Chapter Ten

A Trauma Treatment Model for Interim Work with Chronically Dysfunctional Congregations

Deborah J. Pope-Lance

Some congregations repeatedly wrestle with the same problems, but nothing changes. Interim ministry in these congregations can be extremely frustrating. The usual remedies—conducting healthy congregation workshops, hiring outside consultations, calling a succession of able-enough clergy—bring no permanent fix to their chronic struggle. Interims' efforts to address problems are openly opposed, merely tolerated, or simply ignored. Improvements are temporary. Often the crankiest, most troubled members govern, while those more mature and self-differentiated who might serve as the immune cells essential in a healthy congregation[1] grow weary and withdraw. What is going on in these congregations? Why do they struggle repeatedly and still not thrive? How might interim ministers think about these congregations in a new way? What new model might provide strategies for reducing clergy frustration, ending their chronic struggles, and effecting lasting change?

Failure to Thrive

A discovery by a group of clergy who met regularly for mutual support provides a clue.[2] Each minister had joined the support group because they were unusually stressed and frustrated. Despite considerable experience and past successes, each felt inadequate to meet the challenges of their current ministry. The strain had affected their health, unsettled their families, and led

some to consider leaving the ministry. Meeting together, they discovered some striking similarities in their congregations.

Each congregation was thought to have had promise, but these hopes remained unfulfilled. Each congregation was disturbingly ineffective at governing itself. Each seemed to lack a capacity to make decisions, follow procedures, set appropriate boundaries, establish lines of responsibility, secure their buildings, protect themselves from risk, welcome new members, run successful canvasses, or disagree without divisive upset. Differences were sharply drawn. Conflict escalated quickly and often resolved only when one side or the other left the congregation. Members routinely treated each other badly. Nearly all the congregations had a reputation for being hard on ministers. Members and leaders were overly critical and highly reactive to the person of the minister. Minister-congregant relationships were often perplexing and volatile. Many of the congregations had been served by a series of minsters whose short tenures and unhappy departures were otherwise unremarkable. And all had suffered for many years from what may best be described as a failure to thrive.

"Failure to thrive" is a phrase used in medicine to describe a condition found in young children and frail elderly. When children whose rate of growth, despite proper care and adequate nutrition, does not meet the expected growth rate of children their age, they are diagnosed with failure to thrive. In the elderly, a gradual decline in physical or cognitive function that occurs without adequate explanation is described as a failure to thrive. Whether young or old, those who fail to thrive appear to lack the capacity to adapt, grow, and survive.

Many contemporary congregations are stressed by changes in their surrounding community and the larger world. (See chapter 3, "The Changing Landscape of the American

Church.”). Some congregations, stressed by these same changes, manage well enough. A few even prosper. But other congregations do not and many do not survive. Why? Clearly, congregations have different resources. Some possess more skilled leaders or larger endowments. Others have more difficult problems—older buildings or more vulnerable populations. Nevertheless, some deeply challenged congregations remain intact, surviving or even to thriving, while in others, something appears to have compromised their capacity to adapt and grow in the face of far less significant stresses.

Why congregations, full of nice, capable people fail to thrive remained unclear until the ministers in the group discovered that all their congregations had a similar history. In every congregation, a past minister had engaged in misconduct. Typically the misconduct was sexual in nature, but sometimes it involved breaches of confidentiality, neglect of duty, theft of money, misuse of property, and betrayals of trust. In some congregations, the experience was recent; in others, long ago. In some, the events were a secret; in others, they were widely known. In some, serious conflict had erupted after the misconduct. In others, the misconducting minister simply departed without explanation. Regardless of these variations, each congregation had experienced their minister’s misconduct as a devastating violation[3] and afterwards had exhibited a persistent failure to thrive.

Other types of trauma also occur in congregations.[4] Public acts of violence—random armed assaults, bombings, or arson—do happen in congregations and inflict serious injury and loss of life. Unforeseen accidents caused, for example, by building failures, earthquakes or human error cause irreparable damage and terrible grief. Intense interpersonal conflict, arising from controversy or exacerbated by human behavior, can escalate quickly, injuring people and

shattering lives much like a bomb. These other sudden, hurtful, and intense violations also have a traumatic effect on a congregation. In the aftermath of these traumas, congregations struggle to address their injuries and losses. Some barely manage to survive.

