

“My God, my God, why have you forsaken me?”
Providing a healing environment for those suffering from posttraumatic stress

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Chapter 1

Post Traumatic Stress and Parish Ministry

We live in a fragile and unpredictable world. Every day lives are shattered by loss and trauma. Well-balanced and competent individuals who previously felt secure in every aspect of their lives suddenly find the world collapsing around them. Their whole construct of life disintegrates and they become dysfunctional. Even Jesus felt this sense of abandonment and desolation when, hanging on the cross, he cried out to his Father. “My God, my God, why have you forsaken me” (Mt 27.46)

Yet the Christian knows that loss, disintegration and death are never the end of the story. There is always the possibility of resurrection, transformation and an increased capacity to experience and enjoy life. The challenge to the church today is to build on our experience of pastoral care and spirituality combined with an awareness of the latest research into the effects of trauma so that we may be better enabled to be ministers of God’s transforming love and power in a broken and fragmented world.

Clergy have ministered effectively to bereaved families for generations but when, in 1969 Elizabeth Kubler-Ross published her book *On Death and Dying* it provided them, for the first time, with a framework of understanding on which to hang their accumulated knowledge and expertise. Her model of the stages of the bereavement process (denial, fear, anger, bargaining and acceptance) owed much to the work of Bowlby and Robertson on mourning in infancy and childhood and that of Colin Murray Parkes published in 1965 in the *British Journal of Medical Psychology*. The provision of a clear analysis of these stages provided a starting point which has greatly facilitated the training of all those who minister to the bereaved and those suffering any kind of loss.

In a similar way, ministry to those who have suffered stressful trauma has continued in the parishes largely independent of the vacillating theories and approaches of the mental health professionals. Yet we each need one another. Interventionist therapy whether by psychodynamic or behavioural therapy or drugs can help overcome bottlenecks in the recovery process but sustained momentum towards wholeness depends on the provision of appropriate resources in the family and community. Mental health professionals help not only the extreme cases but by their specialist knowledge and the results of research are able to provide guiding principles for good practice in the community. Most survivors of trauma never receive any professional help and so are totally reliant on other resources. There is much that can be done both within the church and community to improve the quality and quantity of such resources.

“Because trauma symptoms can remain hidden for years after a triggering event, some of us who have been traumatised are not yet symptomatic” (Levine:41)

“When it comes to trauma, what we don’t know can hurt us. Not knowing we are traumatised doesn’t prevent us having problems that are caused by it” (Levine:46)

Even when people think they have been healed from the effects of trauma, symptoms can be triggered again when someone faces an important life change. Because the clergy are often involved at these times they are in a privileged position to detect what is happening at an early stage and to provide help and guidance at a time when it will have maximum effect.

“Resolution of the trauma is never final; recovery is never complete. The impact of a traumatic event continues to reverberate throughout the survivor’s lifecycle. Issues that were sufficiently resolved at one stage of recovery may be reawakened as the survivor reaches new milestones in her development. Marriage or divorce, a birth or death in the family, illness or retirement, are frequent occasions for a resurgence of traumatic memories.” (Herman:211)

Whilst some traumatic events are very much in the public arena many others may be known only to the person concerned. In yet other cases the memory may have been repressed so that conscious recall of the event is not available even to the person who is suffering from lasting ill effects. Even when there is a conscious memory there may be no apparent link between the trauma and its effects on behaviour or personality. This makes it difficult to recognise trauma as the cause of panic attacks, anxiety, depression, psychosomatic complaints and mental illness. The good news for the Christian minister and his congregation is that for most incidences of Post Traumatic Stress (PTS) and even many PTSD sufferers much useful therapeutic benefit can be provided within the context of ordinary parish life without the person concerned even having recognised their need for help.

Yet whilst there is scope for doing a great deal of good there is also the danger of doing harm and causing even more suffering to the traumatised person. Just as in bereavement there are various stages to pass through on the road to healing. Unlike bereavement where the stages identified by Kubler-Ross do not necessarily need to follow any particular sequence, with PTS it is most important that the correct sequence (as outlined in chapter 4) is followed.

It is well known that traumatized individuals often have repressed memories of the event. At an appropriate stage these will need to be gradually brought into consciousness, dealt with, and integrated into the personality. If however recall happens before the necessary framework of security and support is in place the result can be further trauma and a worsening of the symptoms. Where painful memories have been repressed this has happened for very good psychological reasons. Whilst this is not an ideal situation and the presence of repressed memories and unresolved trauma is not beneficial at least some control has been established over the situation and the individual has been able to continue to function. Well intentioned but poorly trained Christian counsellors sometimes believe that any repressed memory is better brought out into the open and consciously offered to God. No attempt should be made to encourage recall of the trauma except by someone who is confident that the time is right and who has the skills necessary to slow down or halt the pace of disclosure to what is within the coping capacity of the client’s resource base.

Whilst trauma has enormous destructive potential it also has an equivalent creative potential. The initial trauma pushed the resources of body mind and spirit beyond their limits but it also expanded awareness of these new and previously unvisited regions of experience. Although existing resources were inadequate to the organism has the capacity to expand its resources into this wider arena of experience. If this is successfully achieved the individual will be more alive, more self-confident and more in tune with his or her own body, psyche and spirit than ever before.

“Considerable research documents that many people experience positive post-crisis changes, which are usually the result of cognitive changes as they cope with and survive a negative/traumatic event. Positive changes identified by traumatized individuals include changes in perceptions of self, changed views of relationships, and changed life philosophy, (e.g., there are positive changes in their priorities, there is a recognition of the preciousness of life, their spiritual beliefs are strengthened)” (Collins:31)

“Of all the maladies that attack the human organism, trauma may ultimately be one that is recognised as beneficial. I say this because in the healing of trauma, a transformation takes place - one that can improve the quality of life. Healing doesn't necessarily require sophisticated drugs, elaborate procedures, or long hours of therapy. When you understand how trauma occurs and when you learn to identify the mechanisms that prevent it from resolving, you will also begin to recognise the ways in which your organism attempts to heal itself. By using a few simple ideas and techniques, you can support rather than impede this innate capacity for healing.” (Levine:12)

Whilst the survivor needs a great deal of support and guidance it is ultimately he alone who can effect a cure. The first and most important task of the church community is to empower the survivor and provide him with the resources he will need if he is to complete the job.

There are five major classes of resources:

functional, physical, psychological, interpersonal, and spiritual.

- 1) Functional refers to practical resources such as a physically safe environment.
- 2) Physical refers to physical strength, agility and a general sense of health and wellbeing.
- 3) Psychological resources include humour, creativity, curiosity and intelligence.
- 4) Interpersonal resources include supportive friends and relatives in the present and the memories of positive role models from the past such as teachers and grandparents.
- 5) Spiritual resources include belief in a transcendent other who is able to assist and a relationship with that deity or with the spiritual resources inherent in the natural world. (Rothschild:88-92)

The church community has an important role to play in helping to provide these resources. There are three phases during which the church community can help the trauma victim.

- 1) Prior to the event by building external and internal resources that will facilitate healing
- 2) Immediately after the event by ensuring that links are made with those resources
- 3) During the months and years following the event to maintain resources and encourage the victim to make use of them to manage his own recovery.

Quality care does not appear instantly. It can only emerge as a result of long-term planning in an environment where every member is committed to the health and well-being of every other member and willing to make an effort to achieve this.

Chapter 2.

What is meant by Traumatic Stress

An appropriate amount of stress is necessary for health. Every aspect of our being; physical, psychological, emotional, and spiritual, needs to be at least gently stressed at regular intervals in order to maintain optimum functionality. Where there is little stress decline takes place more quickly than would otherwise be the case and it is for this reason that well-being, particularly in old age, depends on the maintenance of social interaction combined with physical and mental stimulation.

Yet, just as it is possible for an athlete to cause permanent physical injury by forcing his body to go beyond the limits from which it can recover, so with other forms of stress the recuperative capacities of body mind and spirit can be overwhelmed. When this occurs the stress can be defined as traumatic.

A particular event may, for one individual, fall within his ability to cope. In this case it is a positive learning or training experience which further improves his capacity to cope with stress.

If for another person the same event falls outside his ability to cope it will have a negative and destructive effect. For this reason early attempts to define traumatic stress in terms of causative events had their limitations.

“The “helping” professions tend to describe trauma in terms of the event that caused it, instead of defining it in its own terms. Since we don’t have a way to accurately define trauma, it can be difficult to recognise.....The healing of trauma depends upon the recognition of its symptoms.....traumatic symptoms are physiological as well as psychological.” (Levine:23ff)

A typical definition of trauma is that of McBride

“A severe experience of trauma is defined as occurring when both of the following are present: “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others” and “the person’s response involved intense fear helplessness or horror.....Trauma occurs when one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions and experiences.” (McBride:12)

When an individual experiences traumatic stress immediately following a traumatic incident they are said to be suffering from Post Traumatic Stress Syndrome or simply Post Traumatic Stress (PTS). Symptoms of PTS may include intrusive recollections, avoidance/numbing symptoms and hyperarousal symptoms. If such symptoms persist for more than a few days then the person is classified as suffering from acute stress disorder (ASD). When such symptoms persist for more than a month and their combined effect results in significant distress and dysfunction then that person qualifies for a diagnosis of chronic post traumatic stress disorder (PTSD).

“PTSD has very specific characteristics. The DSM-IV_TR (2000) describes a complex assessment of symptoms beginning with the precipitating event:
‘ . . . exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experience by a family member or other close associate (Criterion A1) (p. 463).
Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.

It will be noted that both the above definition and that of McBride place a great deal of emphasis on outlining very strict criteria relating to the precipitating event. This seems to say more about North American culture and the need of the psychiatric community there to work within clear definable boundaries than it does about the nature of PTSD as a condition. It is the view of the author that the final sentence of McBride’s definition in itself provides an adequate definition of trauma which is applicable in all cultures and circumstances. Here it is again:

“Trauma occurs when one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions and experiences.”
(McBride:12)

Whilst threat to life or physical integrity might be the most traumatic stressor to the average North American this is not true for all people at all times. For those with greater psychic or spiritual awareness disruption of integrity in these areas of being can be at least as traumatic as any physical threat. Those whose sense of identity and existence depends almost entirely on the feedback from personal relationships will be severely traumatised by interpersonal violence and betrayal even when this does not include physical assault. For those in the third world the loss of property and loss of faith in the environment following a natural disaster can be severely traumatic even if there was sufficient warning to prevent injury and loss of life.

“Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life.” (Herman:33)

Even using a narrow prescriptive definition of PTSD the number of those known to be suffering in this way has far exceeded expectations. In 1980 when PTSD was first defined by the American Psychiatric Association it was thought that the sort of precipitating event included in that definition would affect only a tiny minority of the population. As awareness of PTS has increased it has become clear that a significant proportion of the population have at some time been subjected to one or another form of traumatic stress.

“Exposure to extreme stress is widespread, and a substantial proportion of exposed individuals become symptomatic. A random survey of 1,245 American adolescents showed that 23% had been the victims of physical or sexual assaults”. Of these 20% went on to develop PTSD. (van der Kolk:5)

Another survey suggests that PTSD affects 9% of the U.S. population increasing

to approximately 14-15% if one adds subthreshold cases. (van der Kolk:491)
It can be safely assumed that in any church congregation there will be some individuals living with the effects of previous trauma, whether or not they are presently symptomatic, as well as many other parishioners with whom the church has contact.

It is clear therefore, whichever definition we use, that our churches and communities are populated by many suffering from the long term effects of trauma.

