chaplaincy Services, a volunteer organization that coordinates and provides trainings for disaster chaplains, told me about her involvement in September 11th recovery and the role of DCS in currently preparing NYC clergy for disaster. She is in her early 40s and has a brusque, yet friendly style. I ask her, "Do you think things are changing with clergy and mental health relationships because of 9/11?"

> I do and organizations like ICSF [International Critical Stress Foundation] those groups are helping a lot because there's a lot of cross training. One of the courses taught is pastoral crisis intervention and an advanced course. I believe it says that you don't have to be clergy to take the class. For anyone interested in spiritual response or learning about it this is good. Mental health representatives are very much encouraged to attend—you don't have to be ordained clergy. These kinds of organizations help that on a systemic level, getting collaboration that way. Also, having organizations that do training and open up for clergy to take crisis intervention, not MH courses, not so clergy can be MSWs but opening crisis intervention up and welcoming clergy in to be part of that, which is really appropriate. And giving training to clergy who have the right intention, which they don't get in seminary. Once they are given those tools it just makes everything work better.

Simpson articulates a perception among clergy that I encountered frequently: since the attacks of September 11th there has been a greater openness to clergy working with mental health professionals in disaster settings (Roberts and Ashley 2008).

Highlighting the importance of system change rather than idiosyncratic collaboration, she points to the role of what she calls “cross training" (having clergy train in mental health) in fostering better relationships. Trainings like those provided by the ICISF provide a recognizable certification that ostensibly softens the historical mutual suspicion of clergy and mental health professionals. But while Simpson advocates for the role of clergy, she makes it clear that they are *not* MSWs, assuring the mental health world that they will not be overstepping their jurisdictional boundaries.

Simpson described challenges of developing relationships with secular organizations. Proselytizing, she pointed out, is one of the major fears that non-religious organizations have about involving clergy in disaster response. She also highlighted the importance of having an institutional affiliation with a high status secular organization like the Red Cross. Many of the conflicts among religious groups that I studied were over recognition from such organizations. Organizations like NYDIS were struggling to establish memorandums of understanding with the New York City Office of Emergency Management and the Department of Health and Mental Hygiene.

> JM: Do you have ongoing relationships with mental health professionals?
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> Simpson: Yes (emphatically). We work incredibly close with them. 80 percent of our calls are from Red Cross. Even on a site if we have enough clergy and mental health we try to tag team and send out one clergy and one mental health so they can really tag team
>
> JM: How have your relationships been?
>
> Simpson: With Red Cross they are very used to us and we them, and we do a lot of you know handing off to each other. The referral process both ways has been very successful. With other mental health there’s a learning curve that’s happening. Mental health can be very suspicious of chaplains and chaplains can be very suspicious of mental health and there’s a learning process for both sides

of that. Part of our orientation course is for referrals. If individual clergy are not willing to refer to mental then this is not the volunteer opportunity for them.

JM: Do you find that to be a problem?

Simpson: Not for us because we screen for that. It's part of the screening questionnaire. From the mental health end… a number of chaplains got a bad rap because there were individuals that came in and were causing harm and doing things that were completely inappropriate and awful.

JM: Like the Christian Scientists[19]?

Simpson: When anyone comes in to proselytize and that was across the board not any individual group. Mental health has good reason to be suspicious in general. Why we are an important organization is because we provide pre-screening and classes. The folks that show up with our badge and do that stuff…we can take their badge and have them arrested. If they are in a place they are not supposed to be, and refuse to leave, we'll take care of it. More mental health City agencies are feeling at ease with our work because we can police our own people.

Simpson illustrates the way in which her organization attempts to gain legitimacy, as well as control access over disaster sites. But since government agencies have been reluctant to get involved with intra-religious conflict, and as I mention above, religious groups are nearly impossible to organize en masse. The power of DCS does not extend as far as Simpson suggests, though they claim to have roughly 100 on-call volunteers. Their association with the Red Cross—which includes some longstanding individual relationships that existed long before the founding of the organization—gives them some prestige and status, but not exclusive control over disaster and spiritual care in New York City.

Reverend Green

[19] Christian Scientists are known for their aggressive proselytizing and anti-psychiatry stance.

I met Reverend Green on a dreary January day with intermittent snow, clouds and sun. A handsome, African American man, he walked into the midtown Starbucks where I was waiting to meet him. We ordered drinks and food, and sat at the table in the crowded café. Green tells me that his wife used to work for the NIMH and was responsible for funding my NIMH program.

Rev. Green is the pastor of a large church and a coach for executives. He has worked with fortune 500 executives and top law firms. He is also a practicing therapist and has a large client base of clergy families and retired athletes. When I ask if there is a connection between the two, he says, "Yes, both were used to getting their lunches paid for, to being put on a pedestal and then have to deal all of sudden with the change, with not being seen in that light, and other people not getting why they feel bad about that. With clergy, the NYT stops calling for quotes," he says.

"Would you say that we are living in a new age of anxiety?" I ask him. He nods his head in agreement. "Yes, people are much more stressed. Many people I have been talking to have been stressed about Sadaam's hanging, to my surprise." This he says in agreement with my question about whether or not 9/11 is now just part of a continuum of stress.

"People are worried about the hanging, people I wouldn't expect to be worried. It happened right around Ramadan, and as he points out later in the conversation, "it was a lynching, and the black community obviously has feelings about that."

Green was very involved in 911 relief efforts and spent time in New Orleans after Hurricane Katrina. He spoke about the large numbers of clergy who left the area after

the hurricane, citing a study by Lutheran disaster relief. When I ask if the same was true for NYC, he said:

> No, that we found out that NYC is a destination city. You know the Frank Sinatra song is in people's hearts. We found also that if clergy have new skills to meet new needs they are less likely to be themselves disasters. Disasters require a whole new set of skills—theology and psychology were at one time under one roof. After 9/11 I was hired to talk to psychology and religion—to help them communicate better and find commonality. We went to the PhDs and MDs and said, 'you see that guy over there who you think is ignorant. Well, 5000 people show up to his services on Sunday. If he says the medicine is bad, people won't take it. If he says that it is good they will.' There are real reasons why blacks, Muslims, Native Americans don't trust doctors. We need to make clergy more comfortable. Columbia [University], initially, didn't do that. They had the usual intellectual elitism and arrogance. They didn't have any community input, and thought they did put together a curriculum that looked good on paper. I told them that they need people who are in and understand the community to teach. They needed to pair up professionals and religious leaders.

Green echoes the common view that I heard many times: clergy are part of communities and have a degree of trust that doctors and other professionals do not have. This is even truer, he argues, in non-white and immigrant communities. He also points to one of the important justifications for the inclusion of religious leaders in disaster planning—people listen to them. This anti-expert rhetoric—though Green himself has a doctorate—is one of the important ways that clergy justify their role.

> When Charlie Rangel was running in the 70's, he tells this story of the FBI coming to Harlem to ask about him. Do you know Charlie Rangel, they ask? No, I don't know him, never heard of him. FBI wondered why no one, not even his neighbors, heard of him. They didn't understand the culture in Harlem. People don't talk to law enforcement. Before 9/11 there wasn't much going on with religion and mental health. There were some institutions that incorporated spirituality, but it was vague and not real religion--flower children selling spirituality. They didn't start where people are as you learn in psychology. They were trying to take religion without replacing it with something. You can't do that. 9/11 force-fed the need to having a meeting of minds between religion and MH. The change has been significant. NYC should be given a great deal of credit—the Saul Alinsky mindset, all of our interests.

Green highlights additional conflicts that may exist between clergy and mental health professionals, pointing to the specific difficulties of minority groups and their historic distrust of doctors and researchers. He expresses a view commonly held by clergy: that mental health professionals and academics look down on them. He also historicizes some of the conflicts, pointing to the tension between "flower children," a dominantly white expression of spirituality, and what he considers to be "real religion" (Wuthnow 1998).

Green speaks to the highly political nature of the work of the clergy in New York City, and raises issues not addressed by others I interviewed. As someone who had a long involvement with local politics and as a psychotherapist in a much broader context, he saw spiritual care embedded in larger social and political issues.

> JM**:** Yes, but also as I remember there was a lot of conflict between mental health and spiritual care workers?
>
> Rev. Green**:** Yes, there was a lot of pain. First the people from Oklahoma came to teach us. But NYC is not Oklahoma. It's different. Larger. Then psychology came in not respecting religious. They weren't asking what people needed. We didn't want to make a new industry of fear and panic. Katrina taught us that there were some basic needs that needed to be met—people need flashlights, water. But government might not be the solution. I'm 53. I grew up in the 1960's and have the same attorney as Malcolm X and Martin Luther King. NYDIS wants to be the only voice. It's not healthy to have one voice. Religious organizations must claim their authority. They can't do that based on their relationships with government organizations. In some communities that doesn't help and it's not only a racial issue. The trinity is politics, religion and business. You need to work with all three and NYDIS is not doing that. Business gets things done. We see that with Michael Bloomberg—we needed a politicians' authority and in disaster even atheists get religion real fast, even if it's temporary.

Green clearly places the conflicts that he witnessed in disaster religious care within the realm of politics. As an African American minister involved with Harlem

political issues and with a long history of activism, Green was particularly attuned to race and cultural issues. He also highlights some of the difficulties in organizing religious communities across faith lines. His comment about "flower children" points to a cultural divide between institutionalized religious practice and what is often seen as part of the degradation of religion—the New Age practices that came out of the 1960s. *Real religion* has roots in established institutions, not in what Green characterizes as the vague practices of the hippy generation. The attacks of September 11th, he said, mark an important cultural shift that showed psychology and mental health need to work together.

Another African American minister in east Harlem who I interviewed, Randall Jeffrey, resonated with Reverend Green's view."A lot of people in our communities have been terrorized by surviving in the inner city. Many African Americans are familiar with terrorism—lack of education, housing, unemployment, things people confront living in the city. 9/11 impacted existing trauma. It's difficult to tease out the impact of 9/11. People are under the constant bombardment of social conditions. Within a radius of two blocks from here they're building luxury housing. People in the community know they will pressure to leave. Many people we work with are suspicious of mental health because they fear being labeled so we focus on the spiritual. Some have been abused by agencies and have more confidence in ministry."

Rabbi Rubin

I had seen Rabbi Julius Rubin speak at various disaster-related events, and was told by several chaplains that he was an important figure in the Jewish community. He has long been involved with fire departments and police departments as a chaplain. A

man in his 60s, he has the demeanor of a Catskill hotel comedian—he smiles a lot and cracks jokes. As the director of the Board of Rabbis, an umbrella organization representing over 800 New York City synagogues, Rubin is experienced and politically aware. His office is filled with books, mostly Jewish topics, and pictures of the Rabbi with various political leaders. "Rabbis need continuing education in order to deal with people in disaster," he tells me.

He starts by talking about the importance of how to inspire people when one is having doubts about faith. "That's one of the challenges of working disaster," he says. Rubin was chaplain for the FDNY for nearly eight years, and was very involved at Ground Zero for many days. "The bible is clear about the connection between spiritual and physical—when the physical is waning spiritual takes over and the other way around." Rubin is connecting biblical ideas to modern ideas about mind/body connections. He goes on to say,

> There was a time when MH was on one side and religion, on the other. 9/11 has changed this along with collaborations such as Naturally Occurring Retirement Communities (NORCS). End-of-life services, because of the collaborative nature of that work, also has caused greater collaboration. Before 9/11 collaboration was happening in a scattered fashion. During 9/11 we interacted so deeply that we recognized we don't have all the answers. If we don't have the answers, who does? For too long religion felt it was omniscient. The tragedy continues after 9/11, the effects stayed and then Katrina came about. Katrina was positive in the sense that MH worked with religions groups and recognized human inadequacy.

Contrary to the views of many other clergy I came to know, Rabbi Rubin suggests that clergy have been at fault for thinking they did not need mental health professionals. For someone representing a large mainstream organization, this view is not surprising. One of the arenas where medical professionals and clergy began to work together in the

past 30 years has been in hospice settings (Lewis 2006). Perhaps more than any other medical settings, hospices foster collaboration because of the general perception that, as with disaster, death raises questions that medicine cannot deal with. In other words, the argument goes, doctors do not have the *expertise* to handle questions about the afterlife or even to help patients deal with unresolved issues in this life. Clergy—often in the role of chaplains—play a more crucial role in treatment teams in end-of-life contexts. Hospices have provided an arena where personal and professional networks have been formed, as well as protocols for dealing with spiritual issues relating to death (ibid.). The argument for religious involvement in end-of-life care is not very different from the argument for involvement in disaster care: despite technological and scientific knowledge, when people are facing death and extreme suffering, what they really want is religion and spirituality.

"The pain of many is a partial comfort," Rabbi Rubin tells me. "The move from why me to we—like the therapeutic impact of *Kaddish* when people get up and see that others have lost people. When Job wants to know why, the answer is that the heavens are higher than the earth. We don't understand. Much blame was directed at God after 9/11 and also after the Holocaust—if God could intercede at the Exodus why not the Holocaust people wanted to know." By drawing connections between 9/11, the Holocaust and the Book of Job, Rubin makes a characteristic argument for the role of clergy in disaster settings. The reference to Job and the Holocaust link disaster work to a biblical source as well as the paradigmatic 20th century human catastrophe. The holocaust has become the central metaphor for a world turned horrific, a civilization without moral roots. Theology and psychology have found the Holocaust to be one of

the defining events in the development of questions about the nature of suffering, and the limits of human ability to cope—it is now a question of whether the Holocaust will continue to maintain its centrality; or if more recent, and future, atrocities will draw greater attention for the current generation. This question grows increasingly relevant as the majority of Holocaust survivors are now elderly or are no longer alive. Rubin, as a Rabbi and man in his 60s would unsurprisingly see the holocaust as important to his view of disaster work and suffering. As one of the looming paradigmatic 20th century human-disasters— along with the unforgettable mushroom clouds of Hiroshima and Nagasaki—the Holocaust, with images of heaping piles of bones and skeletal prisoners awaiting rescue from allied forces, has played a crucial role in our understanding of coping and trauma (Lasch 1984; Micale and Lerner 2001; Shephard 2001). Until recently it was difficult to talk about the historical and cultural aspects of trauma without reference to the Holocaust[20]. However, 9/11 and other more recent disasters seem to be changing this. It is yet too soon to predict what type of religious, moral and psychological tale 9/11 will tell, and whether it will continue to have significant cultural resonance in the future—as there is a high likelihood that much larger disasters await us in the not-so-distant future.

Conclusion

This chapter has shown how the development of organizations addressing disaster religious and spiritual care emerged and developed following September 11th. I have shown how organizations and individuals that helped create them competed over issues of legitimacy, the

[20] Personal conversation with Allan Young.

interpretation of distress, and how conflicts over credentialing and interpretation of distress intertwine. I have also drawn connections between the individual lives and organizational dynamics—the inextricable connections between the way organizations form and the lives of the people who create them.

Many of those involved in disaster religious and spiritual care before 9/11, have become part of current organizations, and are important players in disaster religious and spiritual care on local, national and international levels. The attacks of September 11th took place within a context that allowed for a relatively quick response from clergy, in part because networks of relationships already existed prior to the attacks. But it was the perception that we have entered a New Age of Anxiety that brought the different people described in this chapter together. Reverend Simpson, Green and Rabbi Rubin articulated various anxieties about the emerging dangers and the importance of collaboration between religious leaders and mental health professionals. They also pointed to the different ways that "historical traumas" and personal traumas informed their professional trajectories, and the expertise of "disaster religious and spiritual care."

The next chapter will examine Critical Incident Stress Management Crisis Interventions Pastoral Crisis Intervention training, an attempt to establish credentials for clergy working in disaster settings.

Chapter Four

Training for Disaster: The Critical Incident Stress Management Model

This chapter focuses on a training designed for clergy working in disaster settings, Critical Incident Stress Management's (CISM) Pastoral Crisis Intervention (PCI) training. CISM is a model of psychological debriefing designed for interventions immediately following crisis, and PCI is an adaptation designed specifically for the needs of clergy or lay spiritual caregivers. I will describe how the training differentiates between spiritual and psychological distress and emphasizes a particular model of "disaster religious and spiritual care" expertise—one with a highly mechanistic view of human functioning.

I first learned about CISM from Reverend Simpson (chapter 3), who had told me that her organization was cosponsoring training for clergy. Some months later, I enrolled in the 4-day, 2-part Pastoral Crisis Intervention (PCI training offered by the Critical Incident Stress Foundation. The website claims that they train 40,000 people a year in PCI, though I was unable to confirm this. Its stated goal was to *"the functional integration of any and all religious, spiritual, and pastoral resources with the assessment and intervention technologies germane to the practice of emergency mental health."* CISM has had an important impact on emergency services and has been the subject of great debate in the disaster response world. For these reasons I go into detail about its history and the technology of the intervention model.

<u>History and Background of Critical Incident Stress Management</u>

In 1974, Jeffrey Mitchell, an emergency medical service worker and volunteer fireman, conducted the first Critical Incident Stress Debriefing, later to become CISM. Nearly 20 years later**,** as a result of the Oklahoma City bombing, PCI was developed as one of the programs offered by CISM**,** adapting CISM training for the clergy or lay audience who wanted to provide pastoral crisis interventions.

Later Mitchell met George Everly, a professor of psychology and public health at Johns Hopkins University and Loyola University, and together they founded the Critical Incident Stress Foundation. CISM is often referred to as the Mitchell model. After working many years as a firefighter and paramedic, Mitchell went back to school and earned a PhD in Human Development from the University of Maryland. Mitchell recently stepped down as president of The Critical Incident Stress Foundation and is now Clinical Professor of Emergency Health Services at the University of Maryland in Baltimore County, Maryland.

Integrating the language of religion and spirituality into the CISM model entails translating ideas into the language of debriefing and crisis intervention. Since emergency services require justifications for interventions that meet the standards of their own system, religious practice is transformed into a mechanism. The training manual, for example, proposes that:

> In sum the goals of pastoral crisis intervention as defined herein, are fundamentally the same as those of non pastoral crisis intervention, i.e., the reduction of human distress whether or not the distress concerns a significant loss, a crisis of meaning, a crisis of faith, or some far more concrete objective infringement upon adaptive psychological functioning […]the pastoral crisis intervention brings with it a "value added" over and above the traditional non-pastoral approach to crisis intervention. This corpus of "value added" ingredients has been enumerated above as mechanisms of action, or agents of change, and appear to be unique to the pastoral perspective as it employs religious, spiritual,

> and theological resources in an effort to "shepherd" an individual from distress and dysfunction to restoration (Workbook 14-15).

The above quote illustrates how far the language of PCI is from traditional theological approaches to crisis and disaster. It is a language of utility rather than faith. Religious practice is not seen as good in itself but rather good in so far as it might be *effective*—and in no way discusses the significant theology of a persons' responsibility to "God."

Numbers, bullet points, discrete categories, and lists characterize the training materials. Quantification of actions and clear protocols for those actions are central. It comes as no surprise that such a system would be born of organizations involved in emergency response, which often share similarities with the military and find a home in large bureaucratic institutions. What is unique is that CISM has developed a well-attended program for faith leaders around the country. As part of the post-traumatic stress debriefing trend, CISM represents a movement within the first-responder community designed to train lay people in a structured form of processing meant to prevent the worst traumatic symptoms. The theory suggests that if you are able to talk about an event immediately after it happens, it is possible to prevent "freezing" from occurring. Freezing (Young 1995) is a key component of a particular theory of memory that underpins post-traumatic stress disorder (PTSD) and was the product of 19th century memory theories.

Disagreement over early interventions extends to a larger debate about the concept of resilience, which resonates with political issues and a long tradition of anti-expert rhetoric in American culture—the extent to which people are able to deal with the

impact of traumatic events without the intervention of experts. Debriefing occupies a position between lay and expert training. Virtually anyone can take the trainings, which confers a certificate indicating at least some level of expertise. Most trainees will not become full-time “debriefers,” but instead will incorporate the skills into the work they are already doing in police departments, fire departments, and the military. Debriefing was described in a recent textbook on disaster mental health:

> Yet at the very core of psychological debriefing is an emphasis on discussing the details of a distressing event, as well as one’s accompanying cognitive and emotional reactions, shortly after the incident occurs. The process was often found to be beneficial among military and paramilitary groups including emergency responders, but it is not now and has never been a recommended intervention for primary victims following a disaster. Yet over the last 20 years, the technique has become widely used as an early intervention tool following exposure to a traumatic event in diverse settings where adverse events sometimes occur, such as businesses, schools, and hospitals” (Halpern and Tramontin 207: 256).

CISM and Debriefing Debates

Following 9/11, the efficacy of programs like CISM has been the subject of contentious argument, called the debriefing wars, in the popular press (Satel 2001). As one of the most widespread models of debriefing, CISM has been at the center of controversies over how to treat trauma. The term debriefing had its origins in operational debriefing or instrumental or after-action debriefing (Tramontin and Halpern 2007: 257) developed mostly for military and paramilitary organizations. September 11th produced a highly publicized debate (Groopman 2004) about debriefing that found its way into some of my interviews. This debate has great importance in how we understand the vulnerability and the needs of people impacted by disaster. The protocols for care following 9/11 have changed. The perfunctory use of debriefing in, for instance, office settings was heavily critiqued because it was believed that people who may have been

traumatized were mixed in with those who were not. This mixing of the untraumatized with the traumatized, the theory suggests, leads to contagion—an unavoidable spreading of PTSD.

<u>The Training</u>

Day One

On a warm June day after a difficult night's sleep wondering what I might confront in my 4-day training in Pastoral Crisis Intervention, I made my way uptown on the subway to the "God Box." This large building on the Upper West Side of Manhattan, near Riverside Church, houses many Christian charities. When I arrived, the marble lobby was crowded with people, mostly men in police, firemen, and emergency medical service uniforms.