The significance of a congregation's past in the evolution of its present challenges has long been recognized.[5] The first of the traditional five tasks of interim ministry—making sense of a congregation's history[6]—is informed by this recognition, as is the widely held belief that a congregation cannot know where it is going unless it understands where it has been. But these ministers, serving congregations with similar histories, recognized something more. They recognized that their congregations' failure to thrive in the present was rooted in the trauma of these past violations. Now, in the present, their inability to adapt and grow, their chronic dysfunction, pervasive distrust, uncivil behavior, frequent conflict, and difficult relations with ministers were the persistent evidence of past trauma.

When interim ministers understand the experience of violence, intense conflict, or clergy misconduct as a trauma in the life of the congregation, what is required to address trauma's often persistent effect becomes clear. Resources developed to address psychological trauma in individuals can be applied to traumatized congregations. A trauma model provides a new perspective with which interim ministers might discern different priorities and strategies to navigate the chaos of chronically dysfunctional congregations. Even in congregations without known trauma histories but with chronic patterns of dysfunction, difficult ministries, or inexplicable failure to thrive, the treatment model provides a novel, effective approach. Employing these priorities and strategies, the adverse effect of trauma on a congregation, among these a chronic failure to thrive, can be reduced.

What Is Trauma?

Trauma is the effect of an extreme difficult or unpleasant experience. This effect can cause a person to have mental or emotional problems for some time afterwards. Traumatic experiences can be brought on by severe weather, an accident, an act of violence, or by any event that threatens the physical safety, living conditions, and assumed meaning of those who experience it. Soldiers, for example, who daily witness gruesome acts of violence and whose lives are routinely threatened, can suffer acute emotional distress long after leaving the battlefield. The emotional problems caused by traumatic experience were first recognized in soldiers returning from war. What was called "battle fatigue" in World War II, "shell shock" in World War I, and "soldier's heart" in the Civil War came to be identified in the aftermath of the Vietnam War as "post-traumatic stress disorder" (PTSD). Since then, PTSD has also been diagnosed in non-combatants, in mourners after complicated loss, and in survivors of assault, domestic abuse, political oppression, and civil unrest.

Trauma impacts all aspects of an individual's functioning. Traumatic injury is not only physical and emotional and not only evidenced in dysfunctional or self-destructive behavior. The impact of trauma, especially as evidenced in PTSD, is more accurately described as bio-psycho-social.[7] Neurological research, for example, has shown that trauma physically alters the brain structures of survivors.[8] Studies of communal experiences of trauma identify changes in social structures and relationships.[9]

Trauma's impact is most evident in a broad array of psychological symptoms. These include difficulties with concentration, intrusive thoughts, compulsive behaviors, panic attacks,

and recurrent nightmares. Symptomatic individuals report irritability, agitation, anger, acute anxiety, depression, and sleep disturbance. Some display exaggerated startle responses or hypersensitivity to normal sights, sounds, or smells, especially when aspects of present experience resemble the trauma experience. Hypersensitivity can lead to distortions in thinking and feeling, inaccurate recollection, and sensations that the past trauma is being re-experienced in the present. A soldier back from war hears among the normal sounds on a city street an automobile loudly backfire and is triggered by this explosive sound to re-experience the imminent threat of enemy bombs and react by diving into an alley for safety. Similarly, some trauma survivors, when thinking about a trauma in the past, report dissociating or feeling disconnected from what is happening in the present. This dissociation generates gaps in survivors' memories.

Psychologists view these symptoms as normal reactions to the extremity of trauma and consider them sufficiently predictable that even in the absence of a known history of trauma, their presence may be considered reliable evidence of a past trauma. Persistent, chronic symptoms are evidence of a survivor's ongoing struggle to cope in trauma's aftermath. Coping strategies such as obsessive attention to tiny details evolve overtime and become automatic. When normal pre-trauma conditions return and these coping strategies are no longer necessary, they nevertheless persist as chronic symptoms that impair daily functioning and threaten survivors' well-being.

Normal responses to trauma vary in individual survivors. Some survivors cannot remember what happened. Yet others can describe their experience in impressive detail. Some re-experience the trauma in nightmares or in daytime flashbacks. Some do not. Some compulsively

replicate aspects of the trauma experience when the dynamics of present situations or relationships resemble those of the trauma, increasing their distress and reinforcing symptoms. Others do not. Some survivors, overwhelmed by chronic symptom and unmanageable lives, become passive and careless, while others are obsessive and hyper-vigilant. Some suffer from lifelong emotional distress and self-destructive behavior. A few others report that after the trauma, their lives gained renewed purpose.