Trauma has a dual nature. It has power to rob victims of their capacity to enjoy life and live it to the full yet, when the healing process is worked through effectively, it also has the power to strengthen the individual and enlarge their capacity to enjoy and engage in life.

How can Post Traumatic Stress be recognised

Post Traumatic Stress is defined by particular symptomatic changes in behaviour. These behavioural changes are described in the next chapter in the context of why they occurred at the time of the trauma together with an explanation of why they persist once the trauma has passed or, as is sometimes the case, why they reappear spontaneously after a gap sometimes of many years. Close friends and family are those who are most likely to notice behavioural changes but, in the absence of an understanding of PTS they may be unaware of the real meaning or significance of these changes. Often they may be aware of a past traumatic event affecting the person concerned and this can help them to make a connection between the behavioural change and the trauma. Sometimes though, what has been a significant trauma for an individual, may for a variety of reasons have been kept secret from other family members. It is important to recognise that trauma symptoms can result not just from major traumas representing a physical threat to life but also from apparently routine events such as moving house which can cause a person to lose their sense of identity, be estranged from their support networks and be left with no safe place where they feel confident and secure. This is especially true of children who, when their parents move house, may be placed in an alien environment where their opportunities for forming supportive relationships are limited. Here is an opportunity for churches to welcome new families and to invite children to age-appropriate activities where they can be affirmed and valued.

Whilst few people go through the whole of life without at some time encountering a level of stress which could be described as traumatic many of these either seem resistant to its effects or because of adequate resources recover quickly. There is still much debate about the factors that help people to avoid symptoms of PTS or promote recovery but provisional lists of such factors are given below:

Factors predisposing resistance to the negative effects of PTS

- 1) Alert active temperament - task oriented coping strategies
- 2) High degree of sociability and skill in communicating with others
- 3) Strong sense of being able to affect their own destiny (internal locus of control)
- 4) Desire to find meaning and purpose in all activities and to share that with others
- 5) Sense of responsibility for self and others
- 6) Moral sense and effort to remain in control not giving in to rage or hatred

7) Acceptance of fear and risk but effort to minimise this by appropriate preparation
(Herman:58-59)

Research suggests that around 10% of the population fall into the above category. One reason why the above personality type is less likely to exhibit symptoms of PTS is that directly because of having such a personality he is likely to be able to put ticks against many of the criteria in the following list.

Factors which promote recovery from the symptoms of PTS

- 1) Preparation for the possibility of having to cope with the traumatic event. This may be in the form of specific training, the memory of an account of how someone else coped with a similar event or simply having previously imagined the event and thought through the possible responses. Training has a dual effect. It can equip individuals with specific skills and procedures which can be followed by reflex in the event of a predictable incident but more importantly it generates a sense of being mentally equipped and providing an inner expectation of a positive outcome. (van der Kolk:87)
- 2) Experience of dealing with other traumatic events. This may be the result of employment in the military, law enforcement or emergency services. It may have been acquired through participating in hazardous pursuits as a leisure activity or by having coped reasonably effectively with another different but equally traumatic episode.
- 3) A feeling of having coped well with this particular trauma, either by fight or flight especially where this includes having rescued other survivors and assisted rescuers.
- 4) Possessing a religious belief resulting in a confident expectation of divine assistance at the time and after the event.
- 5) A world view and attitude to life that sees stressors as challenges to be met and learned from rather than threats to be survived.
- 6) Loving support from family and friends free of any blame for having contributed to causing the traumatic event.
- 7) An accepting non-judgemental network of support in the community, at work and/or through social and leisure activities.
- 8) Being part of a family where members have flexible roles, which sees the problem as a challenge for the entire family and which mobilises resources together.
- 9) Friends and family members who can be clear and direct about feelings and reactions, who are able to communicate well on different levels and where highly charged emotional outbursts can be accepted as normal and acceptable at times of stress yet without resorting to physical violence.
- 10) Family where there is mutual commitment, tolerance and genuine affection for one another which is freely expressed.
- 11) Having experienced interpersonal intimacy within a relationship followed through from the “love is blind” stage to a mature relationship based on a realistic acknowledgement of one another's strengths and weaknesses
- 12) Having at some time idolised another person.

Before moving to detailed suggestions about strategies it is necessary to have some understanding of the mechanisms which are brought into play during and

after a traumatic event. The next chapter will therefore outline what happens to body mind and spirit as a result of trauma.

Chapter 3

The Mechanism of Post Traumatic Stress and its aftermath

During recent years there has been a burgeoning of interest in the subject of post traumatic stress. This has resulted in many research studies and a consequent avalanche of published material written, in the most part, for the benefit of the practising therapist. When one adds to this the fact that each individual case is different and is influenced by unique factors the subject can appear bewildering to the non specialist. Yet there is much in this material that can be of direct pastoral benefit if only it were more accessible.

Within the medical profession controversy surrounds every aspect of PTSD. There is still disagreement as to whether PTSD constitutes a unique disorder or is simply a collection of other disorders. Every model of any aspect of the disorder finds its advocates and critics. Some of the most contentious debates have concerned the nature of traumatic memory and the effect of dissociative states. There are as many views about treatment as there are about diagnosis and all have something valuable to offer. In the midst of all this debate the layman, being aware that many people recover well from trauma without medical intervention, may well feel that the whole discussion has been medicalised to an unnecessary degree.

It is the aim of this paper to provide a simple basic framework to make it easier for those without any formal training in mental health to make sense both of their own personal and pastoral experience and their reading on the subject. Most victims of trauma exhibit amazing resilience. Their friends, family and colleagues usually want to do all they can to assist recovery but can be perplexed by some of the behaviour of the victim and the symptoms he exhibits. Whatever theories are used to define and describe the condition there is general agreement about the ways that non-specialists can promote recovery. Yet in order to make sense of why certain things are helpful or unhelpful to the sufferer it is necessary to base advice on one theory or another. What follows is one way of looking at the mechanism of PTS and its aftermath. It has its limitations but it is hoped that it is adequate to help friends and colleagues of those suffering the effects of PTS to understand better their experience and to assist the process of recovery and re-integration

An analysis of the effects of repeated trauma such as that experienced by someone held captive as a hostage, a Prisoner of War or in a concentration camp, ongoing child sexual abuse, domestic violence, organised sexual exploitation and membership of some religious cults is outside the scope of this paper. Such cases are complex and can result in longstanding personality disorders that mimic every other classification known to medicine. Nevertheless, planning of pastoral care even for people with such experiences can be enhanced by a better understanding of the processes and mechanisms which operate in a more straightforward situation.

The analysis given below relates to a straightforward classic case of trauma caused by a single circumscribed event. It is events of this type such as combat, disaster and rape which at the present time have furnished most of the material for research.

Within the specialist literature relating to PTS and PTSD there is debate between

those who contend that symptoms result from a normal response to an abnormal situation but which has not been carried through to a satisfactory conclusion and those who would argue that it results from an abnormal response to sometimes less extreme situations. This appears to be a false dichotomy caused by different ways of defining an abnormal situation. If one ignores the requirement for PTS or PTSD to be initiated by an event which conforms to the definition contained in DSM-IV_TR (2000) [quoted in chapter 2] and allows the possibility of what is known as PTSD to have developed from more common stressors then the two approaches are, to a large extent, reconcilable.

The following analysis of what happens during and after a traumatic episode is given in two dimensions. The time dimension consists of four phases: fight, flight, freeze, posttrauma. The second dimension, relating to the effects on the person, is divided into three categories: Neurological and Physiological, Psychological, Spiritual

Fight or Flight

When an individual senses a threat a subconscious assessment will be made between two options: fight or flight. The choice is made subconsciously and instantaneously but involves many areas of personality and so is more complex than a simple reflex action. If fighting proves ineffective then flight will take over in an attempt to escape from the threat rather than overcome it. Similarly if an attempt to flee from the threat does not succeed then fight will take over. If both of these options have been tried to the limit of capability and the threat remains, bringing with it the prospect of death or serious injury, then the body will freeze.

The internal resources mobilised to facilitate these three reactions need to represent the absolute limit of what the organism can muster because its very survival is at stake. Anecdotal evidence abounds of how an individual's capacity for physical or mental effort in such a situation far exceeds their normal capability. Yet these superhuman abilities are achieved at a cost. The entire resources of the organism have been directed towards survival and if successful this is largely due to the fact that the process has been controlled by instinct. Animals without the reasoning capacity of the human allow the recovery process to also be controlled by instinct and rarely suffer long term damaging effects of their trauma. With humans however once the immediate threat has passed instinct begins to lose its grip. The rational mind takes over and prevents the natural instinctive process from reaching its conclusion. To remain under the control of the instinct until healing has been completed is not an option for us. The only alternative is for us to understand the processes that occur instinctively in the animal kingdom so that they can be replicated appropriately under the control of the intellect.

There are a number of approaches which can help us to understand the instinctive recovery process. Levine has much to offer from his observations of animals which can help us to understand our neurological, physiological and psychological analysis.

Fight and flight require heightened perception, lightning fast responses, accurate co-ordination and enormous expenditure of physical and mental energy. The body harnesses its resources to provide these. The mechanism used to achieve these

effects is known as “hyperarousal”. In order for certain functions of the body to perform beyond their normal capacity others lose effectiveness. This is known as “constriction”.

If fight and flight both prove ineffective then the next survival strategy is to freeze. There are two main reasons for this response. Firstly it is possible that the aggressor will lose interest in a victim who appears to be already dead and leave them alone. The second effect of the freezing response is that of dissociation. Connections between body mind and spirit are broken enabling the victim to approach death with equanimity and free from pain.

The freezing response may be triggered by a subconscious assessment that this is the only remaining course of action available. In this case there will be a sense of peaceful acceptance as described above. Alternatively it may be entered simply as a result of energy overload.

“The nervous system recognises that the amount of energy in the system is too much for the organism to handle safely and so it applies a brake so powerful that the entire organism shuts down on the spot. ...The helplessness that is experienced at such times.....is real....This is abject helplessness-a sense of paralysis so profound that the person cannot scream, move, or feel.” (Levine:142)

These four components of hyperarousal, constriction, freezing (immobility), and dissociation will always be present to some degree in any traumatized person. (Levine:132)

Before a surviving trauma victim can return to functioning normally two things must happen. The huge resources of energy mobilised during the fight/flight phase but not expended and which have been “locked in” need to be released. The dissociated elements of body mind and spirit need to be reconnected.

Traumatic symptoms are not caused by the “triggering” event itself. They stem from the effects of energy trapped in the psyche. Levine says that this is simply energy mobilised for the fight/flight phase which remained unused at the start of the “freeze” phase. Kalsched however has a more complex explanation. He suggests that it results from entry into the dissociative state of the “freeze” phase. Dissociation, he says “is not a passive benign process whereby different parts of the mind become disconnected and ‘drift apart.’ Instead, dissociation involves a good deal of aggression....It is as though the normally integrative tendencies in the psyche must be interrupted by force.....We now know that the energy for dissociation comes from this aggression.” (Kalsched:13f)

Whichever explanation we accept it is clear that dissociation and the energy associated with it provides the source and ultimately the explanation for all symptoms of PTS.

“Dissociation at the moment of trauma appears to be the single most important predictor for the establishment of chronic PTSD”. (van der Kolk:66)

Healing is not something that can be achieved by external intervention but it can be facilitated by understanding the natural instinctive processes, removing

obstacles to their operation, and strengthening and reinforcing resources that will assist the person to move through the threat of death to a new and fuller life.

We move now to a detailed consideration of what happens to the body as it prepares for fight, flight or freezing.