After a large session, where we were introduced to the CISM philosophy and history, the room was partitioned in two: one side for secular participants and the other for clergy. The conference room was filled with rows of desks and had high ceilings and fluorescent lighting, giving it an institutional feeling. Our instructor, Tom, a fairly large man in his late 50s, stood in front of the room and introduced us to Pastoral Crisis Intervention. A Navy chaplain for many years, he now runs a chaplain consulting firm[21] that, among other things, works on military contracts. He struck me as a particularly American Christian, probably from the South or Midwest—positive, seemingly earnest, genuine, and eager to help, exemplifying the optimism I described in chapter two. He

[21] Later I *Googled* Tom's firm and found that they were part of a controversy involving the military privatizing religious care. A veterans' watchdog group accused him of opportunism and misuse of statistics aimed at getting government contracts

spoke with great feeling about his military service and experiences with a variety of soldiers suffering from combat experiences. He himself had been wounded, though he did not say how or where. Watching the interactions between Tom and the other chaplains from the armed services, I noticed a sense of camaraderie and mutual respect. They joked about what it was like to be in the Navy or Army, smiling and laughing.

We spent some time going around the room introducing ourselves. Most of the participants were from the New York area, including Long Island and upstate Binghamton. There were also chaplains and ministers who flew in from around the country, including Oklahoma City, Kodiak, Alaska, and South Carolina, sent by their fire departments, police departments, and military units. One Lutheran man with a long white beard from a small town in upstate New York said that he paid his own way. He felt it was important for his work as a volunteer fire chaplain. There was one African-American woman and an African-American Baptist minister from New Jersey. Everyone else was white. Probably because of CISM's close association with police and fire departments, there were only three women. This was in contrast to many of the other events I attended throughout my research, which were often well-represented by women.

The first day consisted of an introduction to the CISM model, which was to lay the basis for the pastoral crisis intervention part. We were given an introduction to psychological first aid along with a history of crisis intervention. CISM is considered to be a form of psychological first aid with the pastoral component as a form of religious/spiritual first aid. The model, as I show below, assumes a dual self—the

psychological/secular self, which is impaired, and the religious self, also impaired, both requiring a restoration to “normal” functioning.

The introduction to the text reads:

> The purpose of this two-day training program is to prepare participants to provide basic crisis intervention services (“psychological first-aid”) to *individuals* in acute crisis using a structured crisis intervention algorithm (SAFER-PCI). The SAFER-PCI represents one element in the integrated multi-componential Critical Incident Stress Management (CISM) crisis intervention system. It is designed to blend standard psychological interventions with pastoral interventions within a context collectively referred to by Everly (2000) as *Pastoral Crisis Intervention* (PCI).

We were given textbooks that included PowerPoint slides and articles about crisis intervention, as well as a variety of tables and diagrams depicting disaster protocol and intervention strategies. The cover of the PCI textbook for the first unit, entitled *Pastoral Crisis Intervention Course Workbook*, is illustrated with a circle containing small sketches of hands held in prayer, a cross, a moon (symbolizing Islam), a Torah, and what appears to be a Buddhist mandala. While the curriculum suggests an interdenominational view, the reality was much more one-sidedly Christian. Nowhere in the book does it mention problems that one might encounter when dealing with non-Christians, though Tom did mention these issues in one of his talks. Based on the introductions, I was the only non-Christian present.

On the page before the slides being displayed the following quote: “*Then I heard the voice of the Lord saying, “Whom Shall I send? Who will go for us?” and I said, “Here I am. Send me” (Isiah 6:8).* This prophetic biblical injunction to “go” was invoked throughout the training. Tom insisted that we were messengers of God, bearing God’s presence, walking into the pit of destruction as representatives of the divine. Amidst the acronyms and technical language of disaster bureaucracy, prophetic rhetoric

seems jarring, but it is this appeal to the mission-oriented motivation of many of the participants in the training that often elicited the greatest enthusiasm, judging from expressions of approval and nodding heads in the audience.

The textbook then provides statistics on the efficacy of Critical Incident Stress Management. Tom was very interested in showing the need to support his statements through science, often citing George Everly. Reproduced below is one of the first slides Tom showed which demonstrated how they code their statistics:

1. Between 7% and 35% of people are in significant distress after a trauma/disaster.
2. 94% Americans believe in God (Tix Frazier, 1998, J. Cons. & Clinical Psych.)
3. 59% likely to seek support from a spiritual counselor, compared to 45% MDs, 40% mental health professionals (ARC, 2001, Ripple Effect).

By asserting that the vast majority of Americans believe in God, large numbers of people experience distress after disaster, and most will seek help from spiritual counselors, this slide creates a mandate for disaster religious and spiritual care. The use of "scientific" data lends greater prestige to the training and provides a sense of authority, particularly the help-seeking numbers, which were often cited by informants. The idea that most Americans want to see a "spiritual counselor" was a highly motivating force.

Tom continued to argue that mental health professionals and disaster workers have often been remiss in their understanding of what suffering people need. "Most

Americans are religious," he said, "and they need clergy in times of disaster." I scanned the faces in the audience for reaction to this, and saw heads nodding in affirmation. Instead of saying that God demanded their service, the reliance on statistics instead points to the ways in which religion relies on "data" to justify its place.

To ally his organization's message to these needs, Tom presented the following slide on crisis. Crisis was defined as "an acute RESPONSE to a critical incident" wherein:

1. Psychological homeostasis (balance) is disrupted
2. Usual coping mechanisms have failed
3. Evidence of dysfunction, impairment.

Homeostasis—one of Cannon's key contributions that I described in chapter two—becomes a way to unify mind-body states, and in the case of PCI, a metaphor for the restoration to a norm of religious and spiritual belief. Homeostasis is linked to spiritual and religious resolution; doubts, questioning belief in God, and existential questions are interpreted as a breach in equilibrium. In order to regain homeostasis it is necessary to quell doubts, and restore faith. The linking of psychological homeostasis and spiritual homeostasis provides one of the key arguments for PCI. Belief is considered one of the foundations of homeostasis, and since crisis can bring belief into question, homeostasis can be interrupted. The assumption in this particular case is that the belief needs to be restored in order to recapture stability. CISM, unlike trainings in the following chapter, is not as concerned with moral and spiritual growth. This

perspective also ties the training in with a tradition of stress research outlined in chapter one, illustrating the power of the stress concept.

Spiritual, Religious, and Psychological Interventions

CISM is conceived of as "emotional first aid," the first line of defense against trauma, and PCI as its religious/spiritual corollary is seen as the first line of defense against crises of faith. "As physical first aid is to surgery; crisis intervention is to psychotherapy," Tom explained. Crisis for CISM might refer to a personal crisis, such as a divorce or loss of loved one, or a large-scale disaster like Katrina or the attacks of 9/11. Spiritual crisis as a distinct class of crisis requires expertise.

The PCI Manual distributed to the group defines spiritual interventions as:

a. unique ethos of pastoral person

b. ministry of presence

c. unique communication

d. ventilative confession

e. individual and/or conjoint prayer

f. belief in divine order or divine intervention (75)

The above interventions are designed to restore equilibrium, to help someone distressed access their "religious coping" resources. The ethos of a pastor (a.) in this case is considered a form of spiritual intervention. God is not explicitly mentioned; rather, the pastor's own ethos acts as a therapeutic spiritual intervention. This is likely a very conscious choice about how to understand intervention and how to present religion. To

say that God is intervening might risk the appearance of proselytizing, which could alienate secular mental health professionals. To say that it is the ethos or the pastor's belief that intervenes keeps the intervention safely within the realm of the acceptable techno-rational discourse—there is no direct intervention by a divine power. The distinction is important: one validates divine intervention; the other simply suggests that personal belief—regardless of whether or not God exists—has intrinsic value. But of course it is implied that God's power is involved.

Throughout the day, Tom used a gesture to vividly implant a concept in our mind. He frequently raised one arm vertically and the other horizontally, proclaiming that "disaster causes you to be vertically impaired and spiritually impacted, and horizontally impaired." "Disasters", he said, "disrupt our vertical relations with God and our horizontal relationships with people. Our job as pastoral crisis interventionists is to restore those relationships."

Mapping the two planes of human relationships—human and divine—with his arms, he was telling that rupture could occur with God and with people after disaster. In order to restore to wholeness to a self in disaster-caused disarray, one has to deal with those two related issues—the vertical and horizontal arms. This mnemonic device seems to work, as now I have a picture of this man in front of the room with one arm pointing toward God and the other at the people in the room stuck in my head (it is also not far from the image of a crucifix). For someone involved in disaster work, I can very easily see how this image would provide a template for action during crisis, and I am fairly certain that the learning theories that such trainings are based on would have exactly this as their goal.

Among the rationales Tom gave for chaplains in disaster scenes are, "They want to talk to you because you have a direct line to God—in their perspective, you're an 'Ambassador of god' in time of crisis." Also, knowing the research becomes part of one's mission. The combination of scientific discourse and connections to God provide a two-pronged justification for expertise. Tom told us that, "you need to know research in order to impart hope." If you are able to cite the data on religion and coping, you might be better equipped to instill hope in those who have been impacted. "The criticisms of CISM are not true," he said. "It's more about the psychologists wanting to keep control. We have the data to show that CISM works." Citing data from Everly and Mitchell, he assured us that the criticisms from the psychological research were not valid. The criticisms, as I mention above, include the possibility of exacerbating or "spreading" trauma by debriefing groups that include both people that were directly traumatized, and those who were not**.** Also, increasingly the necessity of talking about trauma in its immediate aftermath—and in some cases talk about traumatic experience at all—is not considered necessary for psychological healing to occur.

CISM's highly rational account of human action employs a rhetoric that distances the caregiver from the distressed person, illustrated by functional goals in the manual:

> The goals of crisis intervention are:
>
> 1. acute stabilization of symptoms and signs of distress and dysfunction (to keep things from getting worse)
>
> 2. facilitation of symptom reduction (intervene so as to reduce acute distress and dysfunction)

3. facilitation of a restoration of acute, adaptive independent functioning (successful reduction of impairment)

4. facilitation of an access to a higher, or more continuous, level of care, if needed.

In much the same way, the explicitly "religious" content of the training is translated into mechanistic terms. The religious self, though sometimes struggling to represent something different, appears no less mechanistic or no more "holistic." It's not just that, in this case, religion has become subsumed by the American therapeutic ethos, but that this therapeutic ethos itself poses an even more minimal version of the self than was originally the subject of critique. Survival and self-management become the goals rather than expansion of moral imagination or a religious experience of suffering (Lasch 1984).

Day Two

On day two Tom spent a good deal of time describing the differences between crises of faith and psychological distress. "Psychological distress," he said, is one of the places where pastoral crisis interventionists can make a real difference. Disasters make many people doubt and this can lead to a crisis of faith, which is important to prevent. Faith can be people's greatest resource after disaster."

A crisis of faith, he told us, had to do with the vertical relationships, whereas psychological distress concerned horizontal relations. A crisis of faith is one potential form of breakdown. Each potential breakdown requires an intervention in order to restore equilibrium or homeostasis, and while crises of faith and psychological crises are

related, PCI, as a technical discourse, sees these as distinct, so the curriculum insists on a clear difference.

As mentioned earlier, the course did not draw stark distinctions between spiritual and religious interventions. According to the PCI workbook:

> Spiritual interventions may be thought of as nondenominational pastoral interventions which are generically applicable across most religions or faiths. Spiritual crisis interventions may commonly consist of individual prayer, conjoint prayer, the ministry of presence, the unique ethos of the pastoral crisis interventionist vis-à-vis traditional crisis interventionists, ventilative confession, belief in a divine order, and belief in divine intervention. Religious interventions may be thought of as pastoral interventions based upon specific religious doctrine, belief, and/or scripture. Examples of religious pastoral crisis interventions would be specific rituals of worship, sacraments, scriptural education, interpretation, or insight, rituals of confession, rituals of forgiveness, and specific illness or death-related rituals (38).

From an article that Tom wrote and handed out at the training, the table below provides a scheme outlining the difference between a spiritual cry of distress and a crisis of faith. Mimicking psychiatric diagnosis of PTSD, the table breaks down the "symptoms" into units of time and intensity. A cry becomes a crisis if it persists behind cognitive impairment. Particularly interesting, a "more reflective cry" is categorized as more severe than an initial "outburst of distress." This means that persistent doubt over time, after reflection, is considered more worrisome than an initial outburst—deeper trouble than with doubt caused immediately after an event. While this parallels a PTSD diagnosis, when this logic is applied to religious belief it has the effect of making a long-term shift from belief to doubt in God by its nature a sign of pathology. The intervention goal of a crisis of faith is to create a renewed spirit of thankfulness, to restore one's relationship with God. Tom tells us that this is where we are most needed—this is the pit of destruction that we as pastoral crisis interventionists must step into. This pit of

destruction is where the pastoral crisis interventionist does his best work and where the work is distinguished from mental health professionals. “You represent the presence of God”, he tells us. “Just by being there with your color or chaplain badge, you bring hope and provide something that psychologists can’t. Just by being with someone in the pit of destruction and walking with them.”

Table Differential Assessment of a Spiritual Cry of Distress and a Crisis of Faith

	A Spiritual Cry of Distress	A Crisis of Faith
Time Elapsed From Critical Incident	Occurs shortly after the impact of a critical incident	Occurs later after person has recovered from cognitive impairment
	An initial outburst of distress	A more reflective cry or plea
Context of Prevalent Trauma Symptoms	Shock Cognitive impairment Emotional distress	Impairment in relationships horizontally and vertically
Relational Focus	Focus on self and one’s state of being	Focus on impairment in relations horizontally and vertically
Intervention Goal	Minimize shock and symptoms of distress and provide a concrete reminder or witness of God’s presence and love	Promote hope and renewed spirit of thankfulness in the impacted person’s vertical relationship to God

Several people went up to Tom at one of the breaks and told him how helpful they found this presentation. There seemed to be a split among the participants. Some felt that Tom’s use of discrete categories was very helpful while others found that his use of

religion in the service of debriefing did not give religion and faith its due place. There was some confusion about spiritual distress and crisis of faith, and several ministers asked Tom to explain more clearly. “How do we know the difference,” someone asked, “and when is it ok to pray with someone.” Tom suggested that the prayer should come from the person in distress, though it was ok to ask if someone wanted to pray. He also emphasized the importance of presence: “You don’t have to do anything sometimes. Just being there as an ambassador of God can be enough sometimes. Just having a shirt that says chaplain can bring hope.”

Crisis of Faith

> A crisis of faith is when one’s normal, established relationship with God and accompanying theological worldviews are violated and rendered seemingly helpless/useless” (CISM-PCI Workbook I: 53).

Symptoms of crisis of faith include feeling abandoned by God, finding it hard to pray, no yearning for righteousness, no spirit of thankfulness, hopelessness, and seeing no value in scripture (ibid. 53). Again, loss of faith is considered a sign of pathology or a symptom that things have gone awry. This perspective is a long way from the psychoanalytical views that dominated much of the 20th century, which would have seen loss of faith as part of psychological growth.

Tom went on to explain the slide below as further symptoms of a pathological loss of faith. Those trained in PCI, he told us, were equipped to provide an intervention with a person suffering from these symptoms, where a traditional mental health professional would not understand what to do and would likely see the person suffering solely from PTSD or depression. Though they may in fact have PTSD, they are also

suffering from a spiritual crisis that requires a special treatment, he told us. According to the training slide, symptoms of loss of faith include:

1. feeling abandoned by god
2. finding it hard to pray
3. no yearning for righteousness
4. no spirit of thankfulness
5. no sense of hope
6. no sense of comfort from reading or meditating upon scriptures (54)

On the third day**,** I spent much of my time with Anthony, a retired Catholic priest from Boston, and Gabe, the Episcopalian chaplain who was working in Kodiak, Alaska, with the Navy SEALS. Gabe told me that he was thinking about converting to Eastern Orthodox Christianity because they are more mystical than the Episcopalians who have strayed from the roots of Christianity, and we talked about his doctoral studies in patristics—the study of early church fathers—and how they were leading him to believe that Episcopalians had lost touch with the true roots for Christianity. We chatted about the monastic life, and all went to lunch at Tom's Diner on 112th Street. Gabe told me about the challenges of teaching ethics to 20-year-old marines. "Teaching ethics to 19-year-old Navy SEALS," he says, "is really hard." "Do you teach them the classics like Plato, Aristotle, and Kant?" I asked. He looked at me like I was crazy. "These kids are much, much more basic than that," he explained. "They are not functioning on a very high moral level."

My conversations with Gabe brought home the long historical connection between the military, disaster mental health, and pastoral crisis intervention. The number

of military chaplains at the training made this more evident. The perceived need of the military for their chaplains to be trained in PCI seemed curious. I could not understand what someone who had been in the field for several years could be getting out of the training, which provided what seemed to me like very basic information—both psychologically and theologically. Though Gabe agreed with this view, he seemed to be a minority, judging from the seemingly enthusiastic questions from the audience.

By the third day, there was more focus on the explicitly spiritual. Gabe was obviously displeased with the model and didn't like the way spirituality was being forced to fit into a diagnostic system. "Theologically religion is being used instrumentally," he told me, "and there's very little emphasis on true faith." Increasingly he came back late from breaks, an indication of his frustration with the program.
Tom sermonized and told anecdotes about soldiers losing their way because of traumatic experience, "falling into the pit," and finding their way back through the aid of pastoral crisis intervention. In one example, he spoke about a soldier who had killed someone by accident years before and was tortured by it for many years. "By stepping into his pit of destruction, as a pastoral crisis interventionist, I was able to bring him out of the pit and back to faith," he told us.

One of the oft-repeated tenets of disaster spiritual care is the idea that any form of proselytizing in disaster settings is unethical. This forms one of the cornerstones, designed, it seems, to allay the fears of mental health professionals and government agencies that they might be letting fire and brimstone preachers into disaster areas and unwittingly giving them approval. The issue of proselytizing, though, is a much more subtle one than Tom and many of the texts on disaster spiritual care lead one to believe.

As I argued in chapter 3, the often acrimonious conflicts on credentialing, hinged to a large extent on screening out chaplains from groups like the Christian Scientists, who were known as being anti-psychiatry, and proselytizers.

At one point Tom referred to prairie evangelists and their preaching about "the will of God" to traumatized help seekers. I watched two stony-faced Midwestern chaplains' offended expressions, and tried to listen as they whispered intensely to each other. Most of the people in the room would probably agree with Tom if asked, however, judging from the way they talked about their experiences. Ultimately, lines between proselytizing and not proselytizing are much more porous than the training leaves one to believe, a simplification that is part of the model.

Tom distinguishes a crisis of faith from a spiritual cry of distress. He says "expression of religious or theological distress arise in the time frame shortly following the impact of a traumatic event and in the context of physical, cognitive, and emotional symptoms of traumatic stress. Shock, impairment of judgment and memory, and acute emotional distress characterize the state of the traumatized person" (CISM-PCI Manual 41).

> The time frames for the onset of spiritual symptoms of traumatic stress to emerge will vary. For example, with critical incidents like fatal car accidents, the time frame may be in terms of days. In contrast, with a disaster the time frame for behavioral and spiritual symptoms to arise may take weeks. Without intervention, initial expressions of spiritual distress may grow and fulminate to a state of spiritual impairment in one's relationship with God" (ibid. 41-42).

Again, it is the relationship with God that is considered key to psychological health, and distress is considered as a possible threat to this belief. In order to restore one

to healthy functioning, the pastor must insure that "the relationship with God remains intact."

> Rather than giving into panic, a crisis interventionist who is able to make a careful assessment and timely spiritual intervention can enable a person to regain hope and functioning in their horizontal relationships with family and friends and their spiritual relationship with God (222).

Tom spent a lot time talking about whether people were experiencing "an actual "crisis in faith *or* making a cry of psychological distress using religious or faith-based language (35). This is essentially a question of interpretation, one that has plagued mental health professions since the rise of psychiatry. The PTSD diagnostics give clear guidelines distinguishing pathological from normal distress. PCI seeks to remain within the respectable boundaries of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of psychiatry, but the attempt to mimic the scientific criteria [and?] the kind of language that would have historically been used to describe religious crisis is replaced by a strange combination of religious and psychiatric discourse.

As a strategy to make it clear that clergy were not threatening the jurisdiction of mental health professionals—and as a way to distinguish themselves from less educated clergy or clergy from denominations who actively mistrust mental health theory—they were at pains to show a clear distinction between religious distress and psychological distress. Sean, a Russian Orthodox priest who was involved in 9/11 recovery efforts, adamantly told me that there were no grey areas between religious distress and psychological distress. He insisted that the distinctions were very clear. His insistence seemed to me unduly black and white, a style presentation I encountered among clergy

who seemed intent on proving that they were well versed in mental health theory, and would not be at risk crossing disciplinary boundaries by misreading signs of distress.

The last segment of the day dealt with self-care, which in the context of pastoral crisis intervention, we were told, had much to do with faith. Self-care—how we as caregivers maintain our own health—is an issue that is central to disaster work. Everyone who does disaster work is at risk for contagion, burnout, and compassion fatigue. "In the final analysis," one of the slides read, "optimism and unifying belief system, e.g., a religious belief system, appear to be powerful predictors of good psychological health."

The Shipwreck of the Singular[22]

In the course text, Everly defines faith as "that which allows you to accept what you cannot understand (81), a variation on the serenity prayer by Reinhold Niebuhr, which appears in the next slide:

> God give us grace to accept with serenity the things that cannot be changed, courage to change the things which should be changed, and the wisdom to distinguish the one from the other.