Why some people are more deeply or permanently affected by trauma than others or why only some have a greater risk for developing the more acute symptoms of PTSD remains unclear. Differences in personal resources—resilience, self-esteem, and knowledge—may be a factor. Likely other factors—a person's proximity to the event, the extent of disruption to daily routine, the severity of physical injury, and the amount of time required for recovery—make a difference. Survivors isolated from others have a higher risk for developing PTSD, while survivors who receive compassionate support—security, medical care, and basic necessities—from others and who as a result feel safe, do not fear further injury, and do not lack food or shelter appear to suffer less severe or persistent distress.

Trauma survivors frequently are conflicted about their experience. They are seemingly caught between a wish to forget the trauma ever happened and a compulsion to describe its outrageous horrors to all who will listen. Those who witness a trauma from a safe distance (in time or geography) can also be conflicted, silencing survivors with comments such as, "I'm sure it wasn't as bad as you say" or "In time you'll be fine." This ambivalence exacerbates symptoms, raises the risk for PTSD, and increases resistance to treatment. Companions who are knowledgeable about trauma and PTSD may be better equipped to support survivors as they try

to make sense of what has happened.

A Three-Phase Trauma Treatment Model

Trauma's emotional impact is primarily treated through psychotherapy. Many psychotherapeutic treatment models exist, but generally psychotherapy is a process in which a person, talking with a trained psychological clinician, is helped to reflect on the experience and condition and to resolve problems in ways that allow him or her to adapt and grow. In psychotherapy, a survivor describes the trauma experience and aftermath to a non-anxious, empathetic, compassionate, and nonjudgmental therapist. Through this process, survivors find ways to lower their anxiety and increase their capacity to manage the conflicting emotions that are typical after trauma and to resolve difficulties caused by symptomatic behaviors. For some survivors, psychotherapeutic treatment is augmented with medications that reduce acute distress and improve self-control, so that survivors may engage effectively in psychotherapy. Specific psychotherapeutic treatment models have been developed to encourage survivors to remember, reflect on, and reprocess a traumatic experience.

Many models are organized in phases, each attending to specific tasks in the healing process. In a model developed by Judith Herman,[10] the first phase focuses on safety, symptom reduction, and stabilization. The second phase supports survivors' to reconstruct the traumatic story, process memories and emotions, and name and grieve losses. The third phase encourages survivors to discern some meaning in their experience of trauma and to integrate that meaning into their lives. Throughout all phases, survivors are empowered, to the fullest extent their current capacities allow, to take control of their treatment and their lives.

During phase one of treatment, survivors are the most distressed, in denial, and vulnerable. A therapist seeks to establish a safe environment in which a survivor feels both protected from further injury and respectfully heard. Essential to this task is clear acknowledgement that what has happened—the sudden unexpected event or experience, the consequent distress, and persistent symptoms—taken all together, constitute a trauma. In bearing witness to the trauma, a therapist normalizes a survivors' experience. Dissociated thoughts, crazy behaviors, and distressing emotions are transformed into predictable responses and vague recollections into accessible, discussable memories. A therapist helps a survivor find ways to manage the day-to-day upset these thoughts, behaviors, and emotions can cause, but she does so without rescuing or taking over. A neutral therapeutic stance encourages a survivor to take back control of his or her life and to resolve emotional conflicts rather than display them as symptoms. Against a non-neutral therapist, survivors may tenaciously embrace only one side of their emotional conflict and remain distressed. A neutral therapist is not indifferent but rather does not offer an opinion as to what survivors should choose to do now in the aftermath of the trauma.

Phase two focuses on remembering and mourning. Now the goal of treatment is to move from absent or vague memories of what happened to a clear, full story of the trauma experience. The therapist companions the survivor on the journey. Clearer memory increases a survivor's awareness of what has been lost and allows these losses to be named and grieved. A psychotherapist helps survivors to understand grieving these losses as an act of courage and a bold choice to adapt, grow and heal.