1) Neurological and Physiological responses to trauma

a. During the Fight/Flight phase

The adrenal glands release the hormones epinephrine and norepinephrine to mobilise the body by increasing respiration and heart rate. The pituitary glands release adrenocortio-tropic (ACTH) which activates the adrenal glands to release cortisol (a hydrocortizone). The function of cortisol is to restore the body to a steady state following the traumatic incident.

b. During the Freeze phase

During this phase dissociation occurs and there is freedom from pain and a loss of skin sensation. The exact chemical mechanisms leading to these responses is still the subject of research which at the present time remains inconclusive. Until recently dissociation has been defined solely by clinical observation. There is however now evidence that it may be a neurobiological phenomenon.

c. During the Posttrauma phase

Recent research has shown neurotransmitter malfunction in patients with PTSD affecting catecholamines, endogenous opioids, corticosteroids, and serotonin. (van der Kolk:65) The cortisol level of patients suffering from PTSD is abnormally low whereas during the initial trauma it was elevated. What is more the ability to produce cortisol during subsequent traumas is impaired. The mechanism which causes this lowered cortisol level is not yet fully understood but the result is that these patients live in a continued state of hyperarousal “leading to physical symptoms that are the basis of anxiety, panic, weakness, exhaustion, muscle stiffness, concentration problems and sleep disturbance.” (Rothschild:47) In this condition any type of stimulation or arousal, which in a normal person would alert to the possibility of pleasure or minor danger, is interpreted physiologically as a major impending threat.

It is now clear that “traumatic exposure can produce lasting alterations in the endocrine, autonomic, and central nervous systems. New lines of investigation are delineating complex changes in the regulation of stress hormones, and in the function and even the structure of specific areas of the brain.” (Herman:238)

In extreme cases victims can develop a conditioned analgesic response to an environmental stressor which is so severe that the only effective release from the resulting feeling of numbness is to self harm. The cutting or burning must cause the release of some (as yet unknown) neurochemical agent which makes them feel better and restores a feeling of being alive. (van der Kolk:189)

The psychopharmacological treatment of PTSD is still in its infancy. Whilst no drug has proved effective in the treatment of dissociative phenomena some symptomatic relief may be obtained with antidepressants combined with a second drug such as an anticonvulsant or mood stabiliser selected on the basis of the symptom profile. (van der Kolk:521)

2) Psychological responses to trauma

a. During the Fight/Flight phase

The mind is working at lightning speed giving the impression of time having slowed down. There is increased awareness of one's own body, of the surroundings and of the threat. The memory is interrogated quickly and efficiently in search of previously acquired strategies, skills or any information that will assist in overcoming or escaping from the threat.

b. During the Freeze phase

The body is immobilised but it is no longer an advantage for the mind to be intensely aware of what is happening to the body. Now is the time for the mind to attempt to flee by a process known as dissociation. Any traumatic incident involves a number of elements identified by Levine (and quoted by Rothschild:68-69) as Sensation, Image, Behaviour, Affect and Meaning. [The SIBAM model, dealt with in more detail in chapter 5]. The effect of dissociation is to break the normal links between these elements with the effect that the event cannot be consigned to the past and remains free-floating in time and continues to interfere in the present.

c. During the posttrauma phase

In the longer term the person who continues to suffer the symptoms of trauma will experience a sense of disintegration. The abilities and assumptions that made life manageable have been proven to be inadequate with the effect that sufferers from PTSD find it difficult to trust or hope or look forward to anything positive in the future. There will nearly always be some loss of trust in others and this is heightened when the trauma has involved interpersonal violence such as abuse or rape. The combined effect of dissociative responses and hyperarousal lead to fragmentation of memory with some memories being active and vivid whilst others are repressed. (Kolk 8 xiv) A result of the dissociation of constituent parts of memory is that certain aspects of memory, most commonly emotionally charged visualisations (flashbacks), intrude into the present and interfere with the ability to assess and integrate new information.

In a normal psychologically healthy person any situation will be evaluated by balancing the information received from external stimuli via the felt senses with that received from internal stimuli associated with that particular grouping of external stimuli. The traumatized individual will lose discrimination and pay more attention to internal than external stimuli. In some cases he may subconsciously seek out situations reminiscent of the trauma in an attempt to provide an opportunity to complete the withdrawal phase by discharging the "locked in" energy. Unfortunately what usually happens is just the reverse. As in the initial trauma the process doesn't reach completion so, with every attempt, even more energy becomes "locked in" with devastating effect.

There may be heightened sensitivity to certain triggers that cause recall of the trauma. Where this is the case the victim may withdraw from social contact and immerse themselves in work in an attempt to avoid the triggering effect of emotional stimuli.

3) Spiritual responses to trauma

a. During the Fight/Flight phase

Part of the psychological response during this phase is a search of the memory for possible sources of help. Any possibility of which the person is aware may be tried. It is not surprising therefore that anyone who has ever been told that there is a God who cares for them is likely to cry out to him for help even if in less extreme situations and more rational moments they would never dream of doing so. This willingness to communicate with God expands the spiritual consciousness and may help the person to be aware of God's presence with them and to recall previous occasions when God has helped them in times of crisis.

b. During the Freeze phase

If God appears not to have answered the cry for help this creates a dissonance between the belief system/trusting relationship and experience of the event. Alternatively there may be a strong sense of God's presence and a willingness to surrender into his hands resulting in a state of calm acceptance of whatever is to follow.

c. During the posttrauma phase

Just as the individual may have lost confidence in their own physical and psychological resources so there may also be a loss of confidence in God who is seen to have ceased to care. This sense of abandonment by God can lead to a severe crisis of faith. Alternatively there may be a sense of the personality having been invaded by an evil presence which inhibits the ability to accept and experience those things that are of God. As the victim reflects on the trauma he may seek to make sense of it by viewing it as a judgement of God, a test or even an opportunity to grow in humility and trust or he may see it as an attack by Satan resulting from his loyalty to God. The role assigned to God in coming to terms with the trauma will indicate a great deal about the nature of the relationship which the victim had with God at the time of the event and will hopefully indicate useful approaches that can be used by the "soul friend" as he comes alongside and seeks to help the victim to move forward.

There is likely to be a loss of faith in God if he is understood as a disciplinarian father figure, a supernatural deity with an objective existence who possesses the power to intervene but has chosen not to do so. Faith is likely to be more resilient for the person whose normal encounter with God is on a more mystical level.

It is practically certain that some aspects of the victim's belief system and/or relationship with God will have been challenged and compromised. The trauma cannot be consigned to the past until all elements of the SIBAM model (2b above and Ch 5) have been accessed and integrated. Of these the search for meaning can only be accomplished once the person's world view has been adequately modified to take account of the traumatic event. An important element of this re-assessment is an adjustment to the spiritual equilibrium. Where there is a belief in a personal God the nature of relationship with God may need to be re-interpreted or re-negotiated. This process can be assisted by a spiritually mature "soul-friend" who can meet the person where they are on their journey to God and walk with them along the way.

In order for the spiritual life to continue after trauma it will be necessary to cultivate a relationship with God that has moved from one based on reason and emotion to one which can exist and find its expression on a spiritual and mystical level where the relational links are unassailable by earthly factors. This will involve an awareness of the inadequacy of the ego and a realisation that ultimate consciousness demands a letting go of structures and constructs and notions of self and requires the ability to be lost in the other whilst still fully conscious and responsible for one's own choices. It will require the adoption of a world view which whilst it recognises the value of the individual in the eyes of God also recognises that the world is an unjust and unpredictable place in which ultimately one's only security is in learning to engage in life to the full whilst recognising that only in God himself is utter dependability and security to be found.

Chapter 4

Stages of Healing - S I D E S

The healing of the effects of traumatic stress follows a cyclical pattern. Following trauma the person is often in a state of disintegration at many levels of existence, emotional, psychological, spiritual, cognitive, physical. The most important need which must be fulfilled before any healing can take place is to establish a sense of security and safety. The first iteration of the cycle may involve the removal of the victim from an unstable building to a nearby tent where he is wrapped in a blanket, given a cup of tea and some first aid (Safety). He is then able to begin the process of becoming aware of his body, the fact that he is still alive, the extent and nature of his injuries, and what he is or is not able to do physically for himself. (Integration)

He may well then begin to think that this is really a dream. "It can't have happened to me. Am I really here or not?" (Duality) As he sits waiting for transport to a place of greater safety and support he begins to try to remember what happened and make sense of his confused memories. (Engagement) Once he has reached a place of greater safety (Safety) the cycle begins again. The greater level of safety allows a slightly higher level of integration (Integration) and connectedness with the body and the felt senses. From this safer position there must be the courage to be willing to enter a state of dual awareness and dual consciousness so that inappropriate connections between sensations, images, affects and behaviour can be broken. (Duality) If this willingness exists then the victim is ready to engage in a limited way with his feelings and memories of the trauma. (Engagement) This can be quite frightening and lead to insecurity and the need to increase the sense of safety and security (Safety). Once this has been achieved, new more appropriate and normal connections may be made (Integration). The confidence gained by having made some progress should provide sufficient motivation to enter the duality and engagement phase once more. The process continues to cycle continuously for months or years until healing and integration have been fully achieved or the process becomes stuck. To ensure that the process continues its cyclical movement it is necessary to be aware of the stages involved and the appropriate reinforcement necessary to help the victim move onto the next phase. As time goes on the process moves on to increasingly higher levels of consciousness. Having begun on a physiological level it ends at a spiritual level with an awareness of expanded consciousness and a more integrated awareness of self and the relationship of self to other people and the whole universe.

This model of healing can easily be remembered by the mnemonic - **S I D E S**

Safety, **I**ntegration, **D**uality, **E**ngagement, **S**ecurity

Safety and security

environment, social, own body

Integration and connectedness

Dual awareness / dual consciousness - uncoupling

Engage with trauma from position of safety

Memory, psychotherapy, Abreact

Safety and security

Safety

“When traumatized people are asked what resource or emotional state would have made the events or memory of the events less traumatic, they cite common themes of safety, security, strength, mastery, competence, or ‘knowing that I will survive.’” (Williams:406)

It was stated earlier that trauma occurs when one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions and experiences. Progression of the healing process depends on the recreation of such safe places both externally and internally. Initially the most immediate need is for a safe physical and emotional environment. It can often help to recreate situations from the past when the individual felt secure and happy. This could involve renewing old friendships and acquaintances or even spending time in a location associated with positive memories or which is reminiscent of such a place. Feeling safe depends for the most part on being surrounded and supported by a social network which is accepting and non-judgemental. The other aspects of safety are feeling safe within ones own body - being capable of having a full awareness of all the felt senses without any of them being perceived as a threat, and feeling safe with ones own inner being and subconscious mind. It will be evident that safety is not only a prerequisite for further progress but is dependent on previous stages of the process involving greater awareness, acceptance and integration of aspects of personality and behaviour initially perceived as threatening having been accomplished.

