Coordinating Medical and Pastoral Care in Cases of Child Abuse and Neglect

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Introduction

There is a significant body of research documenting the impact of child maltreatment on physical and emotional health.[2] There is also a growing body of research documenting the impact of child maltreatment on spirituality.[3] In this article, readers receive a brief overview of the research on the intersection between religion and health in cases of child maltreatment as well as suggestions for coordinating medical care with spiritual care. Using corporal punishment as an example, there is also a discussion of the possibility of collaboration when faith and medicine are in conflict.

The intersection between medicine and religion

Throughout history, religious communities have played a significant role in the creation of hospitals.[4] In the United States today, religious communities continue to support more than one out of ten of the nation's hospitals.[5] Indeed, the traditional medical symbol of a snake wrapped around a pole reflects an account from the Hebrew Bible.[6] Apart from these historic links, there has been a long-standing belief by many medical providers that spirituality and health are interconnected.[7] This belief is reflected in the fact that 90 percent of medical schools in the United States have courses or at least course content exploring the relationship between health and spirituality.[8]

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Religion, health, and child abuse: an overview of the research

There are a number of studies finding that religious involvement can serve as a source of resilience that protects against the potential impact of child abuse on medical or mental health.[9] However, these studies have several limitations including small sample sizes and a focus primarily on female survivors of sexual abuse.

To correct for these limitations, Reinert and colleagues did a large study that assessed the impact of multiple forms of child abuse on medical and mental health as well as the role of religious involvement in mitigating these impacts. Reinert queried 10,283 men and women identifying as Seventh Day Adventists, on the experience of five types of early childhood trauma: sexual abuse, physical abuse, neglect, emotional abuse, and witnessing family violence.[10] Sixty-seven percent of the participants endured mal-

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

3. Donald F. Walker, et al., "Addressing Religious and Spiritual Issues in Trauma-Focused Cognitive Behavior Therapy with Children and Adolescents," *Professional Psychology: Research & Practice* 41 (2010): 174.

4. Paul A. Offit, *Bad Faith* (New York: Basic Books, 2015), 119–120.

5. Ibid., 120.

6. Num 21:8–9.

7. Harold Koenig, Dana King, and Verna B. Carson, *Handbook of Religion and Health Second Edition* (Oxford University Press, 2012).

8. Harold G. Koenig, Elizabeth G. Hooten, Erin Lindsay-Calkins, and Keith G. Meador, "Spirituality in Medical School Curricula: Findings from a National Survey," *International Journal of Psychiatry in Medicine* 40(4) (2010): 391–397.

9. Terry Lynn Gall, "Spirituality and Coping with Life Stress Among Adult Survivors of Childhood Sexual Abuse," *Child Abuse & Neglect* 30 (2006): 829–844; Terry Lynn Gall, Viola Basque, Marizette Damasceno-Scott, and Gerard Vardy, "Spirituality and the Current Adjustment of Adult Survivors of Childhood Sexual Abuse," *Journal for the Scientific Study of Religion* 46 (2007): 101–117; Jungmeen Kim, "The Protective Effects of Religiosity on Maladjustment Among Maltreated and Nonmaltreated Children," *Child Abuse & Neglect* 32 (2008): 711–720.

10. Katie G. Reinhert, Jacquelyn C. Campbell, Karen Bandeen-Roche, Jerry W. Less, and Sarah Szanton, "The Role of Religious Involvement in the Relationship Between Early Trauma and Health Outcomes Among Adult Survivors," *Journal of Child & Adolescent*

treatment in at least one of the categories, 9 percent were abused in at least three categories, and 5 percent were abused in all five categories.[11] Reinert documented a reduction in the medical and mental health of participants abused in at least one of the categories with a "greater reduction in mental health" for those with higher exposures to trauma and "more than twice a reduction in physical health" for higher exposures.[12]

However, the negative impact of child abuse was moderated by some types of religious involvement. Specifically, the negative impact of child abuse on mental health was reduced by the following:

- Positive religious coping mechanisms (e.g., "I tried to make sense of the situation with God's help.")
- Intrinsic religiosity (e.g., private prayer, study, church attendance)
- Forgiveness (e.g., "I have forgiven those who hurt me.")
- Gratitude (e.g., "I have so much in life to be thankful for.")