Tom had repeatedly told us the only thing you can change is yourself, a common phrase in much self-help literature of recent times. The following slide is a variation on the serenity prayer:

> God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the only thing I can change is MYSELF (PCI workbook 82).

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[22] "Shipwreck of the Singular" is from the long poem, *Of Being Numerous* (2003), by George Oppen.

Oddly stoic, this alteration epitomizes an idea of the self as a contained solipsistic unit. “The only thing I can change is myself” has a peculiar ring for a training that has intervention in its title. Who then were we being taught to intervene upon if the only thing I can change is myself? It sounded like Lasch’s minimal self, so beleaguered by the idea that civilization will cease to exist, the idea of human flourishing collapsed into the individual. *Coping* with life’s exigencies replaces ideas of transcendent goods. They retreat into the management of an isolated self rather, forsaking any possibility of collective action. We are taught to shore ourselves up against the “stresses” of life, the inevitable calamities. It is this shipwreck of the singular that is an extreme form of an American version of the self. That version has been described extensively in social theory literature (Geertz 1973; Taylor 2007). Important to note here is the way the training reinforces a particular idea of the self that has direct bearing on how people heal. The tension is between a view that sees the human mind/body as closer to machine-like—self-enclosed and subject to uniform interventions— and one that sees human embeddedness in a relational world as primary**.**

Anointment

Day four, the last day: “I am sure we are going to be able to go out and do God’s work, and to be ambassadors of God,” Tom said, in what I had come to recognize as his sermonizing persona, a distinctly different style of speech and presentation that he would assume when invoking God and trying to be inspirational. After he concluded, one of the ministers from the audience, a man with a shaved head who worked for a Fire Department upstate, stood up and said, “Tom, you are not going to have the last word. We are going to do some hands-on prayer and anointing and send some blessings to your

wife [who was suffering from cancer] and family." I must have missed that Tom's wife had cancer because I came in later from lunch. This minister took out a small container of frankincense oil and a large group circled Tom, putting their hands on him. He said a prayer wishing Tom blessings from God, grace, and healing, while many of the participants circled around Tom, putting oil on their hands and touching Tom's forehead. Tom was clearly moved and looked like he was crying. Several people hung back, including my friends from Alaska (in particular the young chaplain for the Navy Seals who was studying patristics) who refused to take the oil or participate. David said, "I don't want any part of this." It was clear that there were important theological differences. David seemed to see himself in a more "mainstream" or conservative light and likely saw this kind of display as pandering to a popular evangelical style of religion that he did not agree with.

The anointment provided a stark contrast to most of the training, which was very formal and lacking in explicitly religious content. It hints at some of the anxieties of secular policy makers who fear that chaplains are not capable of checking the religious belief, refraining from proselytizing and providing care to disaster survivors that do not take advantage of their weakened states to foist religion upon them. Despite the neat protocols of the PCI training, this other side of religion came in between the cracks. The hybrid of psychological and spiritual interventions designed to be non-offensive to secular disaster planners was not going to be enough for many of the ministers. The tension between mechanization and the need for a more "ecstatic," or directly religious content was made manifest by the anointment. What, I wondered, might really be happening with some of the ministers at disaster sites when people were faced with

burning houses and flooding towns. I was reminded of something a Jehovah's Witness hospital chaplain once confided to me. “I don’t care if they are Christian or not—when I’m in the hospital room, it’s my job to pray for them and help them accept Jesus, otherwise I wouldn’t be doing what I’m here to do: saving people.”

The Militarization of Spiritual and Religious Space?[23]

> The faith-based community represents a large and influential resource that unfortunately is underutilized during times of violence, social discord, and disaster (including terrorism). The faith-based community, with appropriate training in crisis intervention and emergency mental health, could potentially provide much needed support in times of community discord or mass disasters (CISM-PCI Workbook I: 11).

Since CISM has close ties to the military, and Tom himself was a Navy chaplain, it is not surprising that there would be explicit connections made between spiritual care and national security. References to “catastrophe” and the unimaginable in the religious context cannot help but conjure images of apocalypse, and while not explicitly mentioned, beneath the bureaucratic veneer, as the anointment indicates, I sensed a different side of religion: one that includes salvation, apocalypse, and very definite notions of retribution and morality—one that also sees itself as allied with the military. While I only saw slight signs of this, a closer look at the workbook revealed some ways in which religion might be harnessed to governmental programs in the service of the war on terror, an issue that was clearly on people’s minds, given the location of the training—New York City—and the nature of the material.

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[23] This subheading is taken from an article by Jackie Orr (2004), *The Militarization of Inner Space.*

> Terrorism tests the most fundamental aspects of human resiliency. Mobilization of faith-based resources serves to reinforce resiliency, especially in the face of the catastrophic, the unimaginable. The faith-based community represents a powerful and essential resource against terrorism. It seems important that this resource, once appropriately trained, be fully integrated into any mass disaster mental health response planning. Thus, not only should pastoral crisis intervention initiatives be considered within the public health response, such initiatives should be part of the overall strategic planning against terrorism and weapons of mass destruction (CISM-PCI Workbook II Everly: 86).

This passage puts religion in a purely instrumental light. The "mobilization of faith-based resources" in the service of creating resiliency connects religion directly to the war on terrorism. The religious self then can be seen as a subject to be manipulated, drawn into the overall strategic planning against terrorism, yet another piece in a massive system designed to defend against the potential enemy. Much like the use of psychology to develop national morale during WWII (Herman 1995), the potent blend of religion and mental health makes resilience a patriotic imperative. There was also talk about returning veterans and how they might be cared for, an issue that came up in other events and trainings I attended, bringing full circle the historic relationship between war and trauma.

Conclusion

This chapter has shown the tensions that arise when religion and spirituality are forced to fit into a bureaucratic model. CISM provides an example of what happens to religion and spirituality when it is forced to fit into a bureaucratic psychological model—showing some the inherent problems that arise in the development of disaster religious and spiritual care as an expertise.

Questions of faith and meaning, which in another era would have been accepted and even encouraged as part of dealing with catastrophe, are transformed by PCI into a

“mitigation process” to contain symptoms. Doubt becomes another glitch in a machine constructed for optimal functioning, temporarily disrupted by a disequilibrium brought on by a “critical incident” and in need of restoration to homeostasis. Far from proposing a whole person conception of the self, or even one that has a religious concept of the soul, this reductionist view breaks the suffering body and mind into treatable components. To contain doubt, not to initiate a re-evaluation of one’s relationship with the “divine” or the world around him or her, becomes the goal. The healthy self implied here is faithful and unquestioning because to have what might be seen as excessive doubt in God, is to be impaired.

By constructing a rubric in which to evaluate what is, in many ways, by its nature ineffable—God the divine or spirit—PCI on a theoretical/theological level shows that by using technologies devised for a different context, they do not necessarily become more spiritual. Instead they reproduce what they are trying to correct: the “non-holistic,” or secular, nature of crisis intervention, the lack of religion and spirituality in crisis intervention practice. On a practical level, many have argued that the kinds of information taught by CISM may do more harm than good (Groopman 2004; Halpern and Tramontin 2007; Satel 2003).

The question of the uniqueness of the disaster setting adds to these ideas. While there is room for doubt, it is considered a symptom and questioning is largely seen as something to be contained by quick intervention. Unlike the history of religious thought that addresses the ineffable problems of theodicy, how to live with the contradictions of a God that is both omnipotent and allows apparently innocent people to suffer, CISM simplifies the role of the clergy, turning them into modern technicians, representatives of

therapeutic culture—undermining the very criticism that religious and spiritual practitioners level against routinization.

Bowker (1997) writes that by providing a communal context, religious views of suffering have historically often resisted atomistic, individualist views that many commentators see as the hallmark of modern Western secularism. Unlike the therapeutic model presented by CISM, he suggests that in the past religion has acted in just the opposite way—by tying people together in a belief that has obligations beyond self-fulfillment (Rieff 1966). Whether this is true or not is an open question, but it is clear that in PCI religion did not suggest a broader interconnected perspective on human endeavor, but instead mimicked the individualistic views. The goal was to restore equilibrium, to what 19th century critics of mechanistic science called the "gorilla-machine" (Harrington 1996), working as quickly and efficiently as possible. The distressed person is rendered discrete and legible, subject to clear changes, with prescribed interventions.

Tom's combination of evangelical-style presentation with a highly systematized model of intervention provides an example of how religion and spirituality merge with a rationalized system. The "ecstatic healing" moment at the end of the training was in stark contrast to the rest of training, pointing to the sense the format did not entirely meet the needs of the audience who were mostly ministers. The prayer and anointment showed that many in the audience simultaneously maintained an entirely different view of distress and healing, one rooted in religion and faith. As one Catholic priest said at a conference on pastoral care, illustrating the tension that can emerge when religion is

forced to comply with bureaucratized model, “religion cannot be reduced to a series of boxes. True spirituality is dangerous.”

The cocktail of faith and scientific data gives PCI a powerful rhetorical claim to authority: where faith fails, data might work and where data fails, faith might work, was the message that came through. This flexibility allowed trainees to speak the language of science, bureaucracy, and religion, a synoptic view that lends greater legitimacy to the training.

The training seemed to show that mechanistic perspectives and religious perspectives, which may appear in theory to contradict each other, can actually commodiously exist together.

If in fact religion presents one moral resource for developing critiques of the modern self, as some have argued (Taylor 2007; Meador and Shuman 2003), the strategy that CISM employs does just the opposite. As Tom stood up there with his hands in this L shape and the PowerPoint slides projected behind him, with diagrams pointing the way toward celestial and earthly relations, I had the feeling that the audience was being lulled into a misguided simplicity. If only we could believe that we could find the way through catastrophe by following the axis of this man’s model, we might find some sense of security or control. But the models and diagrams presented by Tom and developed by Everly and Mitchell seemed like unlikely defenses against future calamity.

Chapter Five

Training for Trauma and Disaster II: Mississippi, Virginia and New Jersey

Introduction

This chapter examines the role of mental health training for clergy in the development of "disaster religious and spiritual care" as an expertise. Here I discuss three trainings, which I attended between 2006 and 2007: 1) Strategies for Trauma Awareness and Resilience (STAR) at Eastern Mennonite University (EMU), 2) a training in Mississippi for Katrina-impacted clergy, funded by the International Church Center 3), and a training at Princeton Theological Seminary on trauma and religion. All three trainings drew on different, scientific and institutional perspectives, envisioning and different ways of dealing with distress-related distress, and synthesizing spirituality and mental health. In this chapter I show how each training attempts to combine religion and spirituality with mental health, contributing to the creation of disaster religious and spiritual care as an expertise.

STAR was particularly concerned with the individual trauma journey and connecting individual trauma to group level of trauma, including what they call historical and cultural trauma. Church World Service (CWS) tried to provide a general training, one that had been developed after the Oklahoma City bombings and refined following 9/11, often invoking brain sciences as a means of legitimating. The Princeton training (taught by a health psychologist), was the most "mainstream" and scientifically oriented of the trainings, and largely sought to provide clergy with a model of how psycho-physiological responses to trauma interact with religion.

Background

It was the Prophetess, who I describe at length in the following chapter, who encouraged me to attend the STAR training. The training was developed by the Center for Justice and Peacebuilding of Eastern Mennonite University following the attacks of 9/11. The Prophetess said that attending the training would give me an important view on trauma and spirituality and how clergy were being trained for disaster. She had an important role in revising the training, often criticizing its neglect of race and class. STAR has its roots in a Mennonite religious perspective, one that has been combined with psychological theories of trauma, building on the work of Mennonite Central Committee's international development and peace projects. Mennonites have long been active in international aid, with projects throughout the developing world. For a small religious group they have a remarkably active international program, along with disaster relief efforts in the United States.

In the middle of February 2006, I flew from New York City to Dulles airport in Washington DC and was picked up by John, the husband of one of the women who works in the STAR office. We drove for three hours on a road wandering through rolling hills and farmland covered in snow, talking about NYC. John, a friendly, talkative man who grew up in NYC, talked about what it was like being involved with EMU. When I asked him what the students at EMU were like, he smiled. Not long ago he picked up some students who were returning from a trip to Italy. "You guys can play whatever kind of music you want," he told them. The argument that ensued, he told me, smiling, was between those who wanted to listen to Broadway show tunes and those opting

instead for Christian rock. "That tells you something about the student population, which has 50 percent Mennonite enrollment and advertises itself as providing Christian education," he said. John was suggesting that the college student body was socially conservative, and out of touch with the mainstream of college-aged Americans.

EMU sits in a valley surrounded by hills and farmland. The campus looks like it was largely built in the 1970s. After taking me shopping at the local supermarket, I was dropped off at the guesthouse, a small cottage on the edge of campus. I spent four full days in the training, from 8:30 am to 5 pm. In the evenings I went out to dinner at local restaurants and socialized with the other people in the training.

Day One

On the first morning, the snow came down on the hilly campus, which was mostly empty but for a few students walking quickly in the cold between buildings, farmland distant in the surrounding hills. The training took place in a medium sized seminar room in the main administrative building, with grey office-style carpet and dry erase boards on most of the walls. While I was unsure what to expect from the training, I had read the website, which states the goals as follows:

STAR expands practices related to trauma, security and shows the importance of integrating these concepts on personal, community and societal levels.

"Trauma" is often seen as a phenomenon affecting individuals, and much of the trauma-healing work has been limited to the individual level. STAR relates body and spirit to trauma healing and demonstrates that it needs to be addressed in groups and larger communities.

"Justice" is usually associated with legal systems. STAR presents principles of restorative justice that require the involvement of individuals and communities.

"Peacebuilding," has in practice been most often used at the community-level. STAR presents peacebuilding at the individual, community and state levels and integrates the importance of breaking cycles of victim-hood and violence.

"Spirituality" is usually disconnected from trauma healing. STAR identifies spirituality as a key component in healing trauma at all levels.

"Security" is commonly seen as national security and the duty of governments to protect their citizens. STAR pushes beyond national security to look at global security including economic and human security.

STAR activities honor multi-faith participation and the important interaction of those from diverse backgrounds in the US and around the world.

As this statement indicates, STAR envisions itself as a holistic system working on multiple levels, from the individual to the international level, using trauma and spirituality as central elements. Religious themes like forgiveness and reconciliation were not explicitly tied to religion, but were fundamental components of the system, ways of understanding conflict increasingly found in many international conflict resolution models. This represents an attempt to infuse mechanistic political science and foreign policy conflict models with an emotional, spiritual or psychological dimension. In contrast to CISM, the STAR program engages history and politics in an effort to draw connections among individual level trauma, societal trauma and global trauma.

Spirituality must be included in healing trauma, according to STAR, and has usually been left out. Also, the body and spirit need to come together in order for healing to take place, a central concept in much of holistic discourse.

The SNAIL Model

At the center of their curriculum is the “Snail model," which articulates the interaction between traumatized individuals and society. A spiraling graphic shows the different pathways out of traumatic repetition on the individual, local and global scale. The STAR program, while a direct outgrowth of 9/11, is intended for use in any post-violence setting, including settings in which people have experienced historical trauma, like slavery in the United States.

The spiral is constructed in a way where the only way out of cyclical patterns is through forgiveness. Characteristic of a genre of “systems thinking”[24] common in disaster work, and new age literature on organizational change, the holistic model seeks to integrate individual level psychology and spirituality into a global religio-spiritual-politico-ethical system. The new age sees human growth, as civilization and individual as inextricably tied up with spirituality. Mennonite pacifist roots play an important role in understanding how violence psychologically impacts individuals and societies, and pacifism, their theology suggests, can provide an alternative to trauma, on both spiritual and psychological levels. The glue that holds the training together is the trauma concept. Trauma is linked explicitly to a moral transformation (Biehl et al. 2007) on individual, structural, and cultural levels. The systems approach links individual trauma and healing to societal trauma and healing.

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[24] This genre includes writers like Ken Wilber (1999) and draws from a range of fields, including new age thinking, organizational behavior and cybernetics.

The Idea of Forgiveness

Forgiveness in the Snail model is seen as one of the highest states of individual and collective development. At times STAR defines forgiveness in explicitly religious terms, similar to CISM's (Chapter IV) vertical/horizontal idea of relationships. The goal then of a Snail process would be to get people to arrive at a state of forgiveness where they can take the path of restorative justice, rather than continuing to act out repetitive cycles of trauma. Part of a long history of trauma theory from behavioral, biological and psychodynamic traditions, trauma is seen here as forcing human individuals and groups into repetitive behavior that requires some kind of intervention to get beyond. In the Star model this intervention at its most successful will result in forgiveness.

STAR, which sees trauma, like PCI, as damaging vertical and horizontal relationships, defines forgiveness as

> **A relational change** on the horizontal level—between people, and a vertical change between people and God. Ultimately it is a spiritual process that we can accomplish only as we allow Him access to the deepest places in our hearts and trust Him to do the impossible.

Thus the relational concept of God is acknowledged—and we are conceived of as existing as part of an axis leading up towards God and sideways toward the human world. Unlike PCI there is more room for divine intervention. In contrast to CISM, for instance, the language of STAR presents a much more contextual view of the self, less mechanistic, and based on an "inspirational" style of religious and spiritual discourse.

Religious themes are often described in secular language but are very much part of the system, particularly language around forgiveness and reconciliation, which has become increasingly common since the widespread publicity around the Truth and

Reconciliation Commission in South Africa in the mid 1990s (Colvin 2006). The model thus connects individual healing to societal and global healing. The "heroic journey" begins when a survivor trauma takes a turn away from the cyclical nature of violence towards forgiveness, the only way out of cycles of violence. Characteristic of a genre of "systems thinking" that I have often encountered in disaster work and new age literature on organizational change, the holistic model seeks to integrate individual level psychology and spirituality into a global relgio-spiritual-politico-ethical system.

The Training

Day 1

On the first day we started at 8:30 by going around in a circle and introducing ourselves, followed by a brief introductory talk by the president of the University, and a short prayer for the success of our work. The tables were laid out with nametags and big binders with STAR written on them. Both Sally and Noreen, the workshop leaders, appeared to be in their mid fifties. They spent some time speaking about the different countries they had worked in and described what lead them to STAR. Noreen had spent considerable time in Nicaragua and Guatemala, and Sally had worked in Nepal and India, and most recently had returned from Sri Lanka, where she had been working with survivors from the Tsunami. Sally handed out her card, which described her as trauma consultant.

Noreen began by describing the history of the program. "STAR got its start after 9/11 and was funded by Church World Services, and was originally called Seminars in Trauma and Resilience. We think of the program as therapeutic but not therapy," she tells us, indicating that the curriculum was designed to encourage an internal

transformational process, and should not be seen as a way to deal with serious psychological issues, or confused with professional psychological training.

The course began with 9 participants: a Columbian Jesuit priest, Roberto; a young woman named Heather working for Catholic Relief Service; Darren, a Baptist Minister/family therapist; a self-described observant Christian, Samantha, who worked with drug abusers and former convicts; and Mary an elderly woman active in her Presbyterian Church. Also present were two students from the EMU: Jen, a woman in her 20s, and Mike a man in his 50s, who said he had been very active in several churches.

We introduced ourselves at greater length by describing our backgrounds and why we had decided to take the course. Sally then asked us to define trauma, and handed out paper and markers so people could draw how they experience trauma. We went around in a circle presenting personal symbols of trauma. These consisted of drawings that included a deep hole, a bruising crater, a drop of cold water in hot oil, and open space and fog representing confusion. People described the personal significance of these symbols. Some of the descriptions were highly emotional, and touched on histories of abuse and violence. The emphasis was on the symbolic and personal ways that people create meaning from difficult experiences, rather than on biopsychiatric conceptions of trauma.

After participants presented their views of trauma, Sally described the difference between stress and trauma. With stress, she tells us, we quickly bounce back, but trauma can be more difficult to come back from. “Trauma,” Noreen tells us, “is from the Greek word "wound"—and can be a wound of mind, body and spirit. The body instinctually

wants to recover and there is an "innate wisdom in the body[25]." The body heals because God implanted in us the ability to heal, which she suggests, would be one way to phrase it.

But "innate wisdom" could also be read as metaphor, thus the concept lends itself to both religious and secular interpretations. The biological tendency of the body to heal itself can act as a stand-in for the divine or for a more general spiritual belief in a universal tendency towards healing, which many new age practitioners find compelling.

Noreen tells us that Westerners tend to individualize trauma and think that talking is the best aid, whereas other cultures have different ways of understanding healing. [Despite this seemingly broad statement, I later found this perspective to be absent from their teaching.] "Trauma and violent conflict go hand in hand," she said. She goes on to explain the different kinds of trauma, which are a core part of the STAR model. More than the other models I studied, STAR had identified a number of different kinds of trauma on individual and group levels. This taxonomy makes trauma fit into virtually any analysis of human suffering on any population or time scale. A central component of STAR philosophy, these include "complex, historical cumulative, continuous, chronic, societal/cultural, historical, secondary structurally induced, participation-induced and plural traumas." Each form of trauma is said to interact with others,

[25] Walter Cannon wrote an influential book, *The Wisdom of the Body* in 1932. I mention this to show the continuing thread that runs through the mind/body medicine that Cannon suggested in his work, particularly as it relates to the concept of stress. Also, Cannon had a correspondence with Seward Hiltner, a professor of pastoral counseling at Princeton University's Theological Seminary, about the difference between voodoo death and Christian healing. Presciently, Hiltner saw that Cannon's seemingly far-fetched work might have important implications for Christian theology and healing (Dror 2004).

creating a model with levels ranging from the individual, to the interpersonal to transhistorical and cultural.