Integration

The most important task involved in healing is the re-integration of the disassociated and disruptive components of memory in order that they might be modified and transformed into what is manageable and their devastating intensity reduced. Integration is the process of being able to experience elements of extreme sensation, image, behaviour and emotion, to disconnect them from inappropriate associations and with the help of reason to reconnect them in new ways which are more normal and healthy. A fuller discussion of the process of re-integration of memories is given in the following chapter “States of Consciousness and the SIBAM model of Dissociation”

Duality and Engagement

Duality and engagement belong together. Entry into a state of dual consciousness will usually trigger engagement with traumatic memory whilst an attempt to recall memory will often trigger the state of dual consciousness entered into at the time of the trauma. Whilst a state of dual awareness is the ideal state in which to engage with traumatic memories there is always the danger that the inner stimuli will prove overwhelming causing the victim to enter his past experience and lose touch with the present. If this happens there is the danger of the level of trauma exceeding the capacity of the “safe place” resulting in further traumatisation. In order to avoid this danger the victim should first learn how to pull himself back into the present. This is best achieved by training in awareness of body sensations and the felt senses. Any activity which increases awareness of ones physical body is likely to be helpful. This can include energetic sports, fitness training and body massage. There is however a danger of aerobic exercise for some victims because raised heart rate and respiration can act as a trigger for traumatic symptoms. In such cases an alternative is to do mild muscle tensing and relaxing with attention to awareness of body feelings and sensations and stopping at the point of mild

tiredness. The goal is to build up a positive experience of being in the body. During physical activity, massage, taking a shower etc. the victim should be encouraged to both experience what is happening and observe it at the same time. This is the beginning of the process of becoming comfortable with duality. Once the victim is able to control the extent of his body awareness he is able to use this as an accelerator or brake on the extent of his engagement with the trauma. Lessening of body awareness speeds up the rate of engagement by allowing internal stimuli to dominate whilst increasing body awareness brings a greater awareness of present reality and negates the effect of internal stimuli. The aim is to be able to be simultaneously aware of sensations that arise from external and internal stimuli, to recognise their source and so become skilled in the ability to control the extent of traumatic hyperarousal and capable of differentiating past and present reality. This skill of maintaining a state of dual consciousness, simultaneously aware of both past and present reality, provides the canvas on which the remapping of memory can take place.

The first rule with regard to engagement is that it should not be attempted until the trauma is actually over. If the trauma is ongoing, for instance abuse by a person who is still in contact with the victim, then it is not helpful to start the process of engagement. It is necessary first to have passed through the initial phases of safety and integration.

Engagement does not need to involve psychotherapy and for most people this will not be necessary. In fact several books have been written with the specific aim of helping victims who wish to guide the process themselves. Among those listed in the bibliography the ones by Herbert and Levine are the most accessible.

Recall can be assisted by replicating sensory perceptions that mimic those at the time of the trauma. Examples are: light or dark, warm or cold, background sounds, state of mind including influence of any drugs, bodily posture, clothing, tiredness or alertness, pulse rate, respiration and blood pressure, presence or absence of other people, etc. In the early stages the problem may be one of over sensitisation. In this case recall occurs too readily and inappropriately. At this stage it may be necessary to identify and avoid triggers that lead to recall in the course of daily life and then reintroduce them gradually at each cycle of the process so that the victim only engages at a level appropriate to the degree of safety and integration already achieved.

If, as is likely, recall of the trauma results in the re-occurrence of dissociation and even physical immobility this need no longer be damaging as it can be dealt with through the felt senses using the skills recently acquired. Provided that the repressed traumatic experience is engaged with in a controlled and manageable way in a loving caring environment at a pace acceptable to the individual there is every reason to expect that a new harmony will be achieved.

Contemplative prayer and meditation can be helpful but are best avoided in the early stages until the victim has achieved the ability to control his degree of engagement because the state of consciousness entered into during prayer and relaxation can trigger symptoms. They can be useful later as techniques which make it possible to maintain a state of dual consciousness whilst the process of integration is accomplished.

Safety

Once an awareness of the process has been grasped it becomes possible for the victim to manage his own recovery in a series of stages, each of which is within his coping capacity. Managing the process in this way leads to a growing sense of mastery and confidence. He feels safer within himself and capable of achieving ever greater levels of integration.

Chapter 5

States of Consciousness and The SIBAM Model of Dissociation

During everyday life people move effortlessly between one state of consciousness (SoC) and another. There is one SoC for doing high powered and demanding work requiring a high level of concentration, another for performing routine tasks accomplished with little conscious effort, another for mentally routine but physically demanding tasks, yet others for watching an escapist film, enjoying a quiet romantic dinner, or the sexual expression of intimacy. Each of these S^soC is associated with a particular grouping of sensory experience which helps trigger that particular SoC. Academic study for instance requires one particular SoC. For one individual this SoC may be triggered by sitting at a desk whilst listening to popular music whilst another may not find it easy to enter that SoC except when in a quiet environment free of sensory distraction. S^soC involving dissociation may be learnt through exercises such as meditation and self-hypnosis as well as experienced during trauma.

During a traumatic episode the individual experiences several S^soC, particular the hypersensitive state during the fight/flight phase and the trance like dissociative state of the freeze phase. Each of these states may be unlike any state previously entered and so the sensory groupings which are associated with each of these states (or any subset of these groupings) and which may trigger them will be those experienced at the time of the trauma. Especially when retraumatisation occurs these sensory groupings may become detached from their normal associations and linked only with the trauma. For healing to take place it is necessary to re-attach these sensory triggers to the more normal S^soC whilst not necessarily totally detaching them from connectedness with the trauma. For instance the experience of fear previously associated with the pleasurable SoC enjoyed whilst taking the family to a theme park and riding the big dipper may, in a PTSD sufferer, have become associated only with the SoC encountered at the time of the trauma and trigger hyperactivity or freezing.

Explicit & Implicit memory

Explicit memory is based on thought and comprised of facts, concepts and ideas. It requires language and the ability to order facts into a cohesive whole. Implicit memory

involves internal states and procedures that are controlled by the unconscious mind. Many tasks such as driving a car require the use of both implicit and explicit memory. Simply sitting in the driving seat of a car will cause the brain to make links between all those areas of both types of memory associated with this activity. It appears that during the hyperarousal state the stress hormones released suppress the activity of the hippocampus leading to a loss of function in the ability to retain explicit memories. The amygdala however continues to function normally and so the sensations, emotions and bodily impulses associated with the trauma are recorded vividly in implicit memory without any accompanying information in the explicit memory to explain their context and how or why they arose. (Rothschild:29ff)

All memories are triggered by a sensory input. The smell of floor polish, disinfectant or boiled cabbage may for some stimulate vivid memories of their schooldays whilst lying sunbathing on a beach will assist recall of previous holidays. The sound of classical music or the cheering of a crowd will all have

their associations. Because of the loss of some explicit memory during trauma sensory cues can cause reactions for which the conscious mind has no explanation. For instance if a man has been mugged by someone wearing a leather jacket the victim may not consciously remember the clothing of his attacker but still experience a sense of panic whenever he passes someone in the street wearing a similar leather jacket.

Although it is usually an advantage to have a full awareness of all the felt senses together with fully functioning explicit and implicit memories there can be times when for ones own survival it becomes helpful to learn how to enter a state of consciousness in which certain senses are “switched off” or “disconnected” from consciousness. In such a dissociated state it becomes possible to be totally aware of ones environment and responsive to it while being selectively oblivious to certain physical or psychological pain which would otherwise be felt. Such an ability to enter dissociative states which offer mental escape can be cultivated in a variety of situations. A well known example is that of child victims of routine sexual abuse who will describe entering another internal world whilst watching the abuse almost as a passive observer. Members of special forces who may have to spend days in a lying up position, cold and damp, in a position of extreme vulnerability and danger, unable to move yet having to stay mentally alert and observant can learn the ability to lose awareness of bodily pain and discomfort whilst still being alert and responsive to any possible enemy activity. Persons held in long-term captivity under appalling conditions are also sometimes helped by learning the ability to live in two separate worlds allowing the more comfortable and reassuring interior world to become more vivid than the one experienced by their felt senses.

There is now evidence that those who are already accustomed to using dissociative states as an escape from stressful situations enter such states very readily at an early stage of trauma and as a result are more likely to develop PTSD than those who dissociate later or not at all.

“Dissociation appears to be the mechanism by which intense sensory and emotional experiences are disconnected from the social domain of language and memory.” (Herman:239)

Dissociation has traditionally been understood to result from mental conflict and repression. Breuer and Freud “found that if the lost memories were induced to come up with emotional vividness by hypnotism or long talks, and talked out, the patient felt better”. (Brown:24) They also found that when these repressed stressful experiences were recalled they often caused intense emotional outbursts. They called this effect abreaction or catharsis. (Stafford-Clark:29ff and Hamilton:262ff)

Hypnosis is still used to a limited extent to recover memories which are then dealt with by psychotherapy but as a technique it is generally regarded with suspicion largely because of the controversy regarding the recall of false memories. A number of drugs have been found to induce a state of dual consciousness in which the patient is able to recall repressed memories of traumatic incidents. Grinker and Spiegel used sodium amytal in the 1940’s. Most notably Lisergic Acid Di-ethylamine (LSD-25) was used extensively during the 1960’s. Frank Lake’s “Clinical Theology” (1966) contains hundreds of glowing references to its

efficacy. However even since the earliest investigations into dissociation and abreaction by Pierre Janet and others in the 1880's (which predated that of Freud and Breuer) it was recognised that the discharge of emotions was not in itself therapeutic unless it happened in the presence of other positive emotions such as awareness of the therapist's sympathetic acceptance but rather the key issue was psychological dissociation. Such a view was endorsed among others by Jung (1921-1922) and Grinker and Spiegel (1945). (van der Kolk:308ff, Eysenck:100) Following World War II this knowledge seems to have been forgotten by psychiatrists until the link between trauma and dissociative disorders was rediscovered in the 1980's. Nowadays it is recognised that whilst the discharge of emotions is important this is only one piece of the jigsaw that must be assembled before healing can take place.

“Peter Levine’s SIBAM dissociation model is a useful tool for conceptualising dissociation. It is based on the thesis that any experience is comprised of several elements. Complete memory of an experience involves integrated recall of all of the elements. SIBAM is the acronym for: Sensation, Image, Behaviour, Affect, and Meaning. (Levine, P:1992) These are the elements of experience identified by Levine. He postulates that elements of highly distressing/traumatic experiences can be dissociated from one another. This postulation is based on the premise that less distressing experiences remain intact in memory.....Levine proposes that during some episodes of traumatic stress elements of the experience become disconnected. An individual with PTS or PTSD might later report a visual memory (image) and a strong emotion connected to it (affect), but cannot make any sense of it (dissociated meaning); a child might exhibit repetitive play after a disturbing event (behavior), but doesn’t display any emotion (dissociated affect) or appear to remember it at all (image).....The SIBAM model can be an effective tool for helping to identify which elements of an experience are associated and which are dissociated. Once identified, missing elements can be carefully assisted back into consciousness when the client is ready.” (Rothschild:67-70)

Sensation

The bodily sensations experienced at the time of trauma - awareness of what was happening within the body. Examples are: muscle tension, muscle tiredness or weakness, racing heart, perspiration, defecation, sinking feeling in the stomach etc.

Image

What was observed - awareness of what was happening externally. Can the victim replay a movie of what was going on around them? Rather confusingly hearing and smell really belong in this category rather than under sensation. Whilst they are senses the information they convey is about what is happening in the external environment so they relate to observation rather than experience although it would be valid to include them in either category.

Behaviour

What did the victim actually do or fail to do? It may be necessary to compare his account with that of others present at the time and to explore any discrepancies.

Affect (strong emotion)

What did the victim feel emotionally at different stages of the trauma? Fear, unbelief, panic, anger, resignation, helplessness, vulnerability, desolation, invulnerability, energy, confusion, peace are some of the many possibilities.

Meaning

“The exploration of personal meaning of the trauma is critical; since patients cannot undo their past, giving it meaning is a central goal of therapy.” (van der Kolk:19) When commenting on the significance of life-changing experiences Percy observes that the key to change lies not in any external objective measure of the reality or significance of an experience but how it is interpreted. (Percy 2001:270) This is where the presence or absence of faith can make a tremendous difference. The Christian understanding of death followed by resurrection makes it possible for all negative destructive experiences to be recognised as capable of transformation into vehicles of hope and gateways to new life and consciousness.