Phase three of the model focuses on helping survivors regain trust in themselves, others, and life. During this phase, survivors become increasingly able to re-engage in ordinary life,

albeit a life after trauma. As survivors come to understand themselves—their thoughts and feelings, their insights and intuitions—their capacity to manage recurrent symptoms, to protect themselves against further injury, and to make choices that are in their best interest increases. Confidence in their own capacities allows survivors to trust themselves and choose to be the person they wish to be. Reconciled to the past, in charge of the present, and committed to a future of their own choosing, survivors become more willing to trust and rebuild social connections with others. Survivors who discern meaning in a trauma experience and integrate that meaning into how they live now have the best therapeutic outcomes. Some survivors become activists, working to prevent the type of trauma they experienced. Others contribute to the common good in some unrelated way, transforming the meaning of a personal tragedy into a public resolve to make the world a better place.

This three-phase psychological treatment model can be employed as a model for interim work in congregations with history of trauma. Interim ministers think about their work in phases and focus on specific tasks in each phase.

Phase One: Acknowledging the Trauma, Restoring Order

Phase one of the model directs an interim minister, whether in the immediate aftermath of trauma or after years of chronic dysfunction, to focus first on acknowledging the trauma, establishing safety, and stabilizing congregational operations.

Acknowledging the trauma—quickly, publicly, and safely—is essential to the recovery of individual trauma survivors.[11] Similarly, acknowledging a congregation's experience and naming it as trauma is essential to minimizing the persistent, adverse impact the experience can have on

a congregation. Ideally the acknowledgement will be made in a communal, public way—a letter mailed, a Sunday announcement made, a meeting held. Basic information is conveyed, questions are answered, and members are given time to talk together. These acknowledgments need not be graphic or exhaustive. Simple, gracious language, such as, “After these recent events” or “Given what we have been through,” is clear and honest and lowers anxiety. Lowering anxiety reduces distress and improves both individual and group functioning. When an investigation is pending or survivors’ identities need to be confidential, some information may be withheld. In this situation, a straightforward statement—“This is what we know at this point, and we will keep you informed as we learn more”—is clear and honest and conveys compassion to all. Subsequent gatherings will convey new information as available and provide further opportunity for members to be together.

Some denominations have developed trauma response teams to be deployed to congregations in the immediate wake of a trauma. Composed of trained, empathetic companions, teams offer crisis counseling, restore order, and provide support. Their presence clearly states that what has happened in the life of this congregation constitutes a trauma. Although these teams generally are deployed in the wake of violence or natural disasters, they could be deployed in the aftermath of other types trauma. After intense conflict or clergy misconduct, trauma response teams could provide the early intervention that has been shown in early treatment of individuals to reduce symptom severity and improve recovery.

When a denominational response team is not available, local community members can be brought together to form a response team. Psychotherapists and emergency responders can provide immediate assistance and crisis counseling. Ministers and lay pastoral teams from

nearby congregations can offer pastoral care. Other volunteers can help maintain basic operations, providing, among other services, administrative support, media response, and most importantly, communal worship. This community-formed trauma response team, like a standing denominational team, can also facilitate a trauma debriefing.

A trauma debriefing is a structured opportunity for congregants to learn the known facts and to process the reality of the event. Different formats have been suggested for organizing trauma debriefings. In general, a trauma debriefing occurs within hours or days of a trauma event —for example, after the fire is put out, a minister's departure is announced, or intense conflict has ended. Even if all the facts are not yet available, participants will benefit from being together, hearing each other's feelings, and sharing concerns. Congregational leaders and denominational officials should be present and visible, participating not as facilitators but in their customary roles. A bishop, for example, whose role as bishop includes investigating misconduct allegations, might report on how the investigation will progress. A congregation president who received the fire chief's phone call might report on the status of the arson investigation. An assistant minister might offer prayers for the injured. But a trauma team member who is not the bishop, the president, or the pastor should be the person who facilitates the gathering.

Individuals process difficult experiences at different rates. Some members will need more opportunities than others to process the experience. Some will prefer different formats—one-to-one appointments with a counselor; small, facilitated group process; or weekly or monthly drop-in gatherings. Some groups, such as staff, board members, or survivors, may be served best by separate, dedicated opportunities to talk. Some congregations may be best served by holding periodic gatherings for some years and others by scheduling a meeting only when new

information comes to light or new losses are discerned. Some congregations will benefit from educational opportunities, such as programs on trauma and its effects on individuals and communities. Congregations that have experienced the trauma of a minister's misconduct will benefit from learning more about ministerial roles and relationships and about the ethical standards and state laws governing ministerial practice.