Noreen took out a sheet of paper with the different traumas listed on it. She then took out smaller pieces, each with an individual phrase and clothing pinned on them vertically, asking us to give an example of each one. We were being asked to personify these different kinds of trauma. The exercise suggested that all experience can be fit into a version of trauma on any scale: historically, personally and culturally. Such a broad definition of trauma allowed for this redefining of experience

During one of the more dramatic parts of the day Sally gave a lecture about what STAR calls "participation induced trauma (PIT)." Formerly called "perpetrators trauma" by STAR, the phrase was altered to deemphasize the agency of the "participant." They wanted to show, Sally tells us, that the person committing the act was not acting alone but rather was part of a structure. Like the concept "self-traumatized perpetrator" (Young 2007), indicating a person who becomes traumatized by the acts committed, this change in language has implications for attribution of responsibility. I asked: "What's gained and what's lost by changing the words. You are making a reattribution of responsibility and certain people will find that offensive." Roberto, the Columbian priest, agreed, saying that this was an important political issue. But the discussion did not go much further than that because the logic of the model had placed forgiveness so firmly at its center, resisting other ways of going forward—that maybe some cultures do not see forgiveness as central, or that some acts are simply unforgivable.

"Compassion fatigue is a big problem for people involved in disaster work and is connected to post-traumatic growth, transcendence and resilience," Noreen tells us. "People can become more resilient, and have experiences of transcendence working in disaster settings—what can be called post-traumatic growth." As I have shown in other chapters, resilience has become a key term in "proving" the relevance of spirituality to mental health and more particularly disaster and trauma work. It works well in this context because it allows in part for strong beliefs of various kinds to be defined as spiritual, providing psychological resources to transcend traumatic experiences. For instance, strong love for family and friends can be defined as spiritual and shown to be a "protective factor" contributing to resilience (Pargament 1997). Resilience also shifts the focus from pathology to studying "our innate inner resources," a concept that readily grafts onto many forms of religious and spiritual thinking. Post-traumatic growth, also, is a reaction against the pathologizing tendencies of trauma theory. The argument goes that instead of being damaged by traumatic events, many of us grow religiously, spiritually and morally, allowing people to become more resilient. Again, this redemptive narrative has great appeal for the religious imagination.

We were then led through an exercise where we all had to create and present symbols of trauma. We sat around in a circle and Sally lit a candle, saying that this symbolizes God's light. People provided different examples. Noreen had a picture of a warhead with a dollar attached to it, symbolizing US involvement and the trauma it caused her. Father Roberto, the Columbian priest, showed us a cross, which he had received when he took his priest vows. He described a time when he was working in a remote village and shooting broke out. While trying to dodge the bullets, he left the

cross behind in a shack. When he returned it was broken in the corner, hit by a bullet. "This," he said, "symbolized how trauma breaks things and cannot be fixed," pointing to religious view that differs from the optimistic frame, maintaining a more tragic view of suffering. In this case the clear association with trauma and religious suffering takes on both a material and emotional form. The very symbol of Christ's suffering had been fractured, the internal suffering that Father Roberto had endured, which he suggested cannot be included. Father Roberto's symbol of the broken cross contrasts with CISM's horizontal and vertical axes. Rather than proposing a relational solution, he sees himself as persisting in the face of brokenness.

Towards the end of the day Sally led us through an exercise called "the river of life." We were told to draw a river that represented our lives and along this river to indicate the "traumatic" experiences we have had, which formed our personalities and character. I was struck by the way we were being guided to think of our lives as defined by trauma, as being formed essentially by traumatic events—a redefinition of self in terms of traumatic experience. This narrative view of our lives (Garro 2003) was meant to connect us with our own personal traumas in order to become more effective healers, to understand how our personal suffering could give us insight into the suffering of others. The walls were covered with multi-colored rivers surrounded by drawings of people, some in houses, some outside, depicting wars and deaths. They were meant to give pictorial representation of our personal traumas so that they could be shared in a group setting and spoken about openly, a deeply held psychological value.

We ended the day by talking about personal characteristics—resilience— that helped us "walk with people" experiencing trauma. "Walking with", a common

Christian phrase, refers to the idea of a ministry of presence, which is often evoked by chaplains. In this view, instead of preaching, being present and witnessing provides healing and solace. Lynn, the older student and wife of a minister, asked the instructors what allowed them, both coming from relatively easy lives, to do the kind of work they do in Nepal, Central America and Sudan. Sally quickly responded that she didn't come from an easy home and became visibly emotional. The candle burned in the middle of the circle and we sat quietly. Before leaving, Sally suggested we end with a prayer. She thanked God for giving us different resources and for being able to help people heal from trauma. "We are all wounded healers," she told us. As I have been arguing, personal trauma and the expertise in "disaster religious and spiritual care" are intertwined. The idea of the "wounded healer," (Nouwen 1979) was often mentioned by clergy I spoke with. The wounded healer came up at some point at nearly every conference and training on disaster mental health I attended. Tom from CISM, for instance, spoke about his struggles with cancer, the Prophetess and Frank both spoke about their personal narratives of trauma and how this relates to their work with trauma survivors. This metaphor supplied a valuable redemptive narrative by giving meaning to suffering, creating a framework to handle what might otherwise have been unmanageable life experiences. Deaths, sexual abuse, violence—one can be overcome by their corrosive forces and reproduce them, or one can become a healer and act as a force for good. This is what the wounded healer metaphor seemed to lend to people's lives.

Forgiveness, Grieving and Healing

In describing how people heal from trauma, Noreen says, "Forgive and forget, the brain isn't made that way," explaining that trauma needs to be transformed, not forgotten. The brain, she explains, does not allow for forgetting because memories become imprinted into the neural structure. What does it do in this context to make reference to the structure of the brain? What kind of work does such an explanation do? For one, it forecloses the possibility for things to be otherwise. From this, logic follows that really only one good solution remains: forgiveness. The "trauma journey" becomes part of a biologically inevitable process of development. Not only is forgiveness a good, which it may be, or therapeutically efficacious, which it also might be, or something to be dealt with theologically, which it also still may be, but it is also *biologically* the only positive way forward.

"Through mourning, and grieving," the manual reads, "the desire for revenge is lessened: trauma energy is released and meaning is given to the event over time" (22). This redemptive view of trauma, the *moral* transformation, distinguishes STAR from the other trainings. The religious implications were spelled out as the event went on and forgiveness became a central component of STAR. As nascent disaster experts we were being trained to help people go through an emotional spiritual journey where the highest state of moral, psychological and spiritual development was a state of forgiveness. The transformation of trauma is framed as an inherently moral process. Meaning becomes nearly guaranteed for those who put work into "dealing" with their trauma, ruling out the possibility of a meaningless world, a world where the traumatic events happen for no reason at all.

"Trauma," Sally tells us, becomes a gift from God because God uses all and because trauma can help us become more aware of the suffering of others." As a central Christian idea, where the suffering of Christ redeems, the Snail model has at its core a Christian conception of suffering as leading to grace. This framework makes it possible to see all suffering as meaningful, as part of an ordered universe.

Day Two

The second day started with the light of the candle and talk about the kinds of spiritual resources we draw on to deal with trauma. Some mentioned the importance of friends. Father Roberto talked about the importance of music and nature, and others mentioned family as part of their spiritual practice. Spirituality was defined broadly as that which brings personal meaning. This could include virtually anything. Noreen tells us, "spirituality to resilience, allowing people to overcome trauma by providing meaning in the face of what could consume." Meaning and spirituality are linked by their ability to build resilience in the face of traumatic experience.

Most of the day was spent in lecture format based on the trauma journey model they were advocating. The trauma healing journey, Noreen said, is the heart of the program. The Snail model visually represented it, where it occupied a place in the way people grieve and transform themselves into wounded healers. As one important way that experts in disaster religious and spiritual care understand themselves, the wounded healer offers way to redeem suffering by transforming the suffering self into an agent of healing.

Biologizing reactions to disaster was done in different ways. Noreen cited a study on women in the *Annual Review of Psychology* that shows that women are more likely to

provide care during disasters, to want to take care of “children." “This is at least in part due to oxytocin, a hormone produced during stressful times in women, also produced during breastfeeding,” she said. This provides another example of scientific discourse was used to account for moral and religious behavior. Women are presented as more capable of dealing with catastrophe more effectively than men not because of their moral or spiritual character, but rather due to biological adaptation.

Later in the day Sally showed us a film about a polar bear. We watched the polar bear shaking while several scruffy biologists looked on, explaining that the bear’s response was an example of stress release. Noreen asked us if we noticed that his paws were moving. This, she said, showed that he was getting the trauma out of his system, and animals do better at dealing with trauma and getting it out of their system. They are able to release *stress* in many ways, including snorting or by sleeping it off in the case of the polar bear**.** There was no discussion of the fact that polar bears and humans have quite different emotional lives, and that the comparison may not be quite relevant. Why would the trainers be at such pains to argue that emotional and existential responses needed the legitimacy of biology? Part of the answer, it seems, lies in the legitimizing power of science to de-stigmatize those who might be suffering. The other related part has to do with a need to distance the reaction to trauma from the suffering individual. If we are like the bear, stuck in a flight or fight response, we essentially do not have the responsibility for our reactions—the causes lie in our evolutionary history. This is a compelling theory because it makes for more easily identifiable clinical interventions. This conception of stress goes back to Selye and Cannon’s work, providing a thread that runs throughout thinking about disaster-related mental health in the latter half of the 20th

century. The biological reductionism of the polar bear example provides a material view of healing that is far from a traditional Christian concept of grace, substituting a stress-free redemption as a modern version of theological grace.

The neurobiological bases for these arguments draw on Van der Kolk's theory of traumatic memory. Much debated, this theory takes traumatic experience from the mind and places it within the bodily memory and the "primitive brain" or amygdala (Young 2003). Again Cannon and Selye's imprint can also be seen in this work (see chapter two). Cannon's "fight or flight" laid the groundwork for this key concept in the stress studies literature, which in turn supplies important knowledge claims for the disaster and spiritual care emerging professions.

Culture

Since both instructors had spent many years abroad, they often referred to experiences they had in different cultures. While the specific examples they gave referred to countries they had worked in, including Nepal, Sri Lanka and Guatemala, they used the term more generally to describe the various ways that stress might be manifested. "Some cultures," Noreen said, "don't have an understanding of mental health like we do and they have a harder time with the chaos." Despite rhetoric of cultural sensitivity, the bias towards a version of Christian-American therapeutic religion was clear. Unlike CISM, however, STAR drew from the Anabaptist peace churches, and despite drawing on biological discourse, maintained ties to a more humanistic psychological sensibility. Their attempts to link trauma to political and economic issues evidenced a very different view from CISM's behaviorist-oriented evangelical tradition with military ties.

The people in the Andaman Islands, Noreen said, believed it was devils taking over that caused trauma, and that it was our job to tell them otherwise. Later I engaged her on this issue and she said that she tried to tell them that reactions to trauma are normal and are your body and brain working together the way God created them to work. That is what she tells those who think they are depressed, as well as those around them. "Befriending symptoms," she said, "is a sign of strength." She was trying to shift their understanding of distress to a particularly American cognitive psychological model that aims for the acceptance of emotional states, rather than psychically pushing them away.

"Trauma," she says, "is isolating and it can take acts of God to get people out. People are traumatized and it is like being frozen in a block of ice. It is important to move them from "my pain" to "our pain or pain of the universe."

At one point there was a discussion about whether or not some cultures deal with stress better than others. Noreen gave an example from the Sudan where an older man said that if you make us cry then people will think you are a wizard. The cultural examples were used to show not only how different beliefs about distress could be, but also how much work there is to be done in order to educate people about the true nature of trauma. The assumption, as Noreen indicated, is that cultures without knowledge of Western mental health theory should be taught the "true" nature of trauma. They would fare better if they no longer believed in demons, wizards and the like.

Sally talks about the still small voice as the kind of moral voice, an idea used in relationship to a training done in Bosnia where her team of mental health interventionists

found that most people at some point had a voice inside of them that was telling them not to do what they were doing, but they chose not to listen.

Uma, a former EMU student who worked in the STAR office, whose husband was killed in the 1998 Nairobi bombings of the US embassy, spoke of her trauma, linking psychological and theological. "We knew about Al Qaeda there before you did in the US. 250 people were killed, 12 Americans and 5000 injured," she said.

She said she didn't know what was going on with her until she started reading and studying about trauma. What was clear was that trauma gave her a framework for her narrative, and the STAR model even more strongly enabled her to create her narrative. She is obviously a religious woman and when asked about how people are able to turn from the cycle of violence to the cycle of healing, she pointed to grace. Much of the STAR model has religious principles, even if they are not made explicitly. Transcendence is one way people are able to rise above the cycles of violence, which have religious implications. Even the concept of forgiveness, that we spent so much time talking about, is essentially a Christian idea, as far as I understand it.

Uma describes the morgue and finding her husband's mangled body. The only way she recognized him was by the shirt he was wearing -- the same shirt that she had told him to wear that morning. It took her several days to find him.

"It takes the grace of god to break free," she says. Uma provides a model for the STAR healing journey. Her path of trauma and grief to healing and forgiveness and the recognition of Gods' power and essential benevolence fits with the Snail model's stages, creating a powerful modern way of making sense of suffering, making the world legible and finding ways forward. Here also is an explicit example of the role God plays in the

STAR, and the way personal transformation interacts with codified expertise, translating of life history into a trauma narrative that follows the model we were being taught to see the world with.

Uma made explicit what was often implied by STAR—it is, in fact, God that allows one to break out of the cycle. The transformation she went through is a key way that the idea of trauma transforms everyday moral experience (Kleinman 2007). Individual narrative is tied to an apparatus that, in the case of STAR, includes diagnostic ideas of trauma combined with religious and spiritual transformation. When Uma speaks about her trauma, she invokes multiple intertwining discourses.

At one point I overheard Sandy, the young woman who worked for Christian Relief, talking to Noreen about her work in Sudan. "It's really hard to get the children to cry there," she said. She was clearly frustrated by the idea that children were not expressing the kinds of emotional reaction that she would expect from children in the US, not conforming to an idea she had about the proper way to grieve. I was horrified by the idea of trying to get children to cry, and almost interrupted the conversation, but thought it might be inappropriate. The idea that we are teaching people to grieve correctly, despite claims to being culturally sensitive, is a seemingly misguided, well-intentioned evangelical impetus suggesting that only some have the maps to lead people everywhere through their experience of grief.

We ended the session with a "mind/body prayer" composed by Noreen, in which we were told to focus on the sensations in our body, asking God for flexibility and resilience, letting go of the past and going forward. The prayer drew from Christian

sources with a trace of Buddhism because of its emphasizing bodily sensations, a practice that has roots in Theravada Buddhism[26].

Day Three

On the third day it became increasingly apparent how much STAR combined trauma theory with a particular version of spirituality, and why Christian theology of a Protestant American kind maps so easily onto traumatic experience. This convergence of trauma with religious themes of suffering appeals to many Americans and resonates with popular psychological and religious themes.

Much of the morning was spent on "reconnecting with our bodies." As I have mentioned earlier, the "traumatized body" has become a key concept for contemporary trauma therapies. "Trauma work involves definite body work," Sally notes. She mentioned James Nelson[27] and embodiment, and she spoke about the theological aspect of embodiment. "When the spirit takes on flesh," she said, "when God becomes body like we are, you have incarnation." Survivors of rape and sexual abuse often talk about it is as if their bodies are turned against them and are ashamed of sexual feelings. She says that she tells them "that their bodies are created by god and that when they are touched in those parts [sexual] it is ok to feel a kind of arousal—you are supposed to." In this way she suggests spirituality is used to combat the trauma of rape.

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[26] Similar to Frank's use of Buddhism (chapter 7), these ideas tie in with a particular idea of how trauma is manifested in the body. These meditations draw on the work of John Kabat-Zinn (1990), and a general trend among mental health professionals to include a *mindfulness* or *contemplative* component.
[27] Nelson (1978), I later discovered, wrote a book called *Embodiment: An Approach to Sexuality and Christian Theology.*

She went on to speak about the important role of touch. "I like to stand with people I am working with, my hand on their shoulder, and picture the light of God flowing through and picture myself as a conduit of God and say a prayer of healing." .

We did some breathing and mindfulness exercises. Noreen spoke about the innate "wisdom of the body." "The body knows how to heal itself," she said. "We just need to let it." And then she instructed us on several yogic breathing exercises designed to alleviate stress and anxiety.

"Prayer," Noreen told us at one point," creates new neural pathways[28]."
We were led through the Truth, Mercy, Justice, Peace and personification exercise where we split into groups and had to represent these ideas, and then talk about them in essentially a talk show format. The exercise was framed within the context of a psalm: "Truth and mercy have met together; peace and justice have kissed" (Psalm 85; 10). While the exercise might have been done in a secular way, the psalm inflected it with a religious mission, emphasizing the religious roots of the training.

Trauma provides the unifying thread. What becomes apparent from this exercise is the way trauma and theology are linked. Is trauma then just a stand in for suffering—in this case, the suffering of Christ? It seems that this is partially true but not the whole picture. Trauma, as I have been arguing, has too many other ideas attached to it and the use of trauma as a legitimating trope takes it out of the purely religious realm. What in part gives it such great explanatory power in this context rests on its mercurial usages: it

[28] David Brooks, in a recent op-ed, uses the term "neural Buddhism" to describe the widely publicized studies on the meditation's impact on the brain. In my fieldwork I observed a similar phenomena that could be called *neural Christianity*

can be a psychological term or religious term, depending on the context. Conceptions of resilience easily merge with theological ideas of spiritual growth through suffering.

Day Four

At the end of the final day we said goodbye ending with a prayer. I drove back with Holly, who spoke about her response to the training. Holly and I spoke about the World Bank and Catholic Relief services. She was clearly taken with the STAR model and was eager to get back to her office and see if it was possible to enroll her coworkers in the training. I tried to gently raise questions about whether exporting such trainings around the world was such a good idea; but when she spoke about wanting to work for the World Bank, I reflected on the fact that she was a graduate of a prestigious International Relations program concerned with development, as well as being a committed Christian. While in the car she received a call from a representative of the State Department who was doing a background check on one of her classmates. We then spoke for a while about her impressions of the training. She conveyed her pleasure in having a framework in which to incorporate trauma into her work—and finding commonality with the STAR instructors—particularly one that focused on spirituality. “I’m looking forward to teaching what I learned at STAR to the people I work with," she said. “A lot of this stuff will be really helpful for when I go back to the Sudan.”

On the STAR Manual and the Manual Genre

A key way in which experts define themselves is through the codification of knowledge--often by producing manuals and handbooks. Throughout the research for this dissertation I accumulated a number of manuals on disasters. The STAR manual is a sprawling document, contained in a three-ringed loose-leaf binder. The manual is

designed to provide knowledge for action—that is, as a way to incorporate a whole set of principles into one's professional apparatus in order act "appropriately" in a given situation. The STAR manual is a complex document because it tries to deal with so many different issues that are often in tension with each other. It includes everything from acupuncture to how to identify survivors of torture; from meditation and trauma therapy to restorative justice—a patchwork of ideas that comprises the disaster and trauma professions.

As the account of the STAR training session indicates, STAR draws from many practices, including new age, neurosciences, and religious and spiritual traditions of various kinds. What they end up with is a "holistic" training based on a principle of trauma that allows for re-interpretation of suffering in terms of their particular religious and spiritual ideas of trauma. The tendency to reduce the experience of trauma to a narrative of redemption based on a patchwork of different streams of knowledge undermines the possibility for more complex views of human action.

Church World Service and Mississippi

I first met Jim in a bookstore in mid Manhattan on a warm fall day in 2006. He had been referred to me by an acquaintance at NYDIS. A mild-mannered man in his early 60s, Jim's persona belies what I found out later to be a remarkable life. Jim works for a large multi-faith Christian organization. He has been present at nearly every atrocity in the post WWII era: Pol Pot's Cambodia, Rwanda, Bosnia, Sudan, Tsunami, and Hurricane Katrina. Much later, he told me remarkable stories about living in Cambodia during Pol Pot's regime, and also about being kidnapped by communists in Thailand. Jim had been working for the International Church Center for many years and

had become increasingly interested in issues around spirituality. He said spirituality is a key to the way people are able to deal with trauma. A non-sectarian liberal Christian, Jim said that disaster mental health really needed to have a spiritual component.

After emails bank and forth with Jim for several weeks, it was decided that I was to fly to Mississippi and meet him and his team of religion and trauma experts for training. The training was designed following 9/11, in part by some of the psychologists and clergy who worked in Oklahoma City after the bombing. Moving from Oklahoma City to New York to Mississippi and to other gulf towns, this training has changed to accommodate each disaster, incorporating new experiences and attempting to adapt to local contexts.

I took a fight from JFK to Atlanta and boarded a small plane to Biloxi. In Atlanta I ate catfish and collards, thinking that I would inaugurate my southern journey with southern cuisine. The small, cramped plane from Atlanta to Biloxi was filled with military and religious groups on their way to do relief work in the post-Hurricane Katrina Gulf. When I arrived in Biloxi it was clear that I had entered a different world. The airport was in great disarray, with exposed wiring and a general sense of disrepair—raw concrete floors and construction creating a maze of passages. I stood outside the airport waiting for a taxi for over an hour. The attendant explained that most of the taxis were taking people to New Orleans, which is approximately an hour's drive. An older man with a thick southern accent finally arrived in a mini-van and took several of us to our respective hotels.

Not long after I arrived, Jim called to let me know that we would be going to dinner with Candice, one of the trainers, who had been working with this group since

9/11. Candice was a tall, outspoken woman from Oklahoma who seemed to enjoy testing Jim's reserve by poking fun at him. During dinner at a chain steakhouse I listened to Jim and Candice exchange the latest news. Candice had just come from conducting trainings in rural Alabama, and she spoke about her experiences throughout the Gulf, the extreme poverty she had encountered, and the religious intensity of the rural churches.