Whilst any elements of the SIBAM model are missing from recall of the traumatic event it remains impossible for memory to be configured into a format where it can reside in the memory as a past event without intruding into the present. Once missing elements have been identified it is necessary to recall them. An effective way to achieve this is to ask the victim to engage with an experience all the elements of the SIBAM model except that which is missing and where the elements that are present are similar enough to the trauma to connect with it whilst different enough to change it into a more normal experience.

Chapter 6

Pastoral Care -

What needs to happen? - How can we help it to happen?

An understanding of PTS is clearly of benefit when one is presented with a parishioner known to be suffering from its effects. However its application has much wider benefits. In any congregation there will be those who are still suffering, in varying degrees, from the effects of some stressful event, perhaps many years in the past. Their symptoms may have been unrecognised and untreated. They will have learned to cope but their potential quality of life is curtailed. By the application of a few simple principles, which can with absolute safety be applied in all pastoral situations, the possibility of restoring damaged lives to a quality approaching their God-given potential becomes a real possibility.

Before the Trauma

Here are suggestions about how peoples natural resource base can be strengthened and enlarged so that if and when they do face trauma they will be likely to recover more quickly than might otherwise be the case.

The psychiatrists Grinker and Spiegel, in a study of servicemen during WWII, noted that the strongest protection against psychological breakdown was the morale and leadership of the small fighting unit whose members had developed a high level of co-dependency. The power of love and duty towards fellow combatants or family members can be an important motivator towards recovery.

Trauma sufferers find it difficult to trust. No parish priest can know in advance which of his parishioners may suffer trauma in the future but any who do are unlikely to come to him unless a relationship of trust already exists. Anything that can be done in the course of everyday ministry to establish a reputation of integrity, care and competence may well lay the foundations for future effective ministry to the traumatised. Recent studies have shown that counselling of victims immediately following a traumatic event by persons previously unknown to them (however technically competent those persons might be) is largely ineffective and can be damaging whilst help provided by trusted figures in the community such as doctors, teachers, police and clergy has more beneficial effects even when, as is normally the case, those persons have not had any specific training in trauma counselling.

“Exploring the trauma for its own sake has no therapeutic benefits unless it becomes attached to other experiences, such as feeling understood, being safe, feeling physically strong and capable, or being able to empathise with and help fellow sufferers.” (van der Kolk:19)

The most effective thing the church can do is to seek to provide for all those with whom it is in contact a resource base of positive experience of its members and activities so that it becomes a magnet for those seeking security and affirmation.

General training and education on bereavement should be offered regularly. This should include mention of the reactions and symptoms involved in PTS. Even if participants forget all that they are taught they may, if and when they or their

friends experience trauma, at least remember that there is someone who understands and is likely to be able to help.

Students of the management of change are well aware that the ability to cope with change is easier for those who have become accustomed to coping with regular if smaller changes. The same is true in the spiritual realm. Those who have faced frequent challenges to their belief systems and the expression of their faith and who have developed strategies for adapting and adjusting are far better equipped to cope with a major crisis of faith than someone whose faith and belief systems have remained static. A priest who continually challenges the beliefs of his people making it necessary for them to rethink what they believe and who occasionally introduces new forms of worship is helping them to develop the spiritual resources to deal with a major crisis of faith if and when it occurs. Often heated debates about differences of belief within a congregation can be seen as energy sapping and time wasting. Nothing could be further from the truth. An environment where differing opinions can be voiced and debated passionately whilst everyone is loved, accepted, and supported by members of the congregation with divergent views is an excellent healing environment for the trauma survivor whose spiritual world has been shattered and who is full of questions and emotional reactions.

The dissociation which occurs during the freeze phase may be a completely novel experience for many. If this is the case such a state of consciousness will be associated only with the traumatic incident and there will be a reluctance to recreate this state because the victim will be aware, if only subconsciously, that if he does so the memories associated with the trauma will come flooding back and may cause further trauma. In order to overcome this reluctance therapists have traditionally found the necessity to resort to hypnotism or mind-altering drugs. If, however, a person is already familiar with altered states of consciousness and these have positive associations he will find it much easier to enter such a state after the trauma, to allow dissociation to occur and work within a familiar state, over which he has established control, as he deals with the feelings that resurface. Within the Christian tradition there are many examples of dissociation occurring during times of prayer and adoration. This can happen during private meditation or contemplation as well as on occasions where there is a heightened expectation of spiritual encounter such as during a pilgrimage to a shrine such as Walsingham or Lourdes or attendance at a rally or charismatic healing service. (See chapter 9 for a fuller treatment of Signs and Wonders ministry) The minister who provides opportunities for his people to encounter altered states of consciousness in prayer and helps them understand the benefits and dangers of such states will make recovery from any subsequent trauma inestimably less complex.

2) Immediately after the Trauma

“Although most individuals recover emotionally following disasters, without lasting psychological impairment....those stress reactions that occur during and in the immediate aftermath of a firsthand traumatic experience - are ubiquitous. Although exposure to disaster creates extreme losses and challenges, most individuals evidence amazing resilience.” (Collins:463)

Research into PTSD has revealed that in many cases the trauma has been exacerbated by inappropriate management of the victim immediately after the

trauma. The reactions and behaviour of well-intentioned rescuers, counsellors, helpers and family members can easily cause greater trauma than the event itself. This effect is so marked that for those suffering from chronic PTSD it can be assumed with a high degree of probability that this is the case. For this reason many therapists dealing with such clients will begin by exploring events immediately after the event rather than the trauma itself. (Rothschild:124)

The first and most important task is to move the victim to a place where he feels physically and emotionally safe and secure. Initially there will be great confusion and despair. Those dealing with victims in the initial stages need to be thoroughly professional, communicating clearly that they are in control and that the situation has been stabilised. They should explain exactly what they are doing and why. Nothing should be done to or for the victim without first seeking his permission. It is important to help him feel that he is in control of what is happening. Because the level of trust is low and fragile it is vital that if promises are made to the victim about something being done then they are kept. In this way trust can be re-established. If this does not happen it will increase the sense of abandonment and fear which he will already be feeling. As time progresses and circumstances permit he should gradually be moved to a place of greater security. In order to do this it will be necessary to find out about existing support systems and make links with them. Ask the victim where he would like to be, where he would receive most understanding and support. This may not necessarily be his normal place of residence.

“It is widely accepted that the central issue in disaster management is the provision and restoration of social support” (van der Kolk:24)

Do not be overprotective towards the victim. Encourage them to do as much as possible for themselves especially where this involves the expenditure of physical energy. If the situation allows it, encourage them to help in rescuing or supporting others or clearing up after the event.

It can be helpful to give out a fact sheet on which are listed the most common symptoms, advice to talk about the experience in spite of a temptation to withdraw, and a warning to avoid alcohol as a means of controlling symptoms. When such a fact sheet was given out to victims of a disaster in which an oil rig capsized and they were followed up twelve months later it was found that many had referred to the sheet frequently and still carried it around with them (Herman:158)

Trauma damages relationships and trust. The sense of self is shattered and can only be rebuilt by rebuilding relationships. A supportive environment mitigates this impact whilst any negative response aggravates it.

Families offer the best support but will need training and support themselves. In particular friends, family and other church members may need to be reminded of how important it is to avoid questioning or criticising the victim at this stage and to offer unconditional support especially when they find his behaviour challenging.

Possible sources of stress should be identified so that these can be minimised. There should be an awareness that this is a challenge for the whole family and not

just the individual. The primary focus of all concerned should be on finding solutions to problems not on apportioning blame

Visits by the clergy can be helpful but these should be arranged in advance. After the acute phase (the first two to three months) it is probably sufficient to visit every six to eight weeks. When visiting concentrate on practical help and simply being available. Don't talk about the event unless the victim initiates such a discussion. Ask for permission before praying with him and if you do so pray aloud. If anger is expressed towards God just take it. Empathise and don't seek to defend God.

The military approach is usually to remove the victim to a place of (sometimes only relative) safety for just long enough to control the most severe symptoms and then return him to action after only two to three days. Whilst the person may appear to be functioning normally underlying problems will remain but these can be dealt with at a time of the victims choosing. In the meantime the advantages of being surrounded by friends and colleagues committed to mutual support in pursuit of a common goal and the security and self-confidence which this engenders (even in the face of physical danger) is far more therapeutic than being moved to an alien medical environment and cut off from normal support networks.

Ongoing Support

The final category suggests how the needs of the trauma sufferer may be met in the longer term in order that his recovery may continue to progress and be maintained.

During the months following the traumatic episode one of two things happens. Either there are successive partial discharges of energy followed by further refreezing of increased energy and a worsening of symptoms leading to a chronic condition and ultimately PTSD or the energy is fully discharged, the memories re-integrated and the negative effects of trauma disappear.

At this stage it is useful to attempt some assessment of the needs of the client and the support available to him. A helpful framework from a developmental-ecological perspective is given by the ABCDE (Affect, Behaviour, Cognition, Developmental, Ecological) assessment model which is summarised below. (Collins:24)

Affect Primary feelings of the client in reaction to trauma, identified or unidentified, expressed or unexpressed.

When considering these affective reactions, (which should include reaction not just to the event itself but also to the reactions of others and to the challenges of the new situation) attention should be given to helping the client to move towards being able to express emotion in a way that is appropriate in manner and intensity to both the stimulant and situation.

Fear, for instance, may be triggered by very minor stress and so lose its protective function. The resulting lack of discrimination about relative levels of danger can put the individual at risk. Fear is released through screaming and shaking whilst

sadness and grief are released through crying, and anger through yelling and stomping about. A sense of shame however cannot really be classified as an affect and it does not abreact or discharge. The key to its dissipation seems to be contact with another accepting non-judgemental human being. (Rothschild:62)

Anger and intimacy are difficult for the survivor to modulate. He may oscillate between intolerance of any violence or aggression in others to his own outbursts of extreme rage. Whilst basic trust in others has been disrupted he desperately needs protection and so will both seek and withdraw from close relationships. This leads to intense unstable relationships which can put immense pressure on other members of the family. (Herman:56) They are more likely to be able to be supportive if they understand what is happening and are assured that their own patience and loyalty will in time pay dividends.

Behaviour Clients actions/lack of action in response to the crisis and as an attempt to resolve any lasting effects.

Firstly it is helpful for the victim to understand the reasons for his behaviour at the time of the trauma. In most cases there will be some puzzlement, regret or guilt. An explanation of the instinctive mechanisms controlling behaviour at this time will help the victim come to terms with what he did or failed to do.

Secondly it is necessary to look at behaviour patterns resulting from the trauma which are no longer appropriate. The victim needs to be advised how to manage his symptoms and control any destructive behaviour. In order to do this he will need to feel safe, physically, emotionally and financially. A sense of mastery over the body and its actions needs to be achieved. Exercises in body awareness and training in self-defence can help achieve the necessary physiological reconditioning and psychological mastery.

The chronic PTSD sufferer will often attempt to avoid stimuli that will trigger awareness or if these are unavoidable to face them in situations which will minimise the intensity of the response. Strategies include dissociation, amnesia, emotional anaesthesia and attempts to induce amnesia by the use of drink or drugs which can lead to addiction. If this happens it should be brought to the attention of the sufferer together with suggestions of alternative coping strategies which will enable him gradually to achieve control over his reactions and behaviour.

Panic attacks are the result of a desire to escape coupled with perception of being unable to do so. As the sufferer gradually regains confidence in himself and control over his behaviour these should diminish.