Negative religious coping (e.g., "God is punishing me.") did not moderate the mental health impact of child abuse nor did it "significantly exacerbate the association of [child maltreatment] with worse mental health."[13] Reinert speculates the reason negative religious coping did not have a greater detrimental impact on mental health is because this form of coping was very low in the sample studied.[14]

With respect to medical health, Reinert found "no strong evidence" that religious involvement moderated the impact of child abuse and neglect, but noted that forgiveness was very close to having a statistically significant impact on medical health.[15] According to Reinert, a "very likely explanation" for this limited effect is the "overall good health" of the population studied, reflecting the strong emphasis in the Seventh Day Adventist faith community of healthy behaviors such as proper nutrition and exercise, and the infrequent use of behaviors adverse to health such as smoking, alcohol or drug use.[16] If this is true, then religious involvement may have a greater impact on medical health in other faith traditions with less insistence on healthy behaviors.

Implications for medical and pastoral care providers

There are at least five implications from this research for medical and pastoral care providers:

1. Hospitals and clinics may want to explore the integration of quality spiritual care into the health care treatment of child and adult survivors of abuse.

Trauma 9 (2016): 231–241.

11. Ibid., 235.
12. Ibid., 236.
13. Ibid., 237.
14. Ibid.
15. Ibid., 238.
16. Ibid.

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Since 2002, the percentage of hospitals providing spiritual care services has increased from 53 to 70 percent.[17] According to a group of international experts who gathered to discuss this issue, there is a "silent revolution for creating more compassionate systems of care through the full integration of spirituality into health care."[18] At the same time the experts recommended clear guidelines for spiritual care in a health care setting, rigorous education, and strong research to support this work.[19]

In a similar vein, hospitals providing spiritual care to child or adult survivors of maltreatment should develop guidelines for how this will be done, should make sure spiritual care providers are trained on working with survivors of maltreatment,[20] and should research the efficacy of any spiritual care services offered or provided to survivors of abuse.

2. Hospitals and clinics, perhaps in concert with Children's Advocacy Centers, may want to develop a process for recommending ongoing pastoral care services to survivors of abuse.

In 2017, Tishelman and Fontes published a study noting the "positive aspects of religion" for many survivors of abuse but also noting that some religious tenets and religious leaders can be harmful to maltreated children.[21] Accordingly, while it may be critical to some survivors to receive ongoing pastoral care, it is also critical to ensure the survivor receives competent pastoral care. To this end, medical providers and child protection professionals should, at a minimum, inquire of the capabilities of local clergy to provide pastoral care in cases of child abuse and also their willingness to coordinate that care with appropriate medical and mental health care.

In making this inquiry, the following questions may be helpful:

- What, if any, training on child maltreatment did you have at

17. Stacy Weiner, "Is there a Chaplain in the House? Hospitals Integrate Spiritual Care," *AAMC News,* November 21, 2017.
18. Christina M. Puchalski, Robert Vitillo, Sharon K. Hull, and Nancy Reiller, "Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus," *Journal of Palliative Medicine* 17 (2014): 642–656.
19. Ibid.
20. As one example, Gundersen Health System provides a rigorous three-day course, titled *Chaplains for Children,* for faith leaders interested in working with children or adults impacted by abuse.
21. Amy C. Tishelman and Lisa A. Fontes, "Religion in Child Sexual Abuse Interviews," *Child Abuse & Neglect* 63 (2017): 120–130.

seminary or in another setting?