The next morning we met Jim, Candice, and Candice's training partner, Albert. Albert is Presbyterian minister and works at a counseling center for veterans. He has a doctorate in family systems from a seminary. We drove together to Gulf Community College, and unloaded the car, carrying a projector and boxes of paper into the auditorium where the training was to take place. The college consisted of recently built one-story buildings, seemingly well-funded and taken care of. The conference room where the training took place was a large lecture hall with tables, swivel chairs, and florescent lights. The facilities at the college were new and well kept. The room slowly filled up with mostly African American women. Many were wearing Project Recovery shirts provided by a FEMA funded project for people who go door-to-door, conducting needs assessments and making referrals.

Candice, more animated than Albert, projected herself energetically across the room, walking back and forth smiling with a very direct presentation style. She is direct and humorous. At one point she said, "I am a cognitive behavioral therapist. I don't mess around," suggesting that other, older models of therapy are less rigorous.

The stated goal of the training was to merge spiritual and psychological care, and to create a skill base for clergy working in disaster settings. Candice confidently articulated a synthesis of psychology and religion, relying heavily on neuroscience and

cognitive psychology. Playing more the psychologist than the minister, she did not directly engage theological issues, instead focusing on immediate responses to disaster settings, from individual care-giving to conflicts among competing organizations, as well as burnout of disaster relief workers.

Her presentation included pictures of a stadium that she used as a metaphor for the brain and neurons, though I was not sure that I understood what she was suggesting. When someone is traumatized, she said, the neurons go to one side of the stadium (or brain) leaving the other side low on neurons. Again, the legitimating languages of the brain sciences are evoked. This "folk neurology (Vrecko 2006)," as I showed in other trainings, has become an increasingly common way to explain traumatic suffering[29]. Later, in a private conversation, Candice confided that she thought psychology would tend further towards neurology because psychologists were better than religious specialists at treating mental disorders.

Albert's presentations touched more specifically on theological issues and he did bring up the concept of *shalom* as indicating a wholeness that includes physical, spiritual, and mental. He used biblical stories from the *Book of Job* as a way to illustrate the impact of trauma. Job, Albert told us, was traumatized by the loss of his children and the other tragedies that befell him because of God's seemingly capricious dealings with the Devil.

"You can rewrite the bible in terms of disaster. Noah was the first disaster—

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[29] Several anthropologists have examined this issue. Young (1995) has written about how evolutionary psychiatry understands trauma. The way these scientific theories play out in a clinical setting has received less attention

then there was a settlement program," Albert told a crowd of Katrina relief works outside of Biloxi Mississippi in the autumn of 2005. "In Hebrew thought," he went on to say, "The idea of health was not atomized into physical mental and spiritual. Trauma leaves us separated from God because of what happens biologically—the underlying emotion and fear. Traumatic events attack the meaning system. At times of crisis, because of neurobiological effects of trauma on cognition and emotions, your presence represents God's presence. People experiencing trauma may experience tremendous faith regression." Albert was talking about the belief that trauma has a neurological impact that makes people disoriented, on different points on a continuum, including a biologized version of spirituality.

Demonstrating the almost jarring relationship between neurological language and religious language, Albert's talk shows how the brain sciences were incorporated into disaster religious and spiritual care. In similar ways to CISM, described in the previous chapter, the trainings discussed below illustrate different attempts to integrate various streams of mental health and scientific expert knowledge into disaster religious and spiritual care. Again, as we will see conflicts and contradictions arise when trying to fit religion and spirituality into these different therapeutic schemes.

Candice clearly positioned herself as a different kind of mental health professional from the previous generation. When I asked her what she thought about psychoanalysis, she said that she thought psychoanalysis has no room for God. Emphasizing the importance of drawing a distinction between the work of psychology and the work of religion, Candice said the biological model and cognitive behavioral models are more appealing to religious people because both avoid questions of meaning.

They do not claim to help people to analyze their life but instead maintain a clear division of labor between religion and mental health[30]. The paradox is that the "advancement" of therapeutic models, the move towards rationalization and scientism, allows for great opening for religion and spirituality. I was reminded of the reply I heard from Dr. Wang, the blind Christian psychiatrist, who in an interview made it clear to me that cognitive therapy was the therapy of choice for the Christian therapeutic community. "Unlike Freudian theory," she had said, "cognitive therapy does not get into questions of motive or morality, but rather limits itself strictly to behaviors, and leaves problems of morality and belief to the religion."

Later that evening we drove along the coast amidst the half washed away buildings and rubble, with bed sheets draped ghost-like in trees. One hotel had its side ripped off and you could see inside the rooms, with bedding and lamps intact. The shiny though empty casinos by the water advertised buffets and entertainment while further down the beachfront only destroyed houses remained, save for the ever-present Waffle Houses which somehow had defied hurricane Katrina.

We went to dinner at a Cajun restaurant. Jim, Candice and Albert spoke about some of their work history. The room was filled with volunteer groups, mostly from

[30] Charles Taylor writes, "We can see how fateful the issue is for a human life. To worry endlessly about the meaning of an unease whose whole basis is really organic is to have wasted time and effort and to have incurred unnecessary suffering. But to have tried to get rid of an unease that one really needed to understand is crippling; the more so in that within the culture of the therapeutic, the various languages, ethical and spiritual, in which this understanding can be couched become less and less familiar, less and less available to each new generation" (2007: 622). Koenig (2007) makes similar comments in some of his work, arguing that Freud represents the dark days in relations between mental health and religion. The newer ideas of therapy are much more enlightened, targeting a circumscribed part of human functioning and leaving the "soul" alone, to be dealt with by religious and spiritual professionals.

churches around the country. We spoke about how Candice would handle some of the political problems around disaster planning in NYC that I explained to her**.** Candice boldly added, “I would put out a disclaimer saying that Jews and Muslims aren’t a part of any planning group until they can get it together.”

Day Two

The second day was quite a bit different. Most participants were not clergy. Albert opened the session. “All of the work you do is ministering. Everything,” he said. There was a tense moment when Albert was describing strategies for selfcare. “Selfcare is key if you want to stay in this work. The burnout rate is very high.” He suggested that the participants meditate for an hour every day. A woman raised her hand and said, “I have 3 children. When will I find the time to meditate?” Albert replied, “Try locking yourself in your bathroom at night and take a long hot bath,” She replied with frustration. “We live in FEMA trailers. We don’t have baths.” Albert became defensive and said, “If you are not going to take care of yourselves, then if I come back next year, I will find that most of you won’t be working here anymore because you will have burned out.” This elision of the material reality, despite the seemingly blatant presence of the hurricane’s impact, was striking. A with Tom’s rewriting of the serenity prayer in the previous chapter, Albert was instructing the participants to shore up their inner selves while largely ignoring the ongoing material deprivations that might be impacting their psychological experiences.

“Selfcare” was clearly shown to be an idea that does not translate well across class and geography, let alone between cultures. The problems of importing a model of training designed for one area and applying it to another were clearly evident. Albert’s

unwillingness or inability to examine the mismatched assumptions of his training indicates a widespread problem in importing trainers without adequate knowledge of the local situation from the outside.

When I returned to NYC, I spoke with the Prophetess about the interactions between the trainers and the women participants. She said I had observed something important—what she had been dealing with all along. The racism and exploitation of poor people, she told me, was at the root of her conflicts with STAR, and also with CWS.

On the plane ride home I kept wondering how one could design a training that might better respond to the needs of the people. I also thought about the misalignment between experience of disaster and the kinds of therapeutic models designed by experts. Why, for instance, were locals not taught to conduct the trainings? Was the knowledge so specific that they needed to fly people in from other states? The Prophetess later leveled similar critiques, accusing CWS and other religious organizations as being essentially money makers, siphoning grant dollars from the north while providing second rate services to the south. Reverend Green (chapter 3) had also suggested that there was an unjust distribution of disaster relief money.

Unlike STAR and CISM, and to some extent the Princeton training, the Mississippi training did not present an integrated model or worldview, but was instead a combination of a variety of practices, strung loosely together. This is partly because of the looser institutional structure: both Albert and Candice were contracted through a large organization, and although they sometimes work together, most of the time they work independently, drawing on their own idiosyncratic ideas about disaster, religion

and spirituality, with no official line to impart. Unlike the other trainings, which were associated with particular models of care, Albert and Candice are independent contractors who work together under separate contracts, drawing from their individual professional experiences.

Religion and Trauma at Princeton Theological Seminary

The train ride to Princeton seemingly transports one into another era, another world: from the maddeningly busy maelstrom of Penn Station in Manhattan, to the idyllic, cloistered suburban campus. I went to Princeton to attend a training titled *Religion and Trauma*, which I received notice about from a listserv on pastoral care. The brochure for the seminar reads

> This seminar examines the questions: How helpful is religion for trauma victims? Is there scientific proof that prayer helps the sick? Are there times when religion does more harm than good? These questions and more will be addressed using current psychological and medical research on trauma, religion, and well-being, offering participants who minister to people facing life's adversities the most current thinking in the field.

The description implies the essential instrumental view of religion— the emphasis on whether or not religion is *helpful*. Religion is framed as subordinate to psychology, something seemingly unlikely for a training taking place in a seminary.

While the training lasted only one day, I include it because it represents one of the most influential approaches to religion and health in the US. Our instructor, May, was a psychologist, trained by Koenig in a post-doctoral program at Duke University, and was an advocate of a fairly middle of the road Christian evangelical theology. She was comfortable wielding figures on the health benefits of religion, seemingly seeing no apparent conflict between scientific measurement and faith. The fact that the program

was sponsored by Princeton Theological Seminary, also a middle of the road mainline denomination located in a prestigious Ivy League University, lent greater credence to their messages about religion and health. The audience was made up mostly of chaplains, all white but for two African Americans. There were several military chaplains, and as far as I could tell, I was the only non-Christian in the room. Of the eighteen participants, ten were women.

While May never made her own religious affiliation known, it was clear from the intensity of her voice that she held strong beliefs about the role of religion in medicine and psychology. "Doctors," she said with great disapproval, "don't want to talk to their patients about religion. They are resistant but we know that talking about religion is very important to patients." Though May was at times critical of religion and health literature—and the DSM—there was the general assumption in the room that religion had been pushed to the sidelines by the medical establishment and needed to claim its place. The nodding heads of affirmation evidenced this when she spoke about these issues, and the fact that there were no dissenting views. In line with the research tradition in which she was trained, she placed a great emphasis on data, and the near irrefutable idea that religion is good for your health, as well as the notion that religious people cope better with trauma than those without religion.

A female social worker/minister spoke about faith as a process rather than a discrete category, hinting a critique of May's perspective. However, she then changed her position and said, "That is my chaplain side speaking and I understand why faith needs to be seen in the research context." May mentioned a theologian who did not like the prayer and health studies because they imply that God cares more for some prayers

than others. An African American woman responded by saying, “We just need to learn to live with mystery.”

The introduction to the slide presentation makes apparent the link that I have been making between stress and religion. The PowerPoint slide read as follows:

- **Background on stress, religion, and well-being**
- Issues associated with religion in healthcare practice
- the scientific method
- religion, psychological trauma, and well-being

Another slide emphasizes the role of religion in building resilience, one of the key arguments for the use religion in disaster settings:

- what we do seem to know
- religion encourages adaptation
- religious people appear to be more resilient when confronted with a traumatic event

This slide, directly in the tradition of Cannon and Selye, suggests an evolutionary model, implying that religion itself may be a selective factor. This not uncommon argument went unquestioned at the training. There was no objection to the idea that we are selected based on religious belief. May concluded on a cheerful note, telling us that scientific study of religion had come a long way from the old days of psychology, and that we had important evidence that proved religion’s usefulness. Overall, the training relied on a neat model of religion and health derived from research conducted by Harold

Koenig and his colleagues at Duke University. There was little conversation about the complexity of suffering, or difficult theological questions. Religion can be good for your health and can act as a protective factor against trauma seemed to be the main message. On my way to the train, I ran into someone from the training. He told me that he worked for the military as a chaplain and that they were sending him to Princeton to receive training in "culture" in order to work more effectively in the Middle East. When I asked him what he thought of the training, he said, "It was ok. I don't know that it will really help me in the field. But it's good to see more research in this area."

Conclusion

This chapter shows how three trainings develop the idea of disaster "religious and spiritual care." Despite important differences between them, there are some key similarities that reflect the shifts in how we understand religion, trauma and healing. The pervasiveness of neuroscience, evolutionary explanations and instrumental use of scientific data as a means to justify the role of religion and spirituality in disasters, and the ubiquity of the trauma concept, in its various forms, are presented as an essential ways to understand disaster-related distress.

Brain research was also presented in different ways, but it was part of a general trend towards legitimating the expertise of disaster and religious and spiritual care by referencing its basis in scientific discovery rather than in theology. Thus it is not enough to say that creating a new narrative empowers people who have been traumatized. It is also important to say that "new neural pathways" are created when one tells the therapeutic story differently. What exactly the neural pathways consist of is left to our

imagination, but the image of implanting the trauma therapy process into the grey matter of our brains is powerful at this point in our history. This has particular relevance for the justification of the different approaches to “disaster religious and spiritual care." By referencing hard sciences and translating their own work into scientific terms they hope to gain greater credibility.

None of the trainings described in this chapter approached the systematic quality of CISM, nor did they train many people. The expertise provided by these trainings is also varied, and has little to do with a systematic testing of scientific knowledge. Trainings draw from various religious and scientific sources and the messages change according to event, individual trainers and trainees, geographical location and institutional setting. Expertise in “disaster religious and spiritual care” has little to do with consensus, and more to do with the subjective experiences of those involved in designing trainings and presenting the curricula. Each person brings a complex array of experiences to the interpretation of scientific, historical and cultural information. This was apparent in STAR and the CWS trainings, as well as in CISM.

Important to note in this chapter is the disproportionate number of women involved in the trainings, indicating the wide open nature and newness of the field of “disaster religious and spiritual care.” In the hierarchy of religious jobs, the status and pay is relatively low, yet women seem to rise to positions of power more quickly than in congregational settings. Also, since many of the trainings I attended were concerned with the “soft skills” of emotional response and direct care, the representation of women was in line with other women-dominated professions like social work and nursing.

The overwhelming use of scientific idioms to show the importance of religion suggests that the "epistemological conflict narrative" (Evans and Evans 2008), which has seen science and religion as inherently at odds with each other, is far from the complete picture. The evolutionary vision of the secularization narrative that saw religion withering away in the rays of scientific truth, does little justice to the complexity with which people incorporate both "perspectives" into their worlds. This chapter shows a much more synthetic use of science and religion, one where the clash of epistemologies rhetoric is no more apt than—in another context— the clash of civilizations rhetoric.

Each of the trainings described above illustrates the merging of these disparate discourses and subjective experiences under the conditions of this new age of anxiety. Prayer, as we were told in STAR, creates new neural pathways alleviating traumatic stress, and a statement—combining the latest incarnation of therapeutic culture, neurobiology and religion—that would not have been possible in a previous era.

The following chapter focuses on the lives of three individual practitioners of "disaster religious and spiritual care."

Chapter Six

Spiritual Care for a New Age of Disaster: Frank and the Prophetess and Rose

This chapter focuses on three individuals, Frank, the Prophetess and Rose who have been involved in disaster and spiritual care work. All three were met through contacts I have made in the disaster and spiritual care world over the course of my research and had come highly recommended for their knowledge and experience. Frank's name was given to me by Jim, from Church World Service, and the Prophetess was recommended to me by Maggie, who worked for New York Disaster interfaith services. I met Rose at a disaster conference. All of their lives have been drastically altered by their experiences working in disasters: professionally, theologically, "spiritually" and psychologically. The Prophetess, Frank and Rose exemplify a combination of the spiritual, modern, technological and scientific (Franklin 2004). They exhibit a multiplicity of perspectives on healing and the self, often not recognized as existing within the same person. They illustrate the complicated, often messy, process of making sense of different practices of healing, religion, and science as they relate to providing religious and spiritual care.

Large-scale disasters transform lives, causing those impacted to engage their shifting realities, making personal and professional adjustments—often creatively reforming themselves. People inhabit a patchwork of cultural idioms that correspond in some way to their transforming internal states. As these shifts occur, so do conceptions of what might be considered important. The understanding of suffering shifts along with transformation of moral experience, and changes in economy and governance. New

professions are formed to respond to emerging problems, as in the case of disaster religious and spiritual care.

Many of the others I interviewed echoed the syncretism of Frank and the Prophetess, but due to institutional constraints, or disposition, they were not as candid. While perhaps on the fringes, Prophetess, Frank and Rose were not so aberrant as to find themselves outside the ken of legitimacy, as measured by their affiliation with institutions. All three held positions with "mainstream" organizations, and the Prophetess and Frank were involved in training others. This chapter also examines the trauma concept as a unifying element in all of their narratives, which defined their work and their self-understanding in different ways.

Spirits in the Material World: Prophetess

On a warm autumn day I met the Prophetess in a wood-floored office of STAR in the financial district. I sat across from the Prophetess while she spoke about her experiences with Strategies for Trauma Awareness and Resilience (STAR), a program set up for clergy by Eastern Mennonite University following the attacks of 9/11, discussed in chapter five. This was largely what she wanted to talk about, and since I could see that it weighed heavily, I let the conversation go where she took it. We had three one-on-one meetings over the course of eight months, though I saw the Prophetess several other times at conferences.

A tall African American woman in her early sixties, the Prophetess is an imposing figure. Though I had once seen her at a NYDIS conference for clergy and disaster in New York City, I did not make the connection until the end of the interview. She greeted me warmly and asked me to sit down across from her. Initially, she was very

precise and formal, intent on making sure that I got every word she was saying correct, sprinkling her answers to my questions with “Am I making myself clear?” Throughout our first and second meetings I felt strongly that she was using the conversation as a way to gain clarity for herself. Her powerful voice rose in volume when she appeared to feel intensely about a particular topic. At times she almost lifted herself out of her seat. Much of what she discussed was highly emotionally charged and very much live issues for her. Of particular importance was her experience of feeling depleted after 9/11, and how it has led her to important life decisions.

Part way through the interview, my memory was triggered by something she said, and I was reminded of a scene that had taken place at a conference the previous year. After our meeting, I found the section of my field notes where I had written up the event.

> I am the prophetess,” she said as she stood up. “God speaks through me, and he told me about the disasters and more to come.” I watched how expressions in the room changed, how the bureaucratic rationalized ethos of the event was for a moment interrupted by the irrational, that part of religion that they are in fact trying to keep out of the light, so as not to ruin their image of being professional, and a clean, rational, part of the system. What did it mean? To me in part it represents that piece that exists below the surface that must be there particularly when dealing with disasters, which evoke apocalyptic tendencies even in the most cool and collected of us. Beneath the rationality, the control of risk must be this other tendency. Shortly after the Prophetess ended her speech, another woman spoke up in agreement. “I am here to say that we shouldn’t succumb to the rule of science,” she said. “There is another chief that must be answered to and he has been insulted, the moral fabric has been broken. I am not a theologian of doom,” she said. “My children are foolish because they say there is no God. As people of faith we can’t buy into the scientific view and say god can’t speak. *The moral fabric is torn much deeper than we think.*

The Prophetess and the woman who followed her inserted apocalyptic religious ideas into a context that was essentially rational and bureaucratic, or even secular—to the extent that questions of theology were marginalized, and questions of organization,

bureaucracy and service provision were central. While this might be the best way to save lives, they seemed to be saying it is not the best way to care for the spirit, the soul, or the whole person. They were clearly articulating a rebellion against mechanistic and materialist views of the self, and did not want to see religion subordinate itself to science and government institutions—even in the interest of gaining institutional power. The silence and puzzled, uncomfortable expressions that followed indicated that this perspective was not shared, and was not considered appropriate for the setting. When I later asked someone about her, they said she was “a bit off her rocker.”

Like the anointment of Tom in the previous chapter, the incident points to some of the interpretive discord that arises when certain strands of religion and spirituality come up against secular bureaucracies. “Spirituality," as one priest/theologian told me, “needs to be dangerous. But people do not like the danger, so they domesticate, sugarcoat and make things safe and innocuous. Spirituality needs to challenge.” An anthropologist could not have invented a more dramatic scene. It illustrates how the tensions among rationalization, bureaucracy and religion emerge, particularly in the context of disaster. Even for those who are not prone to visions, disasters have a way of conjuring the apocalyptic. The scene was a blunt reminder that there is another side to religion, one that is not so rational and does not easily conform to bureaucratic agendas and diagnostic criteria. The Prophetess was also pointing to the idea that healing, in the larger sense, takes place in the context of one’s relationship to God. By ignoring this relationship and focusing on science, she was suggesting that the group she was addressing was turning their backs on religion. This was a stark contrast with the

rhetoric of disaster preparedness, which drew on the language of risk management and mental health service intervention.

The work of the Prophetess with STAR and Eastern Mennonite University (EMU) placed her in relationships with people with whom had she would have had little contact with before 9/11. STAR, as I noted in chapter 5, was a direct response to 9/11, though it built on ideas that had been developing for years at the Center for Peace and Justice[31] at EMU. A proud New Yorker, the Prophetess was very clear about the importance of her background in forming her theological orientation.

> I am a first generation northerner. By birth and choice as a young child I was baptized as a Baptist. But it is specific because we come through a geographical system. What am I now? I am multi-faith. God is all—I am not concerned about race or culture, but we must understand race and culture. I must understand the way people live because it impacts how they practice their faith. And since you are an anthropologist I am sure *you* are clear about that. I honor all faiths that honor a higher being that honors love, that honors service. All right? Compassion and understanding—my basic foundation is in the Baptist system of belief.