Behaviour is “intimately connected to and often motivated by, and responsive to, the individual’s emotions and cognitions....We can only understand the meaning of a client’s behaviour, however, when we also assess the emotions and cognitions that motivate it.” (Collins:28f)

Cognition Thoughts, beliefs, explanations that define the meaning of the event and determine affective and behavioural responses.

The trauma is likely to have shown the victim new things about himself and to

have opened up new levels of consciousness. In the absence of explanation or preparation such awareness can lead to fragmentation of the personality. In time these new experiences need to be integrated within the persons lifestyle and world-view. Those who are likely to be of the most help in achieving this are not mental health professionals but close friends and members of the family. They are the ones who have known the person over an extended period. They will understand how that particular person looks at and approaches life and recognise better than anyone the precise nature of why the experience of trauma has been so disruptive to the world-view of that particular individual. Collins mentions that Myer (2001) identified four domains of a life that may be affected by the crisis. These are: safety and security, psychological elements including self esteem and self respect, social relationships, moral/spiritual belief systems. "He suggested that it is essential to discern the affected life dimension as the client perceives it in order to understand the significance of the crisis for that client." (Collins:30)

Family members will know about the presence or absence of faith and the nature of such faith or other co-ordinating principle which previously gave order and meaning to the life and experience of that person. It is they too who will be most aware of the extent and nature of support systems available to the sufferer and who will be able to offer suggestions, advice and encouragement about former friends, colleagues and familiar environments where support and assistance with the re-integration process may be found.

Development Stages of life needs/concerns/tasks affected by the trauma. Assess relevant developmental capacities.

"Developmental theory suggests that as individuals confront various life transitions.....they respond by both utilising previously developed knowledge and skills and by developing new capacities and skills" (Collins:31)

New situations and experiences demand changes in assumptions about the world and inevitably result in changes in behaviour and relationships. After the trauma the sense of self painstakingly constructed over time may be lost and this loss is manifested after the event by loss of trust in self, in other people and in God. There is often a breakdown in personal relationships and faith at a time when these can be of most benefit. Once again the priority is to help the sufferer establish control, to attend to health needs such as sufficient restful sleep, healthy and adequate diet and exercise. Only once a sense of physical and social well-being has been established is there likely to be the emotional and intellectual energy available which will be required for the re-ordering of that person's world view.

Many life transitions are marked with some sort of liturgy which may or may not be religious. These liturgical events provide an important focus for a public expression by the individuals most affected of his feelings and needs at the time. A funeral or memorial service is one of the most obvious examples of such a liturgy. It marks a very clear transition point. The bereaved say goodbye to their loved one, let him go and hand him over to God. They have the opportunity to look forward as well as backwards and should be encouraged to include both these elements within the formal liturgy in a way which is meaningful for them.

Relatives may need some help to give up their loved one to someone larger than themselves. Dialogue with God can be facilitated by writing a poem or giving a tribute. Each of these can be a way of approaching God especially for those who have lost faith in him. It is important to allow expressions of anger or questioning towards God if this would be helpful to the close family. Anniversaries of traumatic events in themselves offer opportunities as transition points for developmental change and appropriate personalised liturgy can often be of help.

Ecosystem Culture/ethnicity of client. Presence or absence and accessibility of interpersonal, informal, and formal resources/supports. Ability and willingness to use supports. Perceived barriers.

Three broad areas of the individuals environment can be defined. These are:

- a. culture, values, traditions and dominant belief systems
- b. social supports - relationships with close friends and family
- c. the larger community within which the trauma occurs

“Identifying key people in an individual’s social system and the type of support they may be able to provide is key in assessing an individual’s interpersonal supports.” (Collins:41) Whilst some potential supports may only be known to family and close friends others, particularly those based in the community, may be better known to clergy, GP’s or others with a community role.

The person who might be expected to offer most help and support is the spouse or significant other. However it is rare for this person to provide as much help and support as they might wish. There are a number of reasons for this. Firstly that person will themselves have been deeply affected by the trauma, even though they may not have been present, and so will have their own symptoms and issues to deal with. Secondly it is normal for a victims capacity for intimacy to be impaired so that he exhibits a fear of any intimacy. It is often helpful to work with partners using traditional marriage therapy integrated with an awareness of the effects of PTSD to help overcome these fears. Five types of such fear have been identified by Patrick Sheehan: merger, abandonment, exposure, attack, own destructive impulses. Sheehan found that these fears were best addressed indirectly via metaphors (stories or descriptions of situations that are different from the person’s situation in content but similar in theme). (Williams:94ff) Improvement of interpersonal relationships often leads to greater physical intimacy which in turn provides an opportunity for greater body awareness, another important factor in promoting recovery.

Any mature and intimate relationship has two components: mutual affirmation and exploration of difference. Each partner affirms and validates the assumptions, beliefs and value systems of the other and gives them a sense of self-worth. Once each is secure in the other then, if the relationship is to survive and grow, there needs to be an exploration of the differences between the partners and a tolerance of conflict.

“There are significant similarities between a person’s ability to tolerate interpersonal intimacy and the capacity to tolerate the challenges to cherished beliefs that follow a traumatic event.” (van der Kolk:539)

One can compare a trauma victim with a lover. Initially love is blind. Partners see only good and mutual affirmation in one another. From this place of security, of knowing that one is accepted, loved and possibly even worshipped comes a sense of deep inner peace and security which enables engagement not only with the external world but more importantly with internal differentiation and dissociation. The ability to accept and receive love with all its liberating effects is closely allied to, and dependent upon, the ability to give oneself sacrificially in love to others, either for their own sake because they are worshipped, or for God's sake as a means of worshipping him.

“Research has confirmed that when a patient has not previously idealized another person....it is virtually impossible to mobilize the trust necessary for eventual internalization and growth” (van der Kolk:555)

When a person has previously had a personal relationship with the living God lived out in active service and worship there is still the memory of the security which this provided even in the confusion and disruption following trauma. With gentle encouragement the person can be helped to re-engage with aspects of how his discipleship was previously expressed in order to re-awaken a sense of the presence of God.

As any relationship develops, partners begin the disturbing process of learning to continue to love the real person who is gradually revealed to them in all their imperfection and complexity. For this to happen the person needs to develop the ability to balance and hold in creative tension all aspects of the relationship. It is this ability, the driving force behind personal development and mature intimacy, which has been compromised in those suffering the effects of trauma. Mature and integrated personhood requires the ability not only to accept and be comfortable with one's own pain, helplessness and disintegration but to be willing to share this with another person. There can be no interior re-ordering unless this is preceded by a re-ordering of human relationships and a re-learning of the ability to trust another person.

Fragility in personal relationships may remain for many years even when all other symptoms of PTS have vanished. The possibility of prior traumatization should always be borne in mind when dealing with cases of conflict between life partners. Even in the absence of previous trauma the breakdown of personal relationships can be so devastating that it triggers symptoms of PTS.

“When the safety of relationships is threatened, people resort to the emergency responses of fight or flight. In traumatized patients it often does not take much to trigger these reactions, which may have been appropriate to being helpless children or traumatized adults, but which are not very helpful in the context of current reality. (van der Kolk:554)

Chapter 7

Potential problems and considerations when ministering to the traumatised

At the time of the incident damage is more likely to result from trying to do too much to help the victim than doing too little. In the immediate aftermath the victim is numb and likely to have withdrawn. Potential helpers may have to be restrained from asking too many questions or engaging in attempts to “cheer him up”. Help the victim to feel safe and secure. Be there for him and attentive to any needs which are expressed but do not force unwanted help on him before he is ready to receive it.

In the weeks following the incident friends and family members will no doubt try to help and some of the help they offer may not be appropriate. In addition they themselves will inevitably suffer secondary traumatisation.

When trauma suffered by an individual or group becomes public knowledge the social environment usually responds positively and sympathetically by providing practical and emotional support for those who are distressed. This fulfils a need not just in the victim but also in the social network itself. Occasionally the two sets of needs can conflict. (van der Kolk:25)

This conflict is most likely to occur when a victim interprets the meaning of an event in a different way to members of their social or support network. The situation is further complicated when a spouse or other close family member is also traumatised either directly or indirectly by the same event but each ascribes meaning differently and/or seeks emotional discharge in different ways.

Because the fight/flight reactions happen instinctively without conscious consideration a survivor can often feel guilt for behaving in a way which, on reflection, he considers to be an ill-advised choice.

It is well known that in any bereavement situation people who might have been expected to offer support withdraw from contact with the bereaved person instead. This happens because the other person cannot easily handle the emotions of the victim nor the reminder of the fragility of their own life situation with which a bereavement situation confronts them. Such a scenario is heightened in a situation which combines trauma and loss with a reminder that life is not as secure and predictable as many might like to imagine.

There is often a strong imperative from society at large to ignore and forget. When this happens it leaves the victim retraumatised and can cause more emotional damage than the trauma itself.

“After every atrocity one can expect to hear the same predictable apologies: it never happened; the victim lies; the victim exaggerates; the victim brought it on herself; and in any case it is time to forget and move on.” (Herman:8)

The victim however demands action. He needs someone to stand by him in his pain, to share that pain and to do whatever is necessary to prevent the same fate

happening to someone else. The Christian who follows the example of Jesus in doing these things may often find himself at odds with society at large. It is part of his Christian vocation to change the attitudes of the society of which he is part.

“Society can only make a commitment to victims if it accepts these two ideas: (1) that victims are not responsible for the fact that they were traumatized; and (2) that if victims are not helped to deal with the memories of their trauma, they will become violent and anxious people, unreliable and easily distracted workers, inattentive parents, and/or people who use drugs and alcohol to help them cope with unbearable feelings.” (van der Kolk:35)

In the longer term good social support is generally beneficial to healing but does not guarantee it in the absence of adequate will-power and motivation on behalf of the individual. Too much support can deskill and demotivate the sufferer and it is important to determine the optimal balance between providing adequate support to aid recovery and too much support which results in the individual abdicating responsibility for his own recovery.

Some problems within families and support networks are caused by transference. The rage felt by the victim is “transferred” from being directed towards the cause or perpetrator of the trauma and is instead directed at someone more accessible, often a major caregiver such as a spouse or GP. This can result in a withdrawal of support which in turn leads to even greater trauma because at this stage it is unconditional support which the victim requires more than anything else to facilitate his recovery.

Sometimes family members identify so closely with the suffering of their loved one that they replicate his symptoms. Figley suggests that this parallels the phenomenon of *couvade* in which expectant fathers simulate the symptoms of their pregnant wives (Figley:18)

Yet another potential problem is that of counter transference. In this case a caregiver or family member who has suffered trauma at some time in the past has the memories and emotions of that event triggered by involvement in the new situation. This person themselves then begins to exhibit symptoms of PTS. If this happens it should not initially be addressed directly. Avoid suggesting that they need help but meet to give them advice to understand what is happening and how to support the survivor. If family members or caregivers themselves continue to exhibit symptoms of PTS consistently for more than a few days it is wise to seek guidance from a professional therapist.

Recovery requires a safe place and often financial as well as emotional independence.