- What, if any, training on child abuse have you had since you graduated seminary?
- What, if any, child protection policies does your church/synagogue/temple have? Do these policies address all forms of child abuse?
- Have you ever delivered a sermon or conducted a Bible study on child maltreatment?
- What, if any, child abuse training do you require of staff working with children?
- What is your familiarity with basic research on the impact of child abuse (e.g., Adverse Childhood Experience/ACE research, etc.)?[22]
- What experience have you had in working with an abused child or adult survivor of abuse?
- Are you familiar with the concept of "poly-victimization"?[23]
- What is your approach for coordinating pastoral care with medical and mental health care?[24]
- Are you theologically opposed to medications for any mental health conditions a child may have?
- Are you theologically opposed to mental health counseling?
- Are you theologically opposed to medical care for maltreated children?
- What are your views of corporal punishment? (Some survivors of physical abuse struggle with any church that still urges parents and other adults to hit children).[25]

As a result of this inquiry, a community is likely to discover that it has very few clergy with seminary or other training on child maltreatment. If this is the case, the community can explore options for growing a base of clergy qualified to work in this area. As one example, the Children's Advocacy Center in Greenville, South Carolina, hired a full-time chaplain with specialized training in responding to child maltreatment.[26] In turn, this chaplain works with the area clergy in providing training and other assistance in growing the knowledge and skills of faith leaders in the community.

While it may be critical to some survivors to receive ongoing pastoral care, it is also critical to ensure the survivor receives competent pastoral care. To this end, medical providers and child protection professionals should, at a minimum, inquire of the capabilities of local clergy to provide pastoral care in cases of child abuse and also their willingness to coordinate that care with appropriate medical and mental health care.

3. When making mental health referrals for someone who has experienced abuse and who is indicating faith is important, medical and pastoral care providers should look for mental health counselors utilizing evidence-based treatment and who are fluent in the research on the intersection between health and spirituality.

Although it is essential to refer victims of abuse to counselors trained and skilled in utilizing treatment models supported by research, it is also possible to utilize these models to address spiritual questions a survivor may be struggling with.[27] To this end, the American Psychological Association has published two treatises to assist clinicians.[28]

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

23. Many children who are abused in one way, such as physical abuse, are abused in other ways, such as sexual abuse or emotional abuse. This concept is called "poly-victimization." This concept is important because we know from research that children violated in multiple ways often suffer greater medical and mental health problems. Heather A. Turner, David Finkelhor, and Richard Omrod, "Poly-Victimization in a National Sample of Children and Youth," *American Journal of Preventive Medicine* 38: (2010): 323–330.

24. The American Psychiatric Association has published a helpful guide to assist faith leaders in working with medical and mental health care providers in addressing mental illness: American Psychiatric Association Foundation, *Mental Health: A Guide for Faith Leaders* (American Psychiatric Association Foundation: Arlington, Va., 2016).

25. Victor I. Vieth, "Augustine, Luther and Solomon: Providing Pastoral Guidance to Parents on the Corporal Punishment of Children," *Currents in Theology and Mission* 44.3 (2017): 25-33.

26. "Julie Valentine Center becomes the First Child Advocacy Center in the U.S. to add Chaplain to Its Staff," *GSA Business Report,* January 17, 2017, available at: http://gsabizwire.com/julie-valentine-center-becomes-the-first-child-advocacy-center-in-the-us-to-add-chaplain-to-its-staff/ (last accessed January 2, 2018).

27. Terri S. Watson, "Counseling the Abuse Victim: Integrating Evidence-based Practice Guidelines with Spiritual Resources," in *The Long Journey Home: Understanding and Ministering to the Sexually Abused,* Andrew J. Schmuzter, ed. (Eugene, Ore.: Wipf & Stock 2011), 248–249.

28. Donald E. Walker and William L. Hathaway, *Spiritual Interventions in Child and Adolescent Psychotherapy* (Washington, D.C.: American Psychological Association, 2013); Donald F. Walker, Chris-

4. When making a medical referral for a child or adult impacted by abuse, clergy should proactively seek a medical provider trained and skilled in responding to trauma and who is sympathetic to the client's desire to use his or her faith as a means of coping.

Just as not every member of the clergy is qualified to work with a survivor of child maltreatment, not every doctor is qualified. A pastor, for example, may be working with a survivor who has multiple health conditions that could be related to the trauma—such as sleep disorders, anxiety, and depression. When this happens, the pastor may be tempted to urge his or her client to discuss a history of trauma with the client's medical provider. Before making this recommendation, it is important to make sure the medical provider knows something about responding to trauma and its influence on health.