Her original adherence to a specific faith group had expanded to include everyone, to a universal spirituality and a different kind of mission. This is what, in part, allowed her to work with different faith groups. It is also clear from this excerpt that the Prophetess has a nuanced understanding of the interactions between religion, geography, faith and race. She often reminded me that she was speaking from a particular location, impressing upon me that she was black, had Cherokee Indian ancestors, and was from a Baptist background. This also gave her claims to several traditions that had experienced what she called "historical trauma." This is important because it informed the way she

[31] See chapter 4 for description of the Center for Peace and Justice. Briefly, the Center is part of EMU and applies a multi-level model of trauma ranging from personal to historical and structural in order to analyze and solve conflicts.

understands the trauma associated with 9/11 and other disasters, as well as how to design modalities that deal with multiple traumas. As the STAR training illustrated, the trauma concept allows for a reframing of historical and personal experience in a system that connects both to a vision of a religious-spiritual social justice. In the STAR training this perspective was evident and the Prophetess, at least to some degree, saw things through the lens of STAR.

> JM: Do you think everyone has spirituality?
> Prophetess: Yeah we do. Everyone …it's just that survival has allowed, has forced us, and you know the beautiful thing about being a human being is that we adapt, but adapting is different from really living. You know? And so survival forces us to adapt. And in adapting we adopt things that help us survive. I mean why do you think that many women no matter what race, culture, and creed background put up with domestic violence. I learned behavior, conditioning, but also adapting just to survive. And then something inside—that spirit is there. I mean when you go into things you have that love, that desire for hope. But to survive it has to get covered and it gets deeper and deeper down when you think it is not there anymore and that's where the numbing out comes in. I have been saying to…in fact I said to my best friend, sister girlfriend, on Saturday. Reverend Anita Bennett. I said, Anita—cause she used to get angry [and asked me] what are you wasting your time with them [STAR and EMU] for; it's a waste of time. I said to her, Anita I have gotten a gift and I could almost feel when it took place. It began last March and all of a sudden by the end of July and this is going to be a metaphor, this is just an image, and I felt as though after 57 years, and I'll be 58 this month, November, my body has landed. My spirit has landed into my body. I'm just being honest; I'm being absolutely honest. I feel like I have landed and I'm ok. I'm not afraid anymore to be here. I'm not afraid of being…that anyone will ever have the right to batter me to make me feel less than I am to tell me that I am stupid when they are taking all of my brilliance and gifts from me. No, I said Anita, I actually felt myself into my body. And I'm ok. So my point is we all have spirit. But sometimes, some things are so difficult that we become fragmented. We all walk around like schizophrenics, afraid to merge. I have chosen to merge and whatever comes with it, I can handle it. Do you understand?

This passage, transcribed from tapes, describes in detail the spiritual journey of the Prophetess and how she arrived at her theological perspective and sense of power, which had to do, at least in part, with her sense of embodiment: *I actually felt myself into*

my body. Frankenberg (2004), in a critique of Lock and Scheper-Hughes' (1987) influential article on the body, writes that Lock and Scheper-Hughes leave out a key bodily experience—the spiritual body. The spiritual awakening the Prophetess described was a bodily experience, which had a great deal to do with past traumatic experiences that had severed her from a spiritual connection with her body. The experience described by the Prophetess provides an illustration of how bodily experience and spirituality interact. The spiritual change, the Prophetess went on to explain, was this landing in her body that allowed her to have a stronger presence of love. This experience of love had implications for her view of religion and interfaith work, as well as understanding how people heal from trauma.

This understanding of the spiritual body connects resilience, a key concept in how spirituality is being studied in disaster settings (Pargament 1997), and one of the ways that spirituality justifies itself to the psychological community: those who believe in a higher power are more resilient than those who do not (Koenig 2005). A sense of meaning creates resilience, which is why people need to believe, particularly in the face of disaster. Spirituality then becomes a key component of resilience and of defining religious and spiritual care. Personal experiences are reinforced by and reinforce ideas that then become central to the expertise of "disaster religious and spiritual care"." The Prophetess' conception of God is not of a figure handing down laws, but rather of a force in the world, a spiritual presence. She sees compartmentalization as one of the problems and that it is at least in part by rediscovering "spirit" that we break down the compartmentalization, and her theology emphasizes process, the presence of spirit rather than doctrine.

The Prophetess:

> So my point is, we all have the spirit. We have it. Every one of us. It is ok that sociologically and geographically we adapt and modify to different things. But I'm going to tell you, Joshua, I have been honored in that if I am coming from a pure place of love and honor and it may sound too simplistic and I do this because I train big groups I can walk into a group of 1000 they pick up my spirit. And it doesn't matter what I look like and it doesn't matter how my words come out, it's what are you bringing with you. And if I come with pure love, agape, unconditional love, each and every one of us in this universe is hungry to be accepted as we are. Not for who we are for what we might be who we were, our good bad and ugly…but just…just let me be. Once you allow people that it allows them to flame. What you just called the spirit and no matter what, it doesn't matter where they go if they never see me again for 50 years. The flame is alive and it's going to continue to grow in its own way, in its own time. The point is we can't make people be or do who we think or want them to do. Don't make them try to be who you want them to be. Let them be who they are. But in doing that you allow them to rediscover spiritually who they are. And to redefine their path. That's resilience to me and resilience cannot go or evolve without hope and here's a clear distinction. I'm not talking about the hope where we are anesthetized—let's say my mouth is saying I'm getting better but I'm still in a catatonic state. I'm talking about something I believe in. Faith and hope with action. Cored right at the center is love and sometimes it takes a lot to get to that love.

The definition of spirituality given by the Prophetess is one that is very much in line with current psychological thinking on resilience and "post-traumatic growth" (Pargament 2007; Bonanno 2004). Spirituality provides the meaning that allows people to adapt to traumatic circumstances. What's important for this chapter is the way that the Prophetess experienced herself differently in part because of her work with STAR and disaster and spiritual care work. She employs the theological concepts of faith and hope in connection to resilience, placing love at the center.

Also, her conception of trauma is broader than the DSM diagnostics, and includes historical background and ethnic heritage.

> That's it [trauma], it's much bigger. They separate it out. We want to compartmentalize. Even we want to know that in the great by and by things are going to be better. We are afraid to challenge the theology that we are so indoctrinated with. To me God is an evolving god. Why do I have to think that he can only fit in one compartment? As I grew up, as I begin to step out my pain, my travail, my anger and my frustration—this allows me to see a greater God, and with that greater God it allows me to see God whatever he or she is in others, and to me God means love. Once again that may go back to my theology, but I found that to be very universal no matter what faith, what the concept of love is, what my concept of God is all about--and service and sharing. But we are afraid to get beyond the compartmentalizing of everything. And that's just us—period. If we go back, and as you go through STAR training, if we go back to even talking about the journey—we all have to take journeys. I look at the slave—my indigenous culture—I'm Native American as well. You have to carry the tears, we carry the tears…I was taught as a child, don't you ever show what you are feeling inside. So we have become very stoic to the point that we have separated from what the essence of spirit is all about. And that is not a judgment. Please don't think I am judging. I'm simply assessing.

The critique of compartmentalization resonates with the holism and anti-modernist discourse that I discuss above. The Prophetess challenges views of trauma that separate suffering from a concept of the person as a whole. She also sees much of theology as victim to similar kinds of rationalizing compartmentalization that she understands as creating a static vision of God.

By the end of our conversation she said it was time for her to ask me questions. "Joshua Moses," she said. "Your name is no joke. Who did that to you, what faith-based tradition did you come out of?" Gesturing towards the recorder she said, you can turn this off this is you and me talking." The conversation then took a greater turn towards the personal. She began to ask me questions about my own background, my views of religion and spirituality, and experiences in studying disasters. Initially I was reticent to speak, but in the spirit of reciprocity (which may have been part of her strategy)—she had just shared a great deal of intimate information about herself—I told her about my

own experience. Much of that material I have chosen not to include, though it was an interesting experience that gave me a different perspective and some insight into the way the Prophetess works as a healer.

My first encounter with the Prophetess was the only experience, up to that point in my research, where I experienced something I did not experience in other interviews. In contrast, almost everyone else I interviewed displayed a controlled sensibility, and was "logical" in their religious expression. There was something about the gaze, the knowing, that felt different, something about the connection that was tangibly unlike, say, sitting across a desk from some of the more technocratic clergy. One could say she possessed charisma in the Weberian sense—unlike many of the clergy that I interviewed who cited data and justified their work through rational argument and instrumental reasoning. The Prophetess, in contrast, relied on a connection to "spirit," a strong confidence in her own ability to channel the power of spirit. She did not cite dates but instead "conjured the spirit."

Her views of trauma are very much in line with what I read about the STAR program. They are broad and have to do with structural violence, racial and personal history. With an awareness of context, her view emphasizes resilience rather than pathology. "Everyone has spirit at the core. And that's resilience. It's hope. Resilience is hope. That's it, that's all." She explained that she was instrumental in convincing STAR to alter their training in order to address issues of race and class. "Can you imagine a someone like me at EMU?" she asked. "Can you imagine how they dealt with me?" Trauma and resilience are easily translated into religious idioms, as I have been arguing: resilience becomes synonymous with hope and belief, and trauma takes on

religious dimensions of suffering akin to Christian conceptions relating to the virtues of suffering.

On my second visit to her office, the Prophetess gave me a warm greeting, shaking my hand and wishing me a happy new year. She introduced me to Jeannie, her administrative assistant, saying, “This is the woman who keeps me on the ground. I can’t function without her." She then asked if I could wait a few minutes.

When the Prophetess finished with her paperwork, she asked if I signed up for the February STAR course and when I say yes, she asks about my travel plans. When I tell her that they haven’t contacted me yet about housing and picking me up at the airport, she immediately has Jeanie call the program and set up my ride and housing.

She wanted to go to a French restaurant in the financial district. Jeanie handed me the card and the Prophetess said to me, “Were you paying attention, being aware? Why did she show you the card and not me? Because when I walk out the door I don’t know where I am going sometimes. I get involved in conversation and end up some place else.” This style of interaction reminded me that the Prophetess seemed to be both instructing me, and suggested that she saw me as her chronicler.

We walked through the narrow streets of the financial district, engaged in conversation about religion, spirituality and disaster, weaving our way around the many suited figures. I tell her of my experience in Mississippi observing the Church world service training, and how it reminded me of a conversation we had about the disconnect between what services were needed and what services had been given in the gulf the last time we spoke. “Yes,” she said. “If you understand that, you get right down to the core of what I was saying, what I experienced down there at EMU and with the STAR

program." It was that kind of small mindedness and lack of sensitivity to difference that she had to fight against.

We entered a crowded restaurant, filled with Wall Street office workers: conversations about hedge funds, investments and the state of the economy surrounded us. Amidst this clamor, the Prophetess and I covered a wide range of topics, including her youth in NYC, her singing career. Through much of the conversation I didn't have to ask anything. She spoke and I glanced at my questions and saw that many were being answered without my having to ask.

When I asked her if 9/11 had brought about changes in mental health and religious care, she said "yes, emphatically. It opened everything up. People are looking and we are going to bring things together or everything is going to fall apart. The earth is sick." This comment, reminiscent of her forceful interjection at the New York Disaster Interfaith (NYDIS) conference, revealed an apocalyptic side that, as I have mentioned, was often obscured in the disaster religious and spiritual care world. Conversations about the disaster that take place in organizational settings tend to use the technical language of risk. Broad statements like, "everything is going to fall apart," would be seen as overly apocalyptic.

"Trauma, she says, "is what we need to work out." When I tell her that I feel a lot of the people I meet in the disaster world are still dealing with the disasters they went through and that gets in the way of their work, she says, "that's what I am saying. They were all traumatized. I was, too. People need to work out their trauma." Here she is pointing out the personal transformation that she sees as necessary for those working in disaster religious and spiritual care. The language of trauma and the spiritual journey are

linked by the need to "work out" suffering in order to come to a greater spiritual understanding, which will in turn allow one to be a more effective messenger of God and healing.

The Prophetess also talked about how her presence does the work: "You could still leave here and say, she's totally crazy, and that's alright. You still would have gotten something." Her presence referred to a certain innate spiritual power, which she spoke of on several occasions. This power, she said, could impact hundreds of people in a room or just work in a one on one setting. The concept of spiritual presence was often repeated among chaplains, and also is a tenet in the literature on pastoral care (Fitchett 1993)—being a spiritual presence to someone's suffering in itself is said to affect healing. Tom, for instance, spoke of "walking with people," and the idea that giving a water bottle to someone means something very different if one is wearing a chaplain vest. An idea with deep protestant roots, spiritual presence is akin to the "ministry of presence," which emphasizes the power of simply being present as a messenger of God. But the Prophetess is suggesting something different when she refers to her impact on large groups of people. This power resembles the charismatic healing of the church revivalist, a more diffuse power to impact those who are in her presence, regardless of what they may believe rationally.

As in our earlier interview, our conversation was often formal and consisted mostly of describing experiences in working with the STAR program after 9/11. For our next lunch-time meeting we went back to the same French restaurant of her choice in the financial district (this time she paid, since I had paid for our previous lunch). In this crowd of mostly young men and women in business suits, I thought that the Prophetess

and I looked a bit out of place. I had just returned from the STAR program at EMU and the Prophetess was eager to hear about my experiences, which I described in chapter 5. In particular she was interested to know how I understood STAR from the point of view of a New Yorker. She emphasized the well-intentioned but misguided efforts of STAR to provide care in New York, the lack of race, culture and class consciousness.

She had spoken for some time about the nature of STAR and the experience that I was going to have. She had also explained the kinds of self-interested fundraising that went on after 9/11 between EMU and Church World Service. The latter's head was a graduate of EMU and so was interested in funneling Red Cross money into his alma mater, she explained. The Prophetess said she had wanted to make sure that money stayed in NYC. The funding for her position at STAR was to be cut shortly after our meetings, though she spoke of expanding her educational and organizational development consulting business in anticipation of this cut.

"Between 2001 and 2002 I worked with over 2000 people," she said. "I don't like to work one on one because it is draining, but for you I'm making an exception. After 9/11 I was hurting and I went to STAR. I had been seeing all those people hurting from 9/11 and my mother had died the year before in 2000. I needed something and that is how I ended up in STAR."

It was this need for a new set of skills that led her to the Mennonites in rural Virginia, an unlikely place. But this move illustrates one-way knowledge flows from disaster sites to academic settings, becomes codified in trainings, and then returns in the form of the embodied practice of expertise. The Prophetess, because of 9/11, found her self in the midst of a world that was new to her—Eastern Mennonite University was a

long way from NYC. Historical forces pushed her, of all places, to EMU where she was confronted with racial, cultural and class dynamics that challenged her personally, theologically and spiritually. Part of the way, she explained, these problems were through the lenses of trauma.

She used trauma in several ways that correspond to some of the ideas from the STAR program. Most importantly she drew connections between personal traumas and historical traumas. One of the problems she said that she encountered at the STAR program had to do with "the fight to step out of personal and individual trauma in order to at least expand enough, to understand collective trauma and then generational trauma. You can't heal if you are still saying I am in Jesus' hands and I'm ok. And these are the greatest pastors."

I asked her at one of our meetings, "How do you know when your healing has been successful." She smiled and said, "Joshua, how did you feel after you left our last meeting?"

"Actually, to be honest, I felt oddly lighter."

"Uh huh," she said with a sly smile.

Months later I tried to arrange a meeting with her. At first she didn't respond to my emails, but later agreed to meet and then cancelled at the last minute. After several more tries on my part I stopped emailing. It is unclear to me what happened, but since the Prophetess seemed to make decisions based on premonitions and perceived "energy," it is possible that she no longer felt that it was energetically appropriate to meet. The New York STAR office, she had told me during our last phone conversation,

had been closed and she was going onto other projects, including a consulting business she had spoken about.

Frank: The New Syncretism

While I was not sure exactly what Frank's work was before I met him, I knew he had been active in local disaster work and was a fire department chaplain. The first time I met Frank, I took the train out to Roslyn, Long Island, on an unseasonably warm November day. When I called the number I had, I got the fire department. He wasn't in but called me back, and several minutes later came by to pick me up in a battered, rusted sedan. A large, bald man in his 50s, Frank is easy to smile, friendly and helpful. His office at the Lutheran church has a large wooden cross and is filled with bookshelves, chimes and a stereo with headphones—which later I learned was for Eye Movement and Desensitization Reprocessing (EMDR), a practice training in and believed in strongly. We spoke for about two hours on our first meeting.

Frank was very articulate and eclectic in his knowledge of "new age" healing and spiritual care. He was born and raised in the Catskills where he worked for years in a local church, and later trained as a seminarian in NYC. He moved to NYC about 14 years ago and had recently finished a master's degree in social work, which he said was a good thing because the Lutherans are closing down churches. Frank represents a type of clergy: those whose work is a patchwork of many different seemingly incommensurable ideas and practices. These include his Lutheran faith, bodywork, and EMDR, Buddhist meditation, chaplain to the local fire department. He has certificates from different trainings on disaster and trauma hanging on his wall, including the Pastoral Crisis Intervention training that I attended, described in chapter IV. He may

represent a new kind of Christian clergy, one who sees value in a vast array of healing modalities. His Lutheran affiliation was barely mentioned in our interviews. His belief in holistic healing, body/mind/spirit is representative of much of trauma therapy, which I outlined in chapter II.

I asked Frank why he got involved in disaster work he said,

> My mother was an alcoholic and because of that I have a sense of hyper vigilance. I have panic disorder, my sister has and my mother probably had it. The theory is that it's genetic. A lot of personal work needs to be done for anyone who puts themselves in harms way. If you want to put yourself in a situation where you encounter death, destruction and grief, overwhelming your senses, you are going to need backup. You can't tell me you are going to see death and destruction and not be affected—a deep understanding of self should be required of you. Before you send someone into the battlefield, you need to prepare them"

Like many others I interviewed, Frank spoke about his own traumatic experiences and how they drew him to disaster work. The relationship between autobiography—personal narrative—and professional choice was repeatedly presented as key elements in the self understanding of those I interviewed. Their personal distress and anxiety resonated with the national and global anxiety, providing them with a professional identity rooted in simultaneously dealing with their own distress and the suffering of those seeking help**.**

When asked about disasters changing relationships between religious and spiritual and mental health disaster care, Frank said:

> Disasters call into question a lot of things. They make us acutely aware that we are finite, physically, and you know, it's a whole shock to the system, it's a shock to the emotional system, the physical system. And what it can do, you can go two ways, and sometimes it goes back and forth. Sometimes there's more openness to the spiritual realm and sometimes there's a block. People can be drawn to faith and spiritual issues during disaster, but it can quickly fade away after the disaster subsides. My experience is that in times of crisis people turn to faith communities. That's just a fact. And so the front line people are going to be

congregations of all faiths and clergy of all faiths. That's why I think it's really important that clergy know about disasters and its effects on people. I have been talking a lot about this lately. And that is why we always think of rescue workers. MH professionals have known this a long time, and that's compassion fatigue and vicarious trauma.

Frank thus echoed many people I interviewed in his view of disasters bringing people to seek help from their religious communities. "Frontline" was a term I heard often during interviews.

> JM Do you think disaster causes syncretism among clergy?
>
> Frank: I think it's probably fairly new, and the reason I say this is that I have other colleagues that have gone down this route over the last 10 years. I think there's a greater awareness of what healing is and what spirituality is and so I think my own expansiveness has come by being around people of other faith traditions, other religious traditions, but also other avenues of how to heal. It's a true holistic approach; it's a mind/body/spirit approach. I really think that that's the way to go. As a pastor I'm mostly concerned with the spiritual and that's my function, and as a social worker I'm concerned with the emotional and physical that goes with it. Union and Chicago now offer an MSW combined with masters of divinity. I think it's very smart because the two professions go together, parallel each other, they interweave…I view it as a ministry, social workers may not view it that way, but I view it as part of my ministry. So I think that there is more of a trend for that, I think you have more faith traditions that are communicating with each other—denominations that are seeing more what they have in common. For me, going to Yeshiva University that has a Jewish tradition is very interesting and being around rabbis a lot. It helps me grow and with my roots, for Christians it's a Judeo Christian background, the Old Testament is part of our background.

Since an expertise such as "disaster religious and spiritual care" opens up the professional terrain, clergy, like Frank, as I have been suggesting, may find it easier to fit in. As another of my interviewees said when I asked him how he would explain the apparently high number of gay clergy in leadership positions in the disaster professions: "It's because it's an emerging area and much more open. Also, it has historically been considered low status. Like hospital chaplaincy. The newness of it allows gay clergy to

find a home." As with the over representation of women, because "disaster religious and spiritual care" is a newly emerging field it provides a space for those who might not readily find acceptance or be allowed to hold positions of power in traditional organizations.

For many clergy, particularly those in the disaster field, secularized forms of Buddhist meditation practice had become part of their repertoire. In the following extract of a conversation with Frank he explains how he learned about a Buddhist practice from a Catholic priest. In STAR training and the CWS training in Michigan and many of the conferences I attended, mindfulness practices drawn from Buddhism were also seen as an important way to deal with traumatic experience. Meditative practices were suggested for both survivors of disaster and caregivers.

> I'm reading a lot, Stephen Levine and Jack Kornfeld, those out of the Buddhist tradition. And I think that there's a lot to offer, that the Buddhists have a lot to offer in terms of meditation and mindfulness, you know our focus inwards. When I go back and read the Gospels and what Jesus says, and a lot of what he says had to do with going inside you. Don't look for god outside in the sky somewhere, God is also within. There's the immanent god and the transcendent god. You know we live in both of those worlds. For that journey has been more expansive. There have been teachers along the way for me. I don't know if I mentioned John Shea[32], the Catholic theologian, like Shea stadium, I'm a Mets fan. He was talking a lot about these issues his writings. There's a very interesting book…on faith and on…I can't think of the name. He talks a lot about this kind of mindfulness approach to spirituality and the sense that there's that personal relationship with god. It is inside; it's something that is not just for the fundamentalist Christians on the right wing to talk about. That's been my journey over the last 10 or 15 years.