In situations where power is unbalanced, such as in an abusive domestic relationship where the abuser controls all the finances or where a child is being abused by a parent, conditions for recovery and freedom may only be achieved at great cost. It is not possible to begin healing trauma until it has ended. The victim is then left with an unenviable choice. Does he choose to remain with the family, together with the security which that offers both socially and financially, but allow the abuse to continue or does he let go of family and sometimes, as in the case of asylum seekers, his country and culture as well in order to achieve healing and wholeness. In the real world, much as we might like it to be otherwise, it is

often not practical or possible to end the trauma, maintain the social network and heal the effects of trauma. (Herman:172)

Where his trauma is perceived by the victim to have resulted from a deliberate or negligent act on the part of another person there is often a desire for revenge, compensation and contrition. If justice is seen to be done and compensation and contrition follow this can be helpful to the victim but such a scenario is the exception rather than the rule. The victim should be strongly discouraged from making his recovery dependent on achieving the humiliation of the perpetrator or receiving an apology. Many victims fantasise about such a scenario but it should be made clear to them that this is what it is and it is likely to never be any more than a fantasy. Healing of the victim depends on his being able to give and receive love and support from others. If the victim does come to the point of being willing to forgive a repentant perpetrator this can be therapeutic but it is not essential.

It has been stated earlier that a previously learned ability to access dissociative states through prayer and worship is of benefit in aiding recovery from stress and preventing PTSD. Yet Spiegel and Cardena claim that those who have an enhanced ability to access such states are more rather than less likely to develop PTSD. (Spiegel & Cardena:366-378) The reason for this difference of opinion is the all-important one of context. The subjects of whom they are speaking as having developed an ability to induce dissociation have learnt to do so in the context of coping with previous threats whereas the Christian has learnt to use the skill not to escape from reality but as a tool for expanding consciousness and experimenting with the re-integration of experience in a loving prayerful and supportive atmosphere.

Chapter 8

Trauma and the Christian - a means to wholeness

The Christian who has suffered trauma initially demands to know the extent of God's involvement before, during and after the event. The answer he comes up with will, to a large extent, reflect the nature of his relationship with God and how that relationship is expressed and nurtured. There are a number of possibilities, some of which are given below.

1) My belief in God was mistaken. If a loving God existed he would not have allowed this suffering to take place. I can no longer believe in him.

2) God has deceived me. I followed what I believed to be his will on the understanding that he would be with me and protect me. He has not kept his side of the bargain and so my relationship with him is at an end. God is supposed to be just. This is not justice. I didn't deserve what has happened to me.

3) God deliberately willed it to happen to me because:

- I needed to be punished or disciplined
- my faith in him needed to be tested
- I needed a lesson which would help me to appreciate the suffering of others
- I needed to be humbled in order to become more dependent on God
- he knew it would strengthen my character and make me a more effective disciple

4) God could have intervened but chose not to because:

- I needed to be punished or disciplined
- my faith in him needed to be tested
- I needed a lesson which would help me to appreciate the suffering of others
- I needed to be humbled in order to become more dependent on God
- he knew it would strengthen my character and make me a more effective disciple

5) God was not directly involved in causing the event. He neither chose to allow this event nor does he intervene to prevent other instances of trauma. Because he has given us free will his involvement with this world depends on the active co-operation of his people. There is no particular reason why I suffered rather than someone else. What I do know is that God will be with me to help me to move forward. He will help me grow through the suffering and disintegration and use it as a means to greater wholeness and awareness. In the midst of the loss of everything that gave value, security, meaning and purpose to my existence he continues to affirm life and invite me to accompany him on the journey to a fuller experience of life. I may have lost everything but he is still with me and I know that this is enough.

The answers and explanations given in 1) 2) 3) and 4) reveal that the relationship with God had not developed to the point where it represented a "safe place" that was sufficiently secure and adequate to be able to cope creatively with the trauma. The explanations listed in 3) and 4), whether they are generated internally by the victim or suggested by others risk causing further damage because each suggests that the victim was in some way responsible for having caused the tragedy. If one

of these explanations is accepted the victim will not only be traumatised further but also made to feel worthless and consumed by a sense of guilt at having pushed God to the point where he needed to act in this way.

A victim who belongs to a church community which in the aftermath of the trauma tries to force such explanations on to him is doing nothing to assist recovery and integration. Church members can help most not by trying to give theological meaning to the trauma but simply by offering practical expressions of love and support.

If a victim answers as at 1) or 2) he may decide to cut himself off from the church community just at the time he most needs to be part of an accepting social network. A Christian who reacts to a traumatic event by deciding that his faith in God was misconceived and subsequently cuts himself off from the church community will add trauma upon trauma. In this situation what is required is for church members to continue to visit with offers of practical support but without initiating any discussion about God or praying with the victim unless this is requested. Practical expressions of care will speak more powerfully of God's love than any words are capable of at this time.

In chapter 5 it was stated that being able to give meaning to the traumatic event is essential in order to integrate the memory and view it as a past event rather than an intrusive present reality. In that context meaning meant "why did it happen?" It is natural for a Christian to believe in some divine purpose and to change the question into "why did God make it happen?" or "why did God allow it to happen?". This natural reaction should be resisted. It is sufficient to ask "what in practical, physical, earthly terms caused the accident or disaster?" Typical answers might be: a discarded cigarette started a fire, a buckled rail caused a derailment, an earthquake caused a tidal wave or collapse of buildings, a lapse of concentration caused a driver to lose control etc. These sort of answers are adequate in the short term for the purpose of integrating memories. What they cannot do is help to restore the damaged relationship with God. Questions about the eternal and personal significance need to be asked but they should be focussed not on the past and the pain but on the future. God brings life out of death, hope where there was only despair and light where there was darkness. The sort of questions which can usefully be asked when the victim is ready to do so are the following: "how can I go on living?", "where can I find a source of motivation that will help me endure the injustice I have suffered?", "who needs me and how can I help them", "how can I go on loving when I feel that I have nothing left to give?", "can I still love God and trust him now that I have discovered he is not as I imagined?" etc. The victim should be encouraged to go on asking these questions and wait for God to provide the answers. The very act of asking positive, forward looking questions which express a desire to regain the ability to love and feel and give and be vulnerable will help the victim to be more aware of how it is possible to do these things.

The victim may well express anger and a sense of injustice. He needs to be aware that his very sense of outrage at the injustice of the world comes from the very heart of God himself. Life is not fair. We need to learn to live with injustice in this world by accepting imperfection in ourselves, our family and our vision of God. The writers of the Old Testament portray Yahweh as having all the

symptoms of a borderline psychotic who lacks moderation, is incapable of self-reflection, has no insight into himself and requires constant affirmation and appeasement to prevent him carrying out the most terrible acts of violence. Jung points out that in the story of Job it is God who is acting unjustly. He knows he is in the wrong and so pulls rank. He flaunts might over right. He behaves towards Job with a lack of faithfulness and projects this unfaithfulness onto Job expecting him to be unfaithful and doesn't rebuke Satan but connives with him. (Jung: *Answer to Job*) If we can accept this image of God who appears to act in a way which even we would consider to be imperfect it should also be possible to accept ourselves and others with all our insecurities and imperfections.

There is some deep lasting perfect reality beyond the reach of our human senses and abilities. Martin Israel reminds us that "all we possess on a purely personal level has to be taken away from us before we can know that deep inner authority that lives in a world beyond the changes of our mortal life" (Israel:24)

He tells us that suffering makes possible "a withdrawal from everything that was held to be necessary for happiness, indeed for life itself. This includes material security, supporting relationships with other people, bodily health, and intellectual certainty." (Israel:23) It has been stressed that the earliest possible restoration of all these things will help assist recovery from the effect of trauma. Whilst this is true it is also an amazing fact that those who have reached a certain point on their spiritual journey are able to recognise the darkness and desolation following trauma as a spiritual opportunity. It is for them a step into the desert where Satan is Lord and where those who have some experience of the dark night of the soul can walk with equanimity as they await deliverance. They know there will be a new dawning because they have already experienced a time when, having reached the limits of their own strength and abilities they found a fresh infusion of energy and with it an assurance that they were not alone and would never be abandoned no matter what their human perception might suggest.

The ability to forgive is very therapeutic both on a natural and spiritual level. The first person whom the victim should attempt to forgive is himself. The amount of forgiveness required will vary enormously but even in situations where by any rational measure the victim was not to blame he may still need to forgive himself for his perceived fault. At the other extreme is the experience of some war veterans who may have not only witnessed but perpetrated atrocities, perhaps involving women and children.

"Forgiveness of self is often a process of nurturing and dialogue. This is particularly true if the survivor wronged others and needs to confess those actions and do restitution for them" (Williams:562)

Forgiveness may never happen but fellow Christians can make it more likely by being supportive and revealing the presence of God's love through their own actions.

"For a person to move forward toward forgiveness, he or she must feel the presence of God as power, energy or a stimulus working from within herself or himself." (Rogers:38)

Chapter 9

Ministering with Signs and Wonders

In “Waking the Tiger” Levine gives several examples of case studies to illustrate his thesis that symptoms of PTS can be healed by encouraging the victim to re-enter the traumatic experience and complete it by discharging the physical and emotional energy which has been frozen. One case involved a young woman who had been traumatised by a hospital procedure as a child (Levine:29ff, 110ff). As she was encouraged to relax “she went into a full-blown anxiety attack. She appeared paralysed and unable to breathe.” As she released the energy “her legs started trembling in running movements...She began to tremble, shake, and sob in full-bodied convulsive waves.” (Levine:29)

Levines interpretation of these manifestations and their beneficial result is as follows:

“Nancy was able to mobilise an intense, biologically appropriate response that allowed her - in the present - to discharge the heightened arousal that had been unleashed as her immobility began to release. By exchanging (in that highly aroused state) an active response for one of helplessness, Nancy exercised a physiological choice. Her organism was learning almost instantaneously that it didn’t have to freeze. The core of traumatic reaction is ultimately physiological, and it is at this level that healing begins. (Levine:110-111)

The manifestations described by Levine bear remarkable similarities to those witnessed during prayers for healing at the Vineyard Conferences of the 1980’s led by John Wimber and in the 1990’s at the Toronto Airport Christian Fellowship (part of the Vineyard movement).

What became known as “The Toronto Blessing” was really nothing new. The events on 20th January 1994 had all been seen before, typically at Wimber conferences in the 1980’s and differed only in their intensity and the resulting media hype. These manifestations have only slight phenomenological differences from those which occurred in the eighteenth and nineteenth centuries, documented in Barton Stone’s autobiography written in 1847. (Percy 1998:114)

Following an address the whole congregation were invited to receive prayer. “They understood the ecstatic behaviour that followed, and on successive evenings, as a powerful move of the Holy Spirit. This included falling to the ground and lying on the floor (called ‘Resting in the Spirit’), shaking, trembling and jerking, laughing, weeping and wailing, apparent drunkenness and intense physical activity such as running on the spot and animal sounds. There were also mystical experiences, such as the receiving and proclaiming of prophetic insights, and visions.” (Steven:33)

John Wimber, writing in 1986 explained that “shaking and trembling....may be of varying severity and involve only a part or the whole of the body. Perspiration, deeper breathing and an increased pulse rate may accompany it. Commonly it is a gentle trembling associated with a quiet sense of joy and peace.....But trembling can also be a shaking of extreme violence.....Church History and contemporary experience contain many examples of people falling over and lying supine or prone for several hours. Most people are aware of a sense of calm and

of sublime indifference to their circumstances. Commonly no after-effects are noted.” (Wimber:225)

Similarly: “Many experience ‘Resting in the Spirit’, especially when they are being healed of emotional need.....The person may be in a conscious state but feels completely at peace, knowing Jesus has taken the burdens from him. He may be unconscious for some time while he encounters the Lord personally freeing him from deep hurt and bondage.” (Urquhart:163)

Writing about his first experience of ‘Resting in the Spirit’ Michael Mitton (later to become Director of Anglican Renewal Ministries) describes what happened when Eleanor Mumford invoked the Holy Spirit upon his life. “After she had prayed I felt I had a strange choice - I could either stand or fall. It sounds cold and clinical when put like this, but actually for me the choice was important. I had to face a question in my life about control. For me, at this particular moment, I had a choice - either to remain fully in control (which for me means over-control) or I could surrender. I decided to give in and felt myself fall to the ground in an undignified heap” (Mitton:6)

Mitton had grasped the key to all these experiences which is “surrender”. He would say that surrender is to God and the power of his Spirit whilst a psychologist such as Levine would say that surrender is to the inner instinctive drives which have been inhibited by the conscious mind.