Restoring Order

Another task in phase one of this trauma treatment model, restoring order, directs an interim minister to focus on stabilizing the congregation's basic operations. In the immediate aftermath of trauma, a congregation is in crisis. When trauma occurred in the distant past, a congregation likely has been in crisis for some time. Basic services have been neglected, buildings poorly tended, and mission unfulfilled. Loss of members and income have diminished program support and worship participation. Concern for the simple survival of a congregation post trauma is well founded. An interim minister who effectively sees to the fulfillment of members' pastoral needs and restores trust in its clergy fosters commitment to the congregation and cultivates confidence in its future viability. Greater confidence and less chaos will reduce anxiety and foster a sense of stability, leading members to participate in and support the congregation going forward.

Encouraging the use of best governing practices is a routine interim strategy that can significantly help address the extraordinary challenges of a traumatized congregation. Congregations that experienced traumas in the distant past have commonly been and remain poorly managed. Helping leaders learn to use best practices, for example, to manage the congregation's finances, personnel, and committees creates order amid chaos and instills a

confidence that leaders can manage their congregation well. A specific governing practice may be considered "best" because it is in keeping with applicable polity, puts into action a congregation's beliefs and values, has proved effective in other congregations of similar size or complexity, or is required by current standards in the business of congregations.

Chronic, poor management is not caused only by congregational leader's ignorance of best practices, however. More often it is caused by leaders' inconsistently or rarely following the good-enough practices already in place. For healthy congregational functioning, the content (or the what) of a practice is less important than the process (or the how) by which it is followed. Practices are best and generate a healthier congregation when they are based on agreements, clearly stated, consistently followed, and updated when necessary. An interim minister who focuses on helping a congregation operate in a manner consistent with its established practices and in keeping with its expressed mission effects a significant move toward health and recovery after trauma.

An essential strategy—highlighted by Friedman, Steinke and others—for fostering best or healthy practices is to focus on process rather than outcomes. When an interim asks questions —about *how* decisions are made, for example, or about *how* the by-laws address this issue, rather than focusing on *what* the correct decision or proper resolution is—leaders will be encouraged to consider how their actual practice compares with their intended practice. Discerning inconsistencies will provoke leaders to rewrite by-laws and policies to reflect more accurately their intended practice. When an interim minister helps leaders and members to reflect on their intended practice, leaders will be better able to articulate those values they wish to express in their relationships with one another.

These articulated values may be used to form a behavioral covenant and establish a values-based standard of interaction to which everyone agrees and can be held accountable. Accountability to a behavioral covenant fosters respect and civil discourse among members, reduces the frequency of conflict common in congregations after trauma, and increases an interim minister's capacity to manage the frustrations and challenges of working with post trauma congregations. Basically, accountability to a behavioral covenant is good boundary maintenance. Boundaries are any of the rules, roles, and relationships that form the culture of a congregation. A boundary is violated when these rules, roles, and relationships are not honored. In congregations, good boundary maintenance reduces anxiety and improves everyone's functioning.

Congregations with trauma histories develop routine coping strategies to survive the immediate aftermath of a trauma. Common among these coping strategies is boundary-violating behavior. A small group, for example, decides to keep secret the truth about the trauma, fearing that if members knew, they would be distressed and withhold support. Now, months or years later, a cultural norm has evolved that encourages keeping secret information that should not be. Or sometimes a cultural norm evolves based on the controlling, boundary-violating leadership style typically seen in misconducting clergy. Even after a misconducting minister's departure, a pattern of boundary violating behavior remains the cultural norm.

For an interim minister serving a congregation where boundary violating behavior has become the norm, good boundary maintenance is a painstaking, repetitive task. Every interaction may contain violations. An interim may have to repeatedly restore boundaries or, unable to attend to every violation, selectively address those that he or she can do so effectively and

without causing undue distress. Coaching leaders and members in how to communicate in direct, truthful, clear, and transparent ways will change a culture of secrecy into a one of openness and honesty. Providing regular evaluation and assessment will encourage accountability and commitment. These changes will lead to greater comfort with difference and skill at consensus building. Interims who model good boundaries in their own conduct will move the cultural norms toward healthier patterns of interaction