Stephen Levine and Jack Kornfeld are figures in the Insight meditation world, an aspect of Buddhism that has made important inroads into medical and mental health settings. This quote highlights the eclectic nature of Frank's interest. One would not be

[32] Shea is the author of numerous works of theology and Christian-oriented fiction.

surprised to find this from a Unitarian minister, but Lutherans, as I mentioned, are not known for their embracing of New Age practices. In addition Frank received Masters of Social Work from Yeshiva University, a Jewish institution, and cites a Catholic priest having had a great influence on him.

> JM Would you say that the emphasis on disaster has intensified these kinds of convergences?
>
> Frank There's certainly some good that can come out of some horrible experiences. So when you have a 9/11 or Katrina you have people who are for no other reason forced to come together and work together, you begin to see you have a common purpose to help our fellow human beings, our fellow brothers and sisters of the creator. You know, let's work together, and let's find a commonality that we can best approach, that healing that happens for people. Obviously providing housing, basic needs of food shelter, in emergency in situations have to be foremost, medical services that have to be foremost. The second area is what we can do for their emotional and spiritual health as well. So it is truly physical, emotional and spiritual. In that way it has to be holistic. Not everyone can do everything. Some folks will do things really well, Mennonites, Lutherans will do things well. Everyone has their niche.
>
> Among MH professionals I see a growing trend to not view spiritual stuff as, "oh, we don't want to go near that." I don't know if there's an embracing of that but there's more an openness and a welcoming of that into the field because people come and present with those issues.

Frank spoke about how 9/11 was increasing the connections between spirituality and medicine. "There is greater awareness," he said, "of what healing and spirituality is, there's an expansiveness, an understanding of other avenues of how to heal, a mind/body/spiritual approach." He ties his views to a holistic perspective, placing himself in the tradition of thought that I outlined in chapter two. The language of holism provides him with a way to tie to together his seemingly widespread interests and practices.

When asked if disasters create better relationships between clergy and mental health professionals, Frank replied, “After 9/11 and Katrina people were forced to work together, finding community, providing housing was seen as foremost but the approach became physical, emotional and spiritual.” This idea is often repeated in the disaster and religious and spiritual care literature (Koenig 2006).

“Hospices,” Frank notes, “were key in creating this shift because there is a spiritual component and a true team effort. Disasters, too, but you do have people butting heads. During disaster, faith questions arise and people are more acutely aware of them, there’s more openness to the spiritual realm. In times of crisis people turn to faith.” Hospices have also been critical in critiquing mainstream medicine and its handling of death. Originally conceived of as a volunteer movement, hospice work has become professionalized and bears some resemblance to disaster religious and spiritual care because it incorporates medical and spiritual/religious knowledge into ostensibly largely secularized settings (Lewis 2006). As I describe above, because death emphatically marks the limits of medical technology, hospice settings provide greatly increased roles for spiritual care (Lee 2002).

Several months after our initial conversation, I decided that I would avail myself of Frank’s offer and undergo an Induced After Death Communication (IADC) process. IADC emerged directly out of a mind/body trauma therapy, EMDR, which has gained some acceptance at the margins of mainstream medicine because of its supposed efficacy in treating trauma. Part of a much larger contemporary debate over trauma treatments, EMDR follows many recent ideas that see trauma as residing, not as once believed in intrapsychic spaces, but rather in the body. Seen as providing alternatives to

traditional talk therapy, these modalities have become increasingly central to treatment of trauma survivors.

Induced After Death Communication (IADC)

On an early spring day in 2005 I boarded the Long Island Railroad Babylon Express train, in a strange mood, to visit with Frank again. This time the biblical significance of Babylon was not lost on me, particularly as I saw a man with his hands portentously in prayer. The day before I was talking to a religious Christian friend about my planned second meeting with Frank to communicate with the dead, and he referred me to a particularly grim passage in *Isaiah* where God condemns and forbids the practice of magic. Though a non-believer, I was still feeling uncomfortable with troubling dead people and spirits. An excerpt from my field notes describes this experience.

> I lost my notebook on the [train], transfer and already being in a superstitious frame of mind, considered that maybe there was some kind of supernatural force stacked against this journey that I had embarked on a sacrilegious excursion to Babylon and might be punished. The loss of the journal, I imagined, might be a sign, I ruminated. But when the doors finally opened onto Roslyn platform, I stepped off onto the train platform and resumed my anthropological stance of curious remove.

After speaking to Frank the first time, I had done some reading on the IADC[33] process and read about it on the founder's website. The founder, a psychologist named Allan Botkin, from Chicago has written extensively about IADC including a book entitled, *Induced After-Death Communication: A New Therapy for Healing Grief and Trauma,* which received a Hampton Roads award for bestselling book in 2006. Botkin

[33] Jan Holden, a psychology professor at North Texas University, has been conducting studies on IADC.

spent many years working with veterans and after he began using EMDR he noticed that many of those undergoing treatment reported communications with friends and family who were no longer living. Many of these communications, Botkin noted, had healing effects on his patients. Also, many consisted of the dead giving instructions to the living, advising them on things they might do to live moral lives, or to make amends for things done in their pasts.

The website explains its technique as follows:

> It doesn't matter what you believe, what we believe, or even what the experiences believe. The IADC® experiences we have induced in thousands of patients result in dramatic life changes that heal grief and trauma in a very short time and are sustained long-term. The technique has worth because it works; it doesn't need for us to agree on a belief system or theory about the source of the phenomenon to support it.

Frank began the session using a long metal pointer going back and forth, which I was instructed to follow with my eyes while I sat in the chair listening to the sound of the ocean and seagulls alternating between headphones. He told me to relax and to pay attention to body. After a while he asked me who I wanted to contact. I said Norma, a friend who had unexpectedly died the previous year. He went back and forth between having me visualize and using the pointer. I felt a sense of relaxation as I listened to the ocean and pictured the waves going in and out. After several rounds trying to contact Norma, he asked me if I felt the presence of any others. I had drifted into thinking about some of my older dead relatives and said that I could see my aunt Sylvia and then later her siblings Sophie, Yudel, Libby. Frank asked me to welcome them in and see if there was anything they wanted to tell me, or if I wanted to ask them anything, if they had unfinished business. It was pleasant to imagine my dead relatives in detail and spend some time thinking about what I might say to them, and I did enter a deep state of

relaxation, but did not have any conversation or sense any other-worldly presence. Time seemed to pass quickly and the process, which felt like about a half an hour, lasted for about two hours. Overall, the impact was pleasing and I could easily imagine how somebody could conjure a sense of really speaking to the dead, but I did not feel any sense of resolution or lightness. Unlike my experience with the Prophetess I felt that I was very much in the realm of someone executing a technical procedure.

In the debriefing, Frank emphasized that it was my experience, and though I did not have an after-death communication it didn't mean that the process was unsuccessful. "The people who are dead" he explained, "know that you would have been skeptical of any dramatic experience and so probably didn't want to give it to you." In this way he left the door wide open to continue to believe that I was communicating with the dead, even if I did not believe it or feel it, creating a kind of circular logic.

After the IADC was over, Frank gave me a brain spotting treatment. He had me think of something stressful and to locate the feeling in my body. As he passed the wand in front of me he asked if the level of stress diminished with different locations of the wand. While he said that he didn't really understand the theory, the idea is that eye movements correspond to different parts of the brain, and you can help get rid of the stress by changing eye positions.

Frank clearly believed in the process and had little doubt that it was efficacious. I did wonder about some of the ethical problems of the IADC, which left me uncomfortable, such as the use of such procedures on vulnerable people in the midst of mourning who might want nothing more than to contact a recently deceased relative. On a later visit with Frank he was more explicit about disowning any firm belief in

supernatural possibilities of IADC, instead emphasizing the importance of the help-seekers interpretation. He continued to hint nevertheless that his own beliefs veered towards the supernatural. "I'm not going to say that people are definitely getting in touch with the dead", he said, "but something is happening that I can't explain. Botkin says the same thing—that he tends to think that something is happening beyond people just imagining the dead." He goes on to say, "There are charlatans in every business. I approach this stuff with a lot of caution. Do no harm is the main thing. I don't care if it's weird, as long as it doesn't harm."

While there is nothing new about human attempts to contact the dead, this version grows out of a particular technology that emerged within the framework of trauma theory. EMDR is a modality that has been used to deal with PTSD, the process first used with veterans and now expanded to civilian populations. All of this places IADC within the scope of the trauma professions, which arguably disaster and spiritual care has also made its home. The potential spiritual and religious elements are framed in terms of healing from trauma and the dual explanations for the efficacy of the modality—supernatural and psychological—both are products of the pervasive impact of the trauma discourse. With IADC as a technological psychopompos, one can be psychologically and spirituality healed by finding a passage simultaneously to the afterworld and submerged internal psychic processes. This provides a perfectly Janus-faced metaphor for the syncretism I have been describing, a modality covering transcendent and earthly forms of healing.

Towards the end of our meeting, Tom was again talking about the need for emphasizing "selfcare" within the structure of organizations. "Some form of spiritual or

psychological processing is needed. How about those who work at the morgue?" he added. "I worked there. I was there at the coroners." He paused, looking up pensively towards the ceiling. "I am a disaster junky, no doubt about it."

Rose: Trauma, the Spirit and the Body

I first met Rose in 2004 at a conference for clergy and mental health professionals honoring the anniversary of 9/11. Many of the people I had grown accustomed to seeing were there, including some city government workers, a FEMA representative, clergy representing many traditions, and mental health workers. Rose was part of a small "break-out group" that I participated in. She was also providing bodywork for some conference participants as part of the of the organizers' attempt to promote self-care. She had a table set-up downstairs with several other body workers and an acupuncturist. After speaking briefly, we exchanged cards and several weeks later I contacted her for an interview.

We met in a coffee shop on the Upper East Side of Manhattan on a cold November day, and then walked several blocks to her apartment. Along the way we spoke about how Rose had become involved in disaster work. She told me that she had recently returned from New Orleans, an experience that had made a strong impression on her. Rose is 51 and she grew up in the Far Rockaway, a neighborhood in Brooklyn, and went to Yeshiva Hillel, an Orthodox Jewish school. She then went on to undergraduate education at NYU and then to law school, where she graduated in 1984.

"From a young age," she said, "I knew I wanted to be a massage therapist. But for a nice Jewish girl this wasn't really a possibility. So I went to law school instead."

Four years later she graduated from the Swedish Institute of Massage in 1988, while studying on the side with a Japanese Shiatsu master who had a strong influence on her. The attacks of 9/11, she told me, had the most important influence on how she viewed her role as a body worker and healer.

In contrast to Frank and the Prophetess, Rose did not consider herself religious, though she saw her work as spiritual. While Rose was not religious, her lack of religiosity provides an example of the way spirituality is combined in different ways to encompass therapeutic practices that do not necessarily have a spiritual component or a history of one. Rose's experience in disaster work helped to consolidate her own spirituality, as well as her vocation, giving her a new vision of her place as a healer—expanding beyond encounters with individual clients to a more general theory of healing from trauma. Also, her work in disaster gave her new insight into the technique of her bodywork practice, expanding her self concept beyond the confines of her training as a massage therapist to a broader notion of energy healing.

As we sat in her large blue living room, I noticed a book on her desk titled *Culture of Fear*: *Why Americans are Afraid of the Wrong Things*. Rose described her experiences, quick-paced and animated, with few questions from me.

As I mentioned, Rose had recently returned from New Orleans, where she volunteered for an organization called the Blessing Project, which had been recommended to her by a friend and colleague. Later she found out that organization had connections to Pat Robertson's organization. "But surprisingly, despite this," she said, "they did good work and did not proselytize." She said that she learned a great deal from working in Katrina recovery, and did bodywork on many people. The levels of

stress were incredible, she told me. Working for the Blessing Project also expanded her concept of Christianity, giving her greater acceptance, and dispelling some of her prejudices. An intense and rapid speaker, she answered most of my questions before I was finished asking.

> Walking around after 9/11, I was devastated, though I didn't lose anyone. I didn't offer any services until around 6 months after. When people are in the middle of trauma they don't need anything then but later they do. I got my license in February, and then started working with the Firehouses. I just started showing up. Firemen needed it really badly. I didn't broadcast what I was doing, but was just there. One of the firehouses had lost 7 people. I didn't try to fix people—I knew my place, and that was not my role. Shiatsu is perfect for firemen—no oil and you don't have to take your clothes off—you don't go into a fire with no clothes on. Firemen were requesting alternative practices; bodywork brings issues to the surface. But the alternative practices were too successful and were cut. They were cut and marginalized. All the MH professionals want massages, they go to yoga etc but they marginalize us. I currently work at Columbia and every patient who gets heart surgery gets a massage. Mostly I work for myself because I don't want to get involved in office politics. I'm not at Columbia for the money--if I get crossed, I will pull out.

Rose recounted that 2 ½ years after 9/11 she was working with a large fireman who must have had an anxiety disorder and started flailing around. She realized that she could have been hurt and "was freaked out." She then decided that she needed more training and enrolled in a trauma touch therapy course in Colorado. She thought, "This is PTSD—it's like its own disease and something I did triggered it. Trauma happens in the body and needs to be gotten out through the body—it's in the limbic neocortex, and it's not rational. Talking may bring peace of mind but it [trauma] is still in the body," she tells me. "The body speaks through the body—period." Psychodynamic therapy as usually understood takes a wrong approach to healing trauma, she suggests, echoing a

widespread view that sees talk therapy as potentially intensifying trauma by forcing people to relive experiences.

She was also trained at NYU Trauma Center with Jack Saul, a known traumatologist. Saul, she said, taught her a great deal about trauma theory and its relationship to the body.

> Trauma touch therapy releases the body. The basic theory is animal fight or flight—numbing is one reaction, playing dead. Hormones numb and you look like you are dead and endorphins reduce pain so if you are eaten you won't feel it as much. It's like in sexual abuse, the way people are not able to push back and their shoulders shook.

Depicting a forward-pushing motion, she shows how bodywork allows one to "push" through these experiences. The research she cites has its origins in the work of Cannon and Selye, and is similar to the ideas discussed in the trainings described in the previous chapter. The idea that people become trapped in a physiological mode—like the example of the polar bear in the STAR training—further supports the view that trauma becomes embedded in "primitive" mental structures in a very literal sense, and thus can only be worked through in a physical way. The physical experience of sexual abuse, she explains, can not be healed simply by talking it out, but rather—again in a very literal way—needs to be re-experienced in some sense through the body. Like the STAR training and the Prophetess's own spiritual awakening, she emphasized an embodied experience as crucial.

She goes on to tell me about her work in Israel with survivors of suicide bombers. "I was very influenced by this work," she says, "and I was totally shocked when I worked down south and discovered that I like to work with first responders because no one takes care of them. When I worked in the emergency room, I calmed people down,

and the guard commented on how much more calm people were, how they didn't keep coming up to see how much longer they needed to wait." She also had this experience in the US, and the lack of long-term care for survivors seemed to be one of the motivations for her work.

> What did I do for them? People feel forgotten after a while. The disaster is long over but they are still in it, it's like yesterday for them. If you tell people that you remember them they feel like humans again. It takes them out of the hyper vigilant state and reminds them of the other side that it's not gone, just disappeared for a while. The hallmark of trauma is helplessness and hopelessness. Get people back into their bodies, which often feel the least safe place to be when traumatized. I'm just there with them—with no agenda— to support where they are. With bodywork there is no story attached, unlike with talk therapy. Stories can be retraumatizing.

In a similar way to the Prophetess, Rose also describes herself as a facilitator, as having no agenda. She also emphasizes the bodily nature of trauma in a way that echoes the Prophetess's description of coming into her body, and her statement about the schizophrenic nature of people's internal lives. They describe themselves as involved in a project of restoration, helping people to reclaim aspects of themselves from the pervasive force of trauma, which threatens to envelope them with hopelessness. Telling your story itself can reenact trauma in this view, and it is only restoring a connection to the body that leads to a sense of wholeness.

> I ask about the future, what they are going to do, not what happened. Non-verbal therapy. A lot of people don't deal well with verbal therapy. Like the people in the Fire department. They are just not good at talking but not about themselves. And some jobs won't let them go to talk therapy, like the military and police. But they can go get a massage. I'll let them call it whatever they want but there is a spiritual component. Energy is spirituality and that is why I do this work. I hate the term healer, can't stand it. I'm more of a facilitator— I channel it. I believe in giving people back their strength. People lose their foundation and I try to help them to keep moving forward, and don't' let it stop you whatever it is. I'm not a massage therapist and I hate the term body worker. I call it *body-centered therapy* though it's not really therapy.

Like Frank and the Prophetess, Rose sees the body as a key component to working through trauma, and sees herself in opposition to the conventional tenets of talk therapy. As I have argued, one of the most powerful mental health discourses, which emerged from the mental health response to 9/11, challenges conventional trauma interventions. *Energy*, in a peculiarly modern way, has become a stand-in for spirituality, particularly for people who may not want to be affiliated with any one tradition. Energy is a concept broad enough to encompass many different phenomena, and is an effective metaphor for healing processes: "blocked energy channels" and "working through energy" are ways of framing problems that allow for many interpretations, and are amenable to scientific explanations. After all, the transfer of energy occurs on almost all levels of physiological processes, so it is possible to talk about energy passing through nerve endings and neurotransmitters, or through meridians and spiritual channels. Far from indicating a simple division between "modern" and retrograde "magic" or superstition, the concept of energy in this context shows the inadequacy of this kind of analysis (Halliburton 2005). It is neither a simple relic of the past or part of scientific advances, but rather, in itself, *energy* generates a contextual meaning of its own.

> It's coming out of my own common sense. I have a child with a disability. We all have our problems. I know what it's like to be hopeless, helpless and out of control. You don't have to have the same experience as someone else to help them to heal. I have been given the opportunity to become a spokesperson for this work, and I can tell you the science the energetic side and stories.

Rose also spoke about herself as channeling energies, not as the locus of healing power. She combines a number of different ideas in her practice, drawing freely from different traditions of massage therapy, psychology, spirituality and her own experience. Unlike the prophetess and Frank, she has no specific religious affiliation, but rather sees her work as spiritual in a way that is characteristic of many Americans' views of spirituality (Frankenberg 2004)—a personal belief in something beyond material reality not tied to organized religion. She cites her experience with trauma, and her increased understanding of this form of suffering, as the main motivation for her work. In this instance, unlike many theological critics of the concept of spirituality—who argue that divorced from religious tradition, spirituality is essentially about self-gratification—her spiritual understanding gives her the motivation to move outwards and heal others from their traumatic experiences. Like Frank, she has a great interest in showing that her work has some scientific basis. She was also very aware of how medical professionals might view her.

A few months later, I contacted Rose to see if I could schedule a session with her in order to understand her work better. I arrived the following afternoon at her apartment, and without much conversation she asked me to lie down on a mattress that was on her living room floor. The treatment took about an hour, and I was fully clothed. It consisted largely of Rose putting pressure on different parts of my body and asking how it felt. She explained that in shiatsu (she trained with a master) they are often very hard on the body, but that she didn't think it was necessary. She felt that she could get better results from being gentle. Over all, the feeling was pleasant but I did not feel very different when I stood up to leave, and I was a bit disappointed. That night, however, I

had one of the most peaceful dreams of my life, and when I woke up the next day, I felt an unusual calm and ease. I emailed Rose to tell her of my experience and express gratitude, which she thanked me for.

I asked her again, via email if she understood her work as spiritual, to which she replied, “It’s experiential and spiritual—whatever that means. What’s heaven? A place where you learn something new every day and you are curious and open.”

Interpreting and Imagining

Anthropologists (Luhrmann 1989: Ewing 1994; Favret-Saada 1980) address questions of belief in the supernatural and the problems they raise for ethnographic research, and more generally for theories of knowledge. Ewing began to receive visitations from *Sufi* masters in her dreams, which lead her to question her own sense of reality. She writes, “Instead of bracketing these sources of significance and, hence, the subjects of our research, we should take them seriously and allow them to play a role in shaping what are ultimately realities we share as participants in a global human community” (1994 571). I am not sure that I was led to question my beliefs about ultimate reality, but it is important to note that there was something very different about the approach the Prophetess took, compared with that of my other subjects. It would be easy to discount my experiences, but at the very least they point to an awareness of human interaction that many of the more rational-bureaucratic professionals I interviewed did not have. They were able to engage me on a different level—perhaps an experiential level, as Ruth calls it.

Other anthropologists, incidentally all of them women, described similar experiences. Harding (2000) discusses the internalizing of evangelical rhetoric

when after a near car accident she hears her internal own voice, simultaneously familiar and strange, using the language of a minister she had spoken with earlier, wondering what God had planned for her. She suggests that the internalization of the fundamentalist rhetoric that she had been hearing in her interviews with born again Christians had begun to alter her self experience. Similar to my experience with the Prophetess, she began to see that regardless of how she understood herself, the fact that she was conducting research with evangelicals was proof to her informants that she herself was on a religious journey. As a person enmeshed in a network of relationships of people holding strong beliefs about the world and the needs of their inquiring anthropologist, there was no way out of this human dilemma. Despite her efforts to maintain scholarly distance, she felt the pull.

The problems of writing about religious experience have also been addressed at length in the religious studies literature (Orsi 2005; Proudfoot 1985; Taves 1999). There has been a great deal of discussion about developing strategies for bracketing off interpretation and remaining open to the experience of religious practice that may seem foreign. Proudfoot's influential distinction between explanatory reduction and descriptive reduction suggests that scholars should describe religious phenomena in ways that would be recognizable to subjects, thus avoiding what he calls "descriptive reduction." Explanatory reduction occurs in scholarly theorizing after descriptions are analyzed. Initially, I was inclined to see the Prophetess' impact as equivalent to the impact of sharp clinical skills, but I realized that this would not do justice to her sense of self.