In order for the frozen energy to be discharged and the natural instinctive process to be re-entered it is necessary firstly for the control of the conscious mind to be disengaged. This is most readily achieved by entering an altered state of consciousness in which the conscious mind and emotional responses are disconnected from one another. The therapist achieves this by first building up an atmosphere of trust with the client and then encouraging him to surrender to his inner drives within a safe, controlled environment. For therapy to be successful the conscious mind must acquiesce to letting go control or be tricked into such a state by the use of mind altering drugs.

The same is true in a religious setting where the crucial component to all examples of emotional release is an environment conducive to the surrender of the will. The process by which Wimber and his disciples achieved this in their meetings is well documented by Percy in “Words, Wonders and Power”. The time of prayer for “the coming of the Holy Spirit” is preceded by worship which serves to bring the congregation into a state of feeling safe and trustful and being willing to surrender. The worship songs are repetitive and focus on the power, closeness, mercy and love of God and express in a very personal way the desire of the individual to be touched by God and receive from him. “It is a realm not only of passivity but of passion; the emotions and feelings that are surrendered to God result in an inward order (control) that can counter the external forces (chaos) of sickness, evil, dissipation and impotence. This is the emotive power of the ideology: suggesting in metaphor, theme and form that surrender of self (especially the emotions and passions), and focusing them on the Lord, will result in the self being accepted by God, and turned into a positive force that can combat harmful outside pressures.” (Percy 1996:66) The songs express a commitment “to be caught up in God’s own dynamic life and pulled into a deeper knowledge of

his love and experience of his power, both privately and corporately.” (Percy 1996:79)

Mitton attributes ‘Resting in the Spirit’ and other physical responses to prayer as being due to the overwhelming power of the Holy Spirit. He says that “In the falling we are witnessing a potential death and resurrection activity. The fallings and shakings are indicative of something that is being put to death, and something that is being raised up.” (Mitton:8)

What seems to be happening is something akin to the freezing response discussed earlier as being part of the instinctive process of dealing with trauma. In a life-threatening situation the response to overwhelming and potentially destructive power is to dissociate emotions from consciousness. Panic and terror are repressed and replaced by a feeling of calm and peaceful resignation. The phenomenon of ‘Resting in the Spirit’ usually occurs in a situation where there exists the expectation of an overwhelming presence of God in power and a willingness to surrender and become totally vulnerable to whatever God wishes to accomplish. Indeed as Percy points out this abandonment of the passive worshipper to the enormous power of God is explicit in many of the worship songs. (Percy 1996 Ch4) Wimber “often refers to the Holy Spirit ‘falling’ on believers with some degree of force, and certainly acting on some without their consent.” (Percy 1996:89) It is little wonder that the instinctive psychological response to the coming of God’s power through the medium of the laying on of hands or a prayer invoking the Holy Spirit is very similar to the “freezing response” encountered as the result of a violent physical assault or other trauma.

For many people the experience of ‘Resting in the Spirit’ may indeed have no aftereffects. Dissociation occurs but the experience is remembered simply as a time of peace and tranquillity during which a trance like state was enjoyed. However if the person is suffering from PTS then entering into the dissociative state will recreate the freezing response experienced at the time of the trauma and instead of returning to consciousness gradually and peacefully there is every likelihood that there will be an attempt to discharge the energy and emotions which were repressed at the time of the original trauma. Such an explanation would account for most of the physical and emotional manifestations of the ‘Coming of the Holy Spirit’ at the Vineyard style worship events as described above.

David Pytches seems to agree with such an explanation for he writes:

“Beware of assuming that all shaking, bodily contortions, hysterical screaming or sudden physical pain etc., is demonic. Many people have deep reserves of suppressed emotion which may become manifest when they are being surfaced to the conscious mind by the Holy Spirit for healing.” (Pytches:201)

Percy explains the phenomena in terms of exchange theory as follows:

“What appears to be occurring is a complex form of social abreaction, which is then ascribed religious significance. Abreaction describes a therapeutic process - conscious or unconscious - group or individual - wherein repressed feelings, desires, traumas or negativity are allowed to be expressed and perhaps resolved. Typically, the process involves a high disposal of emotional discharge; when the

feelings are expressed, psychological, social or spiritual insights into conditions may be gained and behaviour modified. For many, this is a religious interpretation of a 'natural event', a sense of being 'healed' or of being 'touched by God'. Hypnosis, primal therapy, psychodrama and enthusiastic religion can all play a part in any abreactive process, which is gained through catharsis. What is clear from the ecstatic religious experiences that characterise the Toronto Blessing/Toronto Airport Christian Fellowship (TB/TACF) movement is that there are constituent gains in releasing rationality, control, emotions and the like. What the believer gains by yielding to the powers can vary: an altered state of consciousness, social integration or re-integration, increase in conviction, or relief from stress are all possibilities. Thus, the TB/TACF movement operates as a system of exchange. In order to benefit it is necessary to learn the cathartic processes before abreaction can be reached. This makes the movement profoundly individualistic....In spite of the numbers involved.....everybody is gaining something that is mainly of a personal nature, and will remain so." (Percy 1998:113)

There are two possible causes for concern about the way entry into dissociative states is induced during Vineyard style worship events. Firstly there is some danger that having engaged with a previously repressed trauma as a result of prayer ministry the person being prayed for could abreact very violently and then be recalled to the present suddenly in a way that compounded the trauma. In practice this does not appear to happen despite the fact that "prayer counsellors" are likely to lack therapeutical skills. What they lack in technical ability they usually make up for by a sense of genuine care and concern and stay with their client until the catharsis is complete and then gently and lovingly assuring him of God's presence and their own prayerful and loving support. The second concern is that someone who regularly attends such events could learn the ability to enter into a dissociative state at will. This is not necessarily bad in itself. Indeed it has been stated that the linking of such a state with a positive supportive environment is helpful in recovering from trauma. The danger arises where someone with an immature personality who is continually exhorted to allow God to do things to him not only cultivates a version of quietist spirituality but extends such an attitude to the whole of their life. Switching into a dissociative state to avoid any sort of minor unpleasant experience and abdicating ones own responsibility for decision making can happen to those of a suggestible temperament who would like God to control their every move. The use of hypnotism, trances and other dissociative states can have great benefits but also great dangers. Those who lead others into such experiences have a considerable responsibility to ensure that the skills so acquired are used wisely in conjunction with the intellect.

Chapter 10

Implications for Spirituality and Pastoral Care

An understanding of the mechanism of traumatic stress and the process of healing provides us with an insight into the human condition of every person.

The traumatised individual has lost internal integrity and in order to return to health needs to regain inner connectedness. He malfunctions because being inwardly fragmented he is unable to connect normally in loving relationship with his own body, his environment, other people and his creator.

Is this not a description of the effects of the fall? Surely the Genesis story is telling us that we are all traumatised. If this is the case then it is reasonable to assume that those activities and behaviours which promote the healing of trauma will also help to move people towards inner wholeness and a more perfect relationship with God, the world and other people.

In every age people have realised their need to connect better with others and with what is beyond their immediate experience. This search for wholeness is really the search for God, a desire to return to the state before the trauma of the fall. The myth of the 21st century is that this desire can be satisfied by better technological connectivity. As a result we see the growth of cell phone technology and the internet. Yet this can never satisfy our deepest needs.

The church can bring people closer to God by treating them as though they are all victims of trauma - because we all are. Everyone whom we meet should be guided through the trauma healing process outlined in Chapter 4:

- | | |
|-------------|---|
| Safety | - accepted and loved unconditionally resulting in a feeling of |
| security | |
| Integration | - helped to experience the world through Sensation, Image, |
| Behaviour, | Affect and Meaning and to make links between these elements |
| where | they are missing. |
| Duality | - provided with an opportunity to observe and experience at the |
| same | time and to be aware of the duality of this state. |
| Engagement | - encouraged to face the realities and dissonances of their life |
| accepting | that this will cause distress but offering a loving environment |
| where | this can be safely tackled |
| Safety | - brought back to a place of safety in order to begin the process |
| again | |

It is unsurprising that the above model gives a meaningful framework for the life and work of the average parish church as it has existed over many centuries. Intuitively we have engaged in pastoral work (Safety), provided a liturgical experience involving all the SIBAM elements (Integration), encouraged people to open themselves up to God in prayer and see themselves and the world through his eyes (Duality) and finally to accept responsibility for themselves and others knowing that as they enter into the mess of this world and their own interior lives

they are not alone because the incarnate Lord is with them by his Spirit.

Liturgy

The usual Sunday eucharistic liturgy of the average Anglican parish provides a co-ordinated experience of all the SIBAM elements. Here is an integrated whole, celebrated in God's presence. There is the smell of flowers and possibly incense, the familiar music of hymnody, (sensation) the colour of vestments, windows and the drama of the actions performed by the priest (image) the physical involvement in the service with different bodily postures expressing praise or penitence, sharing the peace (behaviour) the feeling of belonging, of being loved, of being caught up in the wonder of praise and the privilege of receiving the sacrament (affect) and help with understanding the meaning of life through the sermon (meaning). Into this integrated experience the individual is able to bring his brokenness and to offer his experiences where one or more element of the SIBAM model is missing that it may be linked to the perfect model of integrity and made whole.

Priesthood and Spirituality

The role of the priest is to make transparent the activity of God, to reveal the connections which are already in existence and need only to be recognised. He helps people realise that God acts not by intervening but by revealing the connections of which they had not previously been aware He teaches them that to believe in the existence of such connections is an act of faith. Wherever a new connection is recognised and an opportunity is opened up or a new integrity achieved there God is present. He is the one who holds all things together and we recognise his presence in the links between all that exists. Once we have this understanding of the nature of God we are able to understand prayer in a new way. It is not surprising that when people pray they often find the answer to their prayers in what others might describe as co-incidences and they perhaps might correctly describe as God-incidences. What God has done is help them connect with what was already there waiting to be discovered. This conscious opening to God to reveal connections might even explain why some Christians claim that God answers their prayer for a parking space. It is unlikely that he makes someone move out but he could just create an awareness of where a space already exists. Placing the difficult situations of life such as illness or unemployment into God's hands should not be seen as a request for him to intervene to change things but the expression of our desire to be more aware of the provision already in existence for healthcare and employment perhaps in places where we might not have thought to seek it. The purpose of daily prayer becomes an expression of our willingness to allow God to reveal where there is disconnection and to act as a co-ordinating principle in our lives. The priest helps his people to see the activity of God where they haven't already recognised it. The more they trust God the more signs of his activity they become aware of. When people live and work together in community and their connectedness increases so the more aware they become of differences. The conflict and distress which inevitably arises when we face the truth about ourselves and others is but a necessary step on the road to wholeness and holiness. It represents the engagement phase of the healing model when conflict threatens to overwhelm us but which correctly managed leads to a greater level of healing and integration before the cycle is repeated. The good news for any priest is that the regular outbursts of emotion are just as essential a component of the move towards God as are the times of safety and security. To feel that parish life goes

round in circles is an affirmation that we are following the trauma healing model which will lead fallen human beings from earth to Heaven.

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