Limiting Acknowledgement of Trauma

In the immediate aftermath of trauma, congregation leaders may attempt to limit public acknowledgement or discussion of a trauma. These attempts are similar to the denial observed in individual survivors of trauma who are as yet unable to accept what has happened to them. Understandably, leaders may believe for a variety of reasons that limiting acknowledgement and discussion is a wise strategy. Where recent intense conflict has led to the departure of members and loss of funds, leaders may fear that talking publicly will rekindle conflict and further endanger the congregation. Where violence has occurred, leaders may be reasonably concerned about retaliation or further unrest. Where ministerial misconduct has been rumored, leaders may fear being sued or not wish to jeopardize a denominational or criminal investigation. Or when a minster has resigned "for the sake of the church" but remained in the area, leaders may fear that disclosing the events that led to his or her departure will provoke further bad behavior. Leaders' efforts to limit public discussion slow the work of recovery**.** Still, interim ministers must respect their reluctance. Dismissing them or forcibly trying to compel them to see or do something that they are not yet able to see or do likely will increase their resistance and generate

additional problems. Feeling disrespected by an interim, leaders may not support or trust the interim. Or constantly at odds with the interim, leaders may undermine the interim's work or try to fire the interim minister. In the presence of strong resistance to public discussion, interims must work at a slower, more prudent pace, much the way a psychotherapist calibrates the pace of a survivor's treatment, so that it remains in keeping with what a survivor can presently manage. A slower pace is better than a survivor's withdrawal from treatment or, in a congregation, than having leaders withdraw their support and trust. In this interim work, pace is not as important as direction. Acknowledgment of a past trauma is not a single event but an ongoing process. In individual therapy, the process of acknowledging a trauma may go on for years. A congregation may take a generation before congregants, individually and together, can fully accept and make sense of what has happened.

Phase Two: Remembering and Mourning

Phase two of the trauma treatment model focuses on remembering and mourning. As in individual therapy, the long-term goal for a congregation in phase two is to work from denial or vague memories to clearer recall and acknowledgement of a trauma, so that losses can be named and mourning can begin. Like a psychotherapist treating an individual survivor, an interim minister serves as ally and advocate, respectfully and compassionately guiding congregants from a reluctant but growing awareness of what happened to a fuller, clearer telling of the story. An interim leader who can occasion the uncovering of a congregation's forgotten or never acknowledged trauma story creates an opportunity for congregants to name and grieve their losses.

Gradually and compassionately the story is pieced together, including the story of how the congregation survived, what they lost and learned, and how the trauma experience has changed the congregation. Piecing together what happened may require a thorough inquiry undertaken by a group of trusted and levelheaded members or denominational representatives. An inquiry takes time, as records need to be reviewed and survivors and witnesses interviewed. After a thorough inquiry, some things will be clearer and others will remain unknown or not yet verified and therefore not yet public. A brief, simple summary of the inquiry is prepared and distributed to the congregation, and a meeting is held to discuss it, ask questions, express feelings, and share concerns.

During an interim, difficult issues from the past often come up without any deliberate effort on the part of the interim. Perhaps they come up because sufficient time has passed and members feel safe or resolved enough to speak of them. Perhaps the interim minister is seen as different, as more trustworthy, a better listener, or more gracious than previous ministers, and members finally are comfortable enough to break their silence. More frequently, especially when acknowledgement of a past trauma has been prohibited or limited, something may need to be done to encourage the story to be told. A history timeline process can create a comfortable, accepting context that often evokes new revelations. Listening circles can connect members with others whose experience were similar and lead them together to a clearer understanding of what happened.

Serving a congregation with an undisclosed trauma history is not an exercise in tough love but an opportunity to offer pastoral care and gifts of grace. The primary task of any interim minister is to be the congregation's pastor, whether or not disclosure occurs and regardless of

members' reluctance to acknowledge their congregation's history. Pastoring congregants requires an interim to minister to people where they are, in the aftermath of a literally unspeakable trauma, until they are ready to know and accept what has happened.

Pastoring congregants who hold varying if divergent perspectives is challenging. Interims must maintain an appearance of neutrality sufficient to allow them to serve as every member's pastor and no one's opposition. Members, for example, who believe a former minister was wrongly accused or poorly treated may feel betrayed by an interim who resolutely refers to a former minister's misconduct. Members, angry that their side lost in an intense conflict, may be put off by an interim minister who appears to side with those on the other side of the conflict.

Mourning Loss

After a trauma, individual perspectives on what has been lost may vary widely, but the experience of loss is shared. Everyone grieves. Focusing on this common experience will help interim ministers find ways to minister to members whose divergent perspectives evoke diverse reactions. An interim minister can say to one member, for example, without appearing to take sides, "I am sorry for your loss. I know the former minister was important to you and your family." And to another member, the interim might offer, "I'm sorry for your loss. I know this congregation means a lot to you, and seeing it go through these difficulties is hard for you." Both statements are true. Each focuses on the common experience of loss. Each allows a congregant to feel pastored by the interim minister. Over time the interim's calling attention to what congregants have in common—surviving a grievous loss—will lessen congregants' reactivity and nurture their capacity to see and accept the truth of what happened.