My own experiences lead to me to believe that we have yet to deal adequately with the issues of belief that I have encountered. On the one hand, I maintain a resolute skeptic as part of my own education and social position; on the other hand, I cannot dismiss my experiences (with the Prophetess, in particular). To simply dismiss them as psychological trickery, or a lapse in reason, would be to miss the relevance of her effect on me and the way it contrasts with the mechanistic modalities I experienced—important to note because it points to the larger issues of holism and mechanization that I have been describing.

I have been arguing that individuals draw from the cultural idioms around them, often navigating change by drawing on and reworking historical narratives and symbols like trauma, holism and redemption. Both Frank and the Prophetess emphasized the role and interrelations of trauma in their personal and professional experiences. Trauma also plays a crucial role in how they understand themselves as experts in their fields.

In the case of the Prophetess, Frank and Rose, the changes relate to social upheaval caused by disaster. They all merge religion, spirituality and science, forming new ideas of healing, and practices designed to meet the emerging need for disaster care. Put another way, their synthesizing of scientific ideas of trauma, religion and spirituality with their personal experience and professional identities creates a particular kind of expert.

"C*ultural ideas",* writes Gananath Obeyesekere*, "are being constantly validated by the nature of subjective experienc*e." Concepts like anxiety and stress, as I show in chapter 2, are pervasive partly because they act as a filter through which a vast array of experience can be given meaning. Obeyesekere goes on to say, "When cultural ideas,

especially those with existential significance, are rationalized and compartmentalized as in the modern West, a gap may result between subjective experience and objective culture (1984:113). This gap between objective culture and subjective experience results in transformation of the idiom—on an intrapsychic level, and cultural level. The personal experiences of the people I have been studying—how they understand trauma, distress and religious suffering—become the navigating force for the organizations they form and the material and concepts they devise for "disaster religious and spiritual care." Frank, the Prophetess and Rose illustrate the ways that these symbols become internalized, personalized and reworked, moving towards generalizable expert knowledge in the form of trainings, manuals and clinical treatment of those seeking relief from distress.

The concept of trauma was very important in their understanding of themselves, their work and their spiritual and religious views of the world. Both their personal experience and expert knowledge of trauma provide them with an identity. "Disaster religious and spiritual care" depends on the trauma concept to give it unity. The trauma concept is part of the way people understand their lives in relationship to others, and make sense of some of the causes and consequences of their actions. One of the key threads holding the individual lives of practitioners together with the expertise of disaster religious and spiritual care is the trauma concept in its various manifestations. The lenses through which practitioners come to view suffering links directly and inextricably with how the expertise of "disaster religious and spiritual care" has formed. Lived experience and professional identities are intertwined.

Conclusion

This chapter has shown how 9/11 and subsequent disasters exerted influence on the decisions of individuals, creating new institutional opportunities, new senses of identity and self-experience. The narratives of the Prophetess, Frank and Rose point to the complex ways individual biographies, life events and expert knowledge interweave. All three combine a variety of views about religion, disasters, spirituality and mental health. While Frank still maintains an affiliation with a mainline faith, his practices take him in alternative directions, some of which would be considered New Age or even heretical by more conservative practitioners. Both Frank and the Prophetess found themselves in new positions because of their 9/11 related works and have carved out professional identities that could not otherwise have been possible, and are part of their evolving spiritual views. They are also both highly educated in "conventional" institutions, but believe in alternative practices that would be frowned upon by many of their colleagues.

In the case of Frank, the practice of IADC is left ambiguous—it could either be seen as a psychological procedure with rational explanations, or as supernatural with explanations that defy rationality. The fact that it is purposefully left ambiguous signals, one of the important elements of the practice, and an important element in many new age spiritual practices. The Prophetess also brings together a number of seemingly disparate practices—Baptist ministry, working with Mennonites, educational consulting, and prophetic visions. While it may be the case that the kinds of practices they both engage in are not as unique as social scientists might often suggest, in my research I found this kind of eclecticism to exist in degrees.

The lives and practices of these three individuals have been altered by the new age of anxiety, providing them with new economic opportunities, new healing modalities, and different understandings of suffering. Prophetess, Frank and Rose were able to find in the disaster world, if not a new sense of identity, then at least an altered one.

Moreover, trauma has become, for the experts, the dominant ecumenical idiom for describing and treating suffering, both their own and that of others. The notion that "we have to deal with our traumas in order to heal" was one they all expressed in different ways. The Prophetess, an African American woman who emerged out of the civil rights era, was more interested in a historical view of trauma, where Frank focuses more on individual, intrapsychic change. Paradoxically, Frank was more interested in maintaining a connection to science, citing studies of meditation and IADC. The Prophetess, on the other hand, maintained greater connections to the spirit world and was willing, true to her name, to invoke prophetic forces. Rose, who left the idea of spirituality open, firmly believed in the need to work traumatic experiences through the body, expanding the idea of massage therapy and fashioning herself as a kind of global trauma energy worker.

In the next chapter I shall offer some conclusions and policy recommendations that result from this work.

Chapter 7
Conclusion: I Cannot Bring a World Quite Round Although I Patch it as I can[34]

This dissertation has shown how the attacks of September 11th 2001 in New York City and subsequent disasters like Hurricane Katrina have led to the consolidation of an emerging expertise, "disaster religious and spiritual care." Throughout, I have emphasized the patchwork nature of relationships between mental health theory and practice and religion and spirituality and the ways that individual lives intersect with historical, scientific and institutional narratives. While I began this dissertation by discussing questions of professional jurisdiction, I ended with the lives of individuals and how they incorporate religion, spirituality and mental health theory into their practice of disaster religious and spiritual care. This shift of emphasis indicates the ways in which it became increasingly apparent that a focus on organizations would not be adequate to the task of understanding the multiple subtle changes in peoples' day-to-day experiences, which in turn have a determining impact on the creation and direction of organizations. The New Age of Anxiety then manifests in the lives of individuals—like Reverend Simpson in chapter two, the head of Disaster chaplain services—whose personal histories and reactions to an increased sense of threat directly translates into the creation of new organizations—"anxious organizations," designed to address emerging psycho-spiritual fears.

[34] The title for this chapter is taken from a line of Wallace Stevens' poem, *The Man with the Blue Guitar* (1959:74).

Chapter two charted the development of this expertise, tracing the history of mind/body medicine in the United States since World War II to show the shifting relationships between science and medicine and religion and spirituality. I demonstrated how September 11th, and Hurricane Katrina ushered in a "New Age of Anxiety," characterized by the increased perception of danger and an intensified search to devise therapies to address the broken bodies, spirits and minds left in the wake of disasters, as well as in preparation for future disasters.

As I have shown, the current age of anxiety differs from the old in its intertwining of religion, spirituality and therapeutic cultures. The concept of trauma has intertwined with religious discourse and has become a defining feature of how practitioners of "disaster religious and spiritual care" see themselves as wounded. As Noreen in the STAR program suggested, it is her own *woundedness* that allowed her to become a healer. This expanding of the category of traumatic experience and its relationship to those who have sought careers in "disaster religious and spiritual care" distinguishes the current trauma-related professions from those of the previous eras. Woundedness and trauma, far from being something that needs concealing, is often seen as making one more qualified for the job. Tom from CISM also illustrated this point when the self disclosure of his struggle with cancer elicited the laying of hands prayer ritual. The connection between personal suffering and the expertise of "disaster religious and spiritual care" was made clear by many of the audience members reactions to Tom's illness. That trauma provides an ecumenical language for suffering that cuts across religious denomination, transcending secular and religious divisions, must be one of the most dramatic shifts in global idioms of distress in recent history—if not human history.

The language of trauma rivals the language of Christianity in its explanatory power and global reach.

The discourse on holism played an important role as one of the master narratives of modernity, marshalling forces from diverse quarters in the name of medicine to treat the "whole" body. Scientific discoveries unwittingly had important implications for how religion and science were to relate to each other many years later. Cannon and Selye's work on stress proved to be defining precursors for later scientific studies of the health benefits of prayer and religion.

Chapter three focused on organizations in New York that have been crucial in the development of the expertise and the individuals involved in the development of these organizations. I demonstrated the connection between individual lives with their attendant experiences in disaster and trauma and the development of the organizations themselves. I showed how conflicts over credentialing embody politics, disagreements over how to interpret distress, and personal differences. I also looked closely at the lives of individuals who have been important in creating organizational structures for "disaster religious and spiritual care."

Chapter four showed how religion, spirituality and science were combined in the CISM, a training originally designed for the emergency medical service. I showed how this training presented mental health theory and framed the concepts of trauma, religion and spirituality for clergy. CISM's strong ties with the military, fire departments and police departments, gave it a particularly rigid structure. I showed how the mechanistic philosophy of CISM attempted to incorporate religious and spiritual perspectives, and how despite its rigid behavioral model, the training ended with an evangelical-style

religious practice, providing an example of how secular mental health practice and religious practice intertwine.

Chapter five focused on three other trainings, and the different ways they incorporated scientific knowledge into spiritual care training. In particular, the use of brain sciences played a key role. The chapter showed how trainings develop ideas of expertise of disaster religious and spiritual care, incorporating psychology, brain sciences and religion and spirituality. The trainings made different use of the trauma concept, molding it to fit the different scientific and religious/spiritual perspectives of the trainers.

Chapter six focused on three practitioners of disaster spiritual care and how their personal lives and career trajectories have been altered, and how views of trauma played a critical role in their self-conception and professional development. I also examined their impact on me personally, how the different healing processes I experienced impacted my body and mind, and the reflexive issues these experiences raised for anthropological theory. I focused on the Prophetess, Frank and Rose, because of the different ways they embody the expertise of "disaster religious and spiritual care." I showed how their lives—career opportunities, theological perspective and understanding of trauma—were transformed by their experiences of disaster work. I argued that they represent a "clergy for a new age," incorporating science, religion and new age practice into disaster mental health. They also embody the seemingly contradictory ways that religion, spirituality, science, medicine and psychology are woven together. I also discussed issues of reflexivity, collective symbols and subjective experience.

Drawing on a tradition of multi-cited ethnography (Marcus 1995), I attended trainings, meetings, conferences and was myself the subject of several healing processes,

in addition to conducting extensive interviews. This fluid approach, which took me to four different states, allowed me to capture the movement of people and expert knowledge throughout space and time. Since my topic was part of a national and international network of ideas and practices, and truly interdisciplinary, following the circuitous trail to disparate sites allowed for a multifaceted picture that more accurately reflects the movement of people and ideas than were I to have remained solely in New York City. By participating in the trainings and "learning to see" (Luhrmann 2001) as a "disaster spiritual care provider," I gained access to a great deal of ethnographic material that would otherwise have remained opaque. While the multi-sited design ran the risk of leading to a loss of focus, I believe that the advantages were worthwhile and provided for serendipitous encounters that would otherwise have been lost—to the detriment of the dissertation.

I have shown that what has been called the epistemological conflict narrative of religion and science (Evans 2008) does not do justice to the complex picture of how people make sense of their lives. Indeed, it has largely been a fiction of academics and social commentators. While America has a unique history of dividing church and state, (Smith 2003), this supposed exclusion of religion from public discourse does little to divide subjective experience—how people actually live their lives and make sense of both daily experiences and disasters. Disasters provide an ideal setting for studying issues of religion and rationality because they force questions of belief to the surface and create a general mood of reflection about core societal values.

Despite the widespread view among social theorists that secularization theory does little to help us understand current religious behavior (Asad 2003; Evans and Evans

2008; Smith 2003; Taylor 2007)**,** there remain large gaps in research on how people actually *live* science and religion, medicine and spirituality, categories that have long been framed as antagonistic binaries. The undue emphasis on epistemological conflicts has obscured lived reality. That people often live quite comfortably with these "different" rationales, picking and choosing what makes sense for them given the contexts in which they function, provides a very different picture from the longstanding metaphors of conflict and even warfare between religion and science. Even the concept of picking and choosing suggests a subject selecting from a menu of choices to solve the various problems of life. This does not provide an accurate conception of how people move through their lives. What I observed was not so much a conscious decision making process, but rather selves that were formed by a world they were engaged in creating (Garro 2003). Scientific language and the language of medicine and mental health form who we are, and shape our experience of self and other. These shared discourses shape the possibilities for our experience, and form our subjectivities (Biehl, et al. 2007), providing architectures for empathy (Luhrmann 2001). Every impulse to empathy is freighted with a culture's valuation of what matters (Kleinman 2006).

A tendency to construct rational models of human behavior has plagued social sciences. As Allan Young argues (Young 1981), anthropologists often presuppose an unduly rational human subject with a consistent consciously articulated system of beliefs governing his/her choices. Instead (as I also found), "individuals use multiple representational schemas and modes of reasoning that are complex and sometimes internally inconsistent or contradictory" (Groleau, et al. 2006). The Prophetess, Ruth and Frank, along with many of my other subjects illustrate these seeming contradictions, and

caution against assuming automatic conflict between religion and science or medicine. Rationality and religion, mental health theory and seemingly exotic practices can often fit together without disharmony, without epistemological conflict or internal strife.

The question of the degree to which my subjects were guided by science or used scientific language to advance their own religious and spiritual goals is complex. Many of those I interviewed were quite comfortable with citing scientific data and believed, happily, that it supported their own beliefs. They largely did not see a conflict between science and religion because for them conflict simply didn't exist. They embrace science; it seemed to give them a sense of confidence in their own abilities to provide trainees with adequate knowledge. The conceptual tangle in social scientific and historical analysis over the epistemological conflict narrative is easily solved in practice, and not simply by resorting to the classic functionalist argument that people only turn to religion when science has exhausted its ability to control risk. This is part of the story, as evidenced by the surging church attendance following 9/11, but it still assumes that science and religion dance isolated psychic dances in the subjective worlds of believers. Often they do not. Frank, Tom from CISM, Sally and Noreen from the STAR program and others, genuinely had admiration for scientifically derived psychiatric and psychological knowledge, while at times embracing what would be considered unscientific beliefs. We need different conceptual tools to study the interactions between science and religion in daily lives, in how people live and not solely in how they think.

This fusion of religion and spirituality and mental health theory occurring in ways hitherto unseen will likely continue apace. This is significant for both study of

religion, the study of medicine and for the study of expert knowledge. It is also particularly significant, as this dissertation has shown, for the mental health and disaster professions. The first Age of Anxiety, which is said to have begun in 1945, saw radical shifts in the how Americans practice religion (Allitt 2003). St. Paul's Chapel, located across the street from the Ground Zero, has become a pilgrimage site of sorts for those seeking to connect with the religious import of the attacks of September 11th. The church provides information for psychological counseling and currently has an exhibit on its role in recovering from the attacks—an example of how the current New Age of Anxiety will continue to alter relationships between religion and spirituality and mental health practice and theory in significant ways.

Some Circumspect Policy Recommendations

Since I started this dissertation as part of policy work for the DOHM, in this conclusion I would like to make some general recommendations for how clergy might better be incorporated into a disaster plan. Questions of theory—self, suffering, healing, and idioms of distress—are not just questions of theory. In order to gain some understanding of the deep conflicts over how to understand distress, we need to look at history and the ways that people make their worlds. But those histories weigh heavily on how we make decisions today. As I have been at pains to show, ideas become embodied, and take on new forms, as people understand them in the context of their own lives, building institutions and creating policies.

Some of these recommendations appeared in the report submitted to DOHMH[35] and others I have made on several occasions to contacts in government and other disaster relief organizations. Since I have great reservations about the way disaster is used as a political idea, it seems clear that re-conceptualizing how we understand the relationship between "quotidian suffering" and catastrophic events requires significant rethinking on both theoretical and policy levels. Disaster can come to mask the everyday sufferings that afflict greater numbers of people than the more spectacular forms of disaster.

A key message that emerged from this research was the need to provide faith leaders with increased support as they confront the rapidly changing mental health context of families and communities in the United States. The potential for clergy to play an important role in providing both daily "mini-disasters" and large-scale extreme events is great. Creating a specific expertise that focuses on disaster runs the risk often found in the disaster professions: taking attention away from building up long-term infrastructure in areas like public health.

Enhancing collaboration among religious groups and mental health professionals through trainings and forums would be a key way to strengthen relationships and reduce the shared burdens of both clergy and mental health professionals (Milstein 2008). The necessity for collaborative care has become clear since 9/11, Katrina and other disasters. Also, on a much smaller scale—local fires, floods, heat waves and other disasters—it is important for clergy and mental health professionals to maintain linkages. Lack of communication, coordination and persistent mistrust hamper capacity for effective daily care as well as for disaster response. Collaboration between clergy and mental health

[35] This report was coauthored with Dr. Kim Hopper with the help of Alix Teleki and Rachel Jones.

workers needs to be ongoing with institutional mechanisms to ensure consistency and not be solely reliant on individual idiosyncratic relationships. As with cultural competency training, understanding of the differences in perspectives between religious leaders and mental health professionals needs to be nuanced and contextualized, avoiding the often pat characterizations of religious and cultural practices that are found in many handbooks.

By taking the time to meet with clergy in their environment and learning about the communities they serve, networks of trust and communication can be built up between mental health workers, disaster planners, religious leaders and their communities. Building on existing networks of community based organizations (CBO) and religious groups, clergy and mental health professionals would do well to create and enhance relationships**.** As mentioned above, there is much ongoing collaboration between CBOs and religious groups that could improve preparedness and day-to-day care. The overlap between CBOs and religious groups is often great, though at times these relationships are informal. These groups have potential for developing more effective mental and public health programs by including the input of clergy.

Those living in local communities often have a good idea of what their mental health needs are, and what kinds of services are available. They are often well aware of the kinds of "alternative" practitioners utilized by community members (these include *Santeria, Yoruba* and other traditional healers). Taking time to develop research questions in *collaboration* with communities may provide valuable lessons on the ground information, leading to a more targeted and efficacious intervention.

If City officials and "mainstream" religious groups are going to be successful in reaching "marginalized populations," developing relationships with these groups needs to be a priority. As indicated by the efforts of NYDIS, New York City Council of Churches and other organizations, independent, storefront and immigrant churches do not readily participate in organized events, and bureaucracies too often function on outdated information in the aftermath of disaster. This highlights the need for ongoing work.

Providing applied training resources for clergy that help to educate them about the wider network of service resources would be an important step to meeting service needs. In order to alleviate mutual suspicion, that first move needs to come from the formal mental health community, offering to meet religious groups on their own ground and negotiate a way forward. Understanding the complexity involved in how people understand their own distress, the way different kinds are linked to intricate networks of place, culture, and economics, is crucial to fostering an understanding of the shared goals in reducing the burden of suffering among those seeking help and facilitating referral linkages and sharing of information (Milstein 2008).

Finally, and maybe most importantly, disaster preparedness requires ongoing effort. It is not possible to have an effective disaster mental health system without a vibrant public mental health system as a baseline (Rosner and Markowitz 2006). The emphasis on disaster preparedness can be as misguided and myopic for clergy as it can be for government policy makers and public health officials. It is tempting to focus on the spectacular, to the exclusion of more mundane planning and daily disasters.

It would be comforting to end this dissertation with some neatly tied conclusion about how to help put back together broken bodies and minds, what nuanced, balanced conception of biology, mind and brain, meaning and mechanism might be best. But the solutions are as varied as the problem. There are of course patterns and things to be learned from the previous events. Yet something continues to elude us—and each successive generation's belief that they have finally found the right kind of therapy, only to be discarded by the next generation—often with derision—attests to this sense that expertise often acts as a mask for ignorance. A way to manage—particularly in the case of disasters—what in many ways is unmanageable. Perhaps it was the sociologist at a disaster conference whose refrain throughout his talk was—"everyday things that have never happened before happen"—who best articulated our limited capacity to predict the future.

With the predicted increasing numbers of disasters and the future will likely continue to see a merging of religion, spirituality and mental health theory and practice in the United States, as well as increasingly opposition to rapprochement on both sides, and with the predicted increased numbers of disasters in the future, the demand for "disaster religious and spiritual care" will likely increase as people seek to live with the inevitable distress caused by the unruliness of contingency. Religion, spirituality, psychology and medicine provide architectures for empathy (Luhrmann 2001), guiding how to respond to suffering, and care for the vulnerability inherent in possessing a human body in a world that may "outstrip the concepts with which we seek to understand it" (Lear 2007: 120). Understanding how people create their worlds, then, lies less in analyzing and picking

apart models and conceptual schemas, than in looking at what they do, how they live and stumble along through the immensities of their lives.

Science, Weber (1958) bleakly noted, at a time when it seemed certain that the Gods would fade away, will do nothing to provide meaning, whether on the death bed or when one loses his or her way in the dark wood of calamity. He disparagingly admonished a return to the churches for those who did not have the strength to face this truth. Weber, however, misread the auguries, and his forecasts on the future of religion did not come to fruition.

Though one might not be religious, or consider themselves spiritual, it is difficult to dismiss the thought that a life lived solely on the principles of science would be lacking in something of value—and an uneasy perplexing feeling of loss, a diminished sense of security (Giddens 1991), seems to be a pervasive societal lament. Perhaps it is a persistent need for a home-like safety that continues to fuel the urge to see cosmic forces as *meaningful*—when homes explode, are submerged in flood, sink into quake-shattered earth, or when skyscrapers disappear into infernal flames, and vulnerability threatens to overwhelm, people will continue to interweave religious, spiritual and psychological narratives, imagining, inhabiting and patching worlds—if briefly— together, again and again.

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