If a pastor is unsure whether a particular doctor is skilled in working with patients who have suffered child maltreatment, a local children's advocacy center may be able to assist the pastor in finding area medical providers who are trauma-informed; any hospital affiliated with the National Child Traumatic Stress Network[29] is also likely able to provide guidance. At a minimum, a pastor can advise a victim to ask some questions about a doctor's familiarity with the impact of abuse on health and, if he or she is not familiar with this research, making an appropriate referral.

5. Medical and pastoral care workers need to collaborate in instances where faith and medicine collide.

There are myriad instances in which faith and medicine may be in conflict; when this happens, the ability to help a survivor of abuse or to prevent abuse may depend on the ability of doctors and clergy to collaborate.

As one example, there is a growing body of research that corporal punishment is an ineffective form of discipline and elevates the risk for poor medical and mental health outcomes.[30] As a result, pediatricians are increasingly discouraging parents from employing a practice that research shows to be detrimental to a child's health.[31] Unfortunately, many conservative Protestant parents believe the Bible requires them to employ corporal punishment and will not yield to health care providers on this issue *unless* they are given a sound theological reason to do so.[32] However, when conservative Protestants are presented with a plausible theological argument for not physically disciplining children,[33] the attitudes of many begin to change and they are much more open to considering research documenting the physical and emotional risks of hitting children as a means of discipline.[34]

It is critical to have in place appropriate guidelines and to ensure that medical and pastoral care providers are trained in working with victims of child abuse and that each discipline respects the role of the other.

This promising research on changing the attitudes of conservative Protestants on corporal punishment suggests it may be possible for doctors and theologians to find common ground even when the respective disciplines come into conflict.

Conclusion

There is research documenting the importance of spiritual care for many patients, with an emerging sub-set of research documenting the importance of spiritual care for children and adults who have been victims of child abuse or neglect. As we move in this direction, it is critical to have in place appropriate guidelines and to ensure that medical and pastoral care providers are trained in working with victims of child abuse and that each discipline respects the role of the other. In cases of child maltreatment in which faith and medicine sometimes are in conflict, the importance of collaboration may be particularly important.

tine A. Courtois, and Jamie D. Aten, *Spiritually Oriented Psychotherapy for Trauma* (Washington, D.C.: American Psychological Association, 2015).

29. For additional information about the National Child Traumatic Stress Network, visit their website at: http://www.nctsn.org/ (last accessed January 2, 2018).

30. Elizabeth T. Gershoff and Andrew Grogran-Kaylor, "Spanking and Child Outcomes: Old Controversies and New Meta-Analysis," *Journal of Family Psychology* 30 (2016): 453–469.

31. Committee on Psychosocial Aspects of Child and Family Health, "Guidance for Effective Discipline," *Pediatrics* 723 (1998): 101.

32. Victor I. Vieth, "From Sticks to Flowers: Guidelines for Child Protection Professionals Working with Parents Using Scripture to Justify Corporal Punishment," *William Mitchell Law Review* 40 (2014): 907–942; John P. Hoffmann, Christopher G. Ellison, and John P. Bartkowski, "Conservative Protestantism and Attitudes Toward Corporal Punishment, 1986 to 2014 63 *Social Science Research* (2017): 81–94.

33. *See e.g.,* Victor I. Vieth, "Augustine, Luther and Solomon: Providing Pastoral Guidance to Parents on the Corporal Punishment of Children," *Currents in Theology and Mission* 44.3 (2017): 25–33.

34. Robin Perrin, Cindy Miller-Perrin, and Jeongbin Song, "Changing Attitudes About Spanking Using Alternative Biblical Interpretations," *International Journal of Behavioral Development* 41 (2017): 514–522; Cindy Miller-Perrin and Robin Perrin, "Changing Attitudes About Spanking Among Conservative Christians Using Interventions that Focus on Empirical Research Evidence and Progressive Biblical Interpretations," DOI: 10.1016/j.chiabu.2017.03.015