Supporting congregants as they mourn is the traditional work of clergy and a primary purpose of religious community. Elizabeth Kübler-Ross's work on death and dying is well known to clergy. Kübler-Ross theorized that a person who faces death or significant loss passes through five emotional stages of grief—denial, anger, bargaining, depression, and acceptance.[12] When these five stages of grief are worked through, Kübler-Ross observed, people endure loss with less upset and move on afterwards without persistent distress. When losses remain unacknowledged and these five stages are unresolved, the work of grief remains undone. People who do not fully grieve experience more emotional or physical problems and greater difficulty in finding meaning and purpose in their lives.

Phase Three: Restoring Trust and Renewing Purpose

Phase three of the model focuses on helping survivors reclaim a sense of control in their lives and a capacity to trust themselves, others, and life. A sense of control allows survivors to discern what the meaning of the trauma will be for them and where this meaning will lead them. In charge of their present and reconciled to their past, survivors can commit to the future. The task of interim work in a congregation after trauma based on phase three of the treatment model is to help a congregation let go of what was before and embrace, with renewed meaning and purpose, what is now and what can yet be.

Trauma robs survivors of the power they once had to make their own choices and control their own lives. Because of this loss of control, survivors may appear helpless or indecisive. Trauma robs congregations of self-direction, too. In the aftermath of trauma, congregational members and leaders also may appear helpless, unable to manage and willing to do whatever any

outside expert tells them to do.

The trauma treatment model cautions psychotherapists not to patronize or try to rescue survivors, but rather to display a consistent neutrality about the choices survivors must make to move forward. This respectful neutrality allows survivors to resume control over their own lives. In a similar way, the model cautions interim ministers not to tell leaders what to do and to remain neutral regarding whatever dilemmas or decisions a congregation must consider. An interim's neutrality empowers leaders and members to take (back) control of the congregation.

This neutrality is especially important in the aftermath of traumas precipitated by a previous minister's misconduct if lasting cultural change is to be made. In ministerial misconduct, ministers abuse their pastoral role, using it not as intended, that is, for the fulfillment of pastoral duties, but rather for the satisfaction of their own personal needs. This misuse betrays a congregation's trust and causes harm to individual members and the community. In order to misuse the pastoral role and avoid being discovered, a misconducting minister manipulates leaders and members and controls what can happen in the congregation. In this way, the trauma inflicted by a misconducting minister is best understood as occurring in many relationships over a time and not as a particular event or behavior. Over time misconduct robs a congregation of self-direction, allows the minister unquestioned control, fosters a sense of helplessness, and changes the cultural norms of a congregation. A misconducted congregation comes to operate in ways that undermine the control leaders might have not only to stop misconduct, but also to create a healthy, thriving congregation. An interim minister who tells a previously misconducted congregation what leaders and members should or should not do risks replicating the manipulative, controlling pattern of the misconducting predecessor. However well-intended, this

replication will reinforce the dysfunctional patterns generated by the trauma of the misconducting previous minister and greatly reduce the opportunity to effect lasting change.

The complex dynamics of pastoral relationships are what make interim work in congregations post trauma challenging and stressful. The seeming helplessness can lead interim ministers to over-function. The constant reactivity can provoke interims to over-express their frustration in angry outbursts at congregants. The stress of managing these and other dynamics can make interim work hazardous to one's health and a family's well being. To limit these adverse effects and keep a post-trauma congregation focused on its own work and not the person of the minister, calling or appointing several interim ministers to serve for a year or less may be a better option than working with one interim who serves for multiple years. Still, regardless of their length of tenure, interim ministers must strive not to over react or take personally the sometimes extreme emotions in post-trauma congregations directed at the person of the minister. Interim ministers who can conduct themselves with integrity, in ways worthy of trust and respect —for example, who do what they say they will do; are compassionate, polite, and non-anxious; act in ways appropriate to the pastoral office; and are able to avoid being the cause of congregational controversy or embarrassment—will be able to keep the work focused on the congregation and not themselves. Through their own trustworthy example, interim ministers foster a climate of trust that rebuilds trust in ministers and allows congregant to reclaim trust in themselves, in others, and in life.

Renewing Purpose

A congregation that has experienced the trauma of extreme violence, intense conflict, or clergy

misconduct, like and individual after trauma, is different from what it was before the experience. An interim minister's task, based on phase three of the model, is to help leaders and members discern that difference, to integrate its meaning in the longer, varied story of the congregation, and to discover where it will lead. Just as a psychotherapist helps individual survivors understand the meaning of an experience of trauma in the survivor's and others' lives, interim ministers help a congregation understand the meaning of their experience of trauma and discern how because of this meaning the congregation is now different.

One way to accomplish this task is to invite reflection on questions such as the following:

- What sort of congregation were you before?
- How did your beliefs and faith direct you?
- What matters ultimately to you now?
- How are you or your congregation different now that this has happened?
- How will you be together now?
- What will you do?
- How might you become the congregation you want to be?
- What must you do to thrive?

These questions can be addressed in a variety of ways. Small and large facilitated group discussions can provide opportunities for members to talk about the issues the questions raise. Groups gathered for other purposes—for example, for Bible study, religious education, mutual support, prayer and spiritual direction—can pause to explore these questions. Leadership trainings and governing board and committee meetings will provide brief or periodic opportunities to stop and reflect on these questions.

A congregation is a community of faith filled people drawn together by common religious beliefs for worship and service. Helping a congregation articulate the meaning of a trauma experience and then integrate this meaning into the congregation's story is essentially a theological task. An interim minister can support these theological tasks by providing opportunities for individual and communal expressions of belief, revisiting the foundations of this congregation's faith tradition, relearning the history of the religious beliefs, and rediscovering the values and purposes that continue to inspire service. What of these has the experience of trauma changed? Which are less compelling and which more compelling? Which support their living out and serving the faith of this religious community?

Conclusions

Many congregations in the aftermath of traumas caused by violence, intense conflict, or clergy misconduct suffer significant adverse effects and may, like individual trauma victims, remain volatile and symptomatic, and require deliberate and strategic efforts for years to recover. A trauma treatment model provides a focus for these ongoing efforts. It also strongly suggests that a congregation that can openly discuss its experience of trauma, can name and grieve its losses, and can discern a meaning in the experience that brings new purpose will fare better, move on in healthy, faith-filled ways, and even thrive. The most important work of an interim leader is not to complete that effort but to help as a congregation set itself in the direction of recovery.

[1] Peter L. Steinke, *Healthy Congregations: A Systems Approach* (Herndon, VA: The Alban Institute, 1996), 91.

[2] Nancy Myer Hopkins and Mark Laaser, *Restoring the Soul of a Church: Healing Congregations Wounded by Clergy Sexual Misconduct (*Collegeville, MN: The Liturgical Press, 1995), 155f.

[3] Beth Ann Gaede, ed., *When a Congregation Is Betrayed: Responding to Clergy Misconduct* (Herndon, VA: The Alban Institute, 2005), 46–50.

[4] See Jill M. Hudson, *Congregational Trauma: Caring, Coping, and Learning* (Herndon, VA: The Alban Institute, 1998).

[5] Loren B. Mead, *The Once and Future Church* (Herndon, VA: The Alban Institute, 2001), 33f; Edwin H. Friedman, *Generation to Generation: Family Process in Church and Synagogue* (New York: The Guilford Press, 1987), 31f.

[6] Roger S. Nicholson, *Temporary Shepherds: A Congregational Handbook for Interim Ministry* (Herndon, VA: The Alban Institute, 1998), 3-13.

[7] Judith L. Herman, *Trauma and Recovery: The Aftermath of Violence—from Domestic Abuse to Political Terror* (New York: Basic Books, 1992), 236f.

[8] Amy Banks, *Post-traumatic Stress Disorder: Relationships and Brain Chemistry—A Manual for Lay People* (Wellesley MA: Stone Center, Wellesley College), 2006.

[9] Sandra L. Bloom, "An Elephant in the Room: The Impact of Traumatic Stress on Individuals and Groups," in *The Trauma Controversy: Philosophical and Interdisciplinary Dialogues,* ed. Kristen Brown and Bettina G. Bergo (Albany: SUNY, 2009), 160-66.

[10] Herman, *Trauma and Recovery,* 133f.

[11] Ibid., 70 and 176f.

[12] Elisabeth Kübler-Ross, *On Death and Dying* (New York: Routledge, 1969).