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Pastoral Therapy/Counselling for Post-Traumatic Stress: A Neuropsychological Perspective

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ABSTRACT

The article takes a closer look at pastoral interventions with sufferers of post-traumatic stress. The limitations of two counselling approaches to address the needs of traumatised victims are explored. The two approaches are the ABCD model of Warren L Jones and the 132-RAP model of AJ Weaver. A case study is discussed to evaluate the value of the models. A Two-Factor Neurocognitive Explanatory Model is proposed to address the limitations of the mentioned approaches. The model addresses the role of spirituality , values and meaning which are of major importance for pastoral counselling .This model explains two aspects of the cognitive-affective interpretation of traumatic events. The factors are, firstly, neurological hypersensitivity comprising of augmented neurotransmitters, decreased inhibitory neurochemicals and changes in neuronal structures. The second factor is psychological hypersensitivity comprising of the violation of the victim's worldview regarding safety, security and sense of self. The implementation of an intervention based on the explanatory model is presented ..

1. INTRODUCTION

The author presents a case study, which is used as a point of departure for deliberating upon the contributions and limitations of selected approaches for counselling persons who suffer from trauma

Case 1

In June 2002 the personnel of a bank in the Limpopo Province

of the Republic of South Africa (RSA) were involved in an armed robbery. The personnel were performing their normal duties when there was a sudden uproar at one of the counters. An armed man threatened the personnel and demanded access to the safe. Another perpetrator used a crowbar in an attempt to enter via the glass windows separating clients from the personnel. As the personnel were moving instinctively backwards towards the safe at the back of the bank a gunshot was heard. A pastoral counsellor, who is also a professional therapist, was contacted by an EAP (Employment Assistance Program) agency to assist bank management with the stress management of the personnel involved in the attempted robbery. Three days later a first debriefing session was conducted and after three weeks a follow-up session. Assessment of the post-traumatic impact was requested with follow-up interventions in terms of the outcomes of the assessment.

The counsellor was confronted with the following questions:

What factors would he consider in assessing the emotional and spiritual needs of the personnel?

How would he evaluate their level of distress and their ability to cope?

If he comes to the conclusion that the survivors were suffering the effects of trauma, what action could be taken to assist the victims to cope in their trauma?

How do the victims interpret and find meaning in their trauma?

What are the stories of the clients?

Against the background of the impact of trauma on the mental and spiritual health of society the question arises whether clergy or pastoral counsellors are sufficiently equipped to handle people suffering from trauma.

2. IMPACT OF TRAUMA ON SPIRITUALITY

2.1 Approaches by clergy

The important role of spirituality in trauma counselling is recognised by both pastoral counsellors and counsellors working from a spiritual or pastoral viewpoint.

Spiritual development is a necessary result of trauma. Trauma results in an increase in the search for an expanded and more meaningful perspective of existence. (Decker, 1993: 34). Decker says that this "increased interest/request for purpose and meaning may not immediately result in improved psychological functioning." Wilson and Moran (1998) confirm that all traumatized people seek a proof that meaningful life is possible even if it remains open to debate wether faith and spirituality could facilitate improved psychological functioning.

They refer to research confirming that recovery from trauma depends on the ability of the survivor to establish a sense of continuity between pre-trauma part and post trauma present. The challenge is to bridge the gap between pre and post trauma religious beliefs, experiences and practices.

This sense for continuity can be achieved by means of the support structures offered through group identities.

Hyman and Yares (2002) says-

"We all need a religious, existential or secular filter through which to interpret the meaning of a traumatic event. The writers believe that this may be offered through religious institutions and the family".There is however a need for model which addresses the impact of spirituality in trauma based on a proper explanatory theory. "

One example is the approach by Erasmus (1983) a hospital chaplain in the South African Defence Force. He addresses the need for finding meaning by injured and disabled soldiers in the South African National Defence Force. His approach is a typical example of pastoral therapy from a confessional or systematic theological view with no proper understanding of the cognitive processes involved in trauma. He address aspects like the God image and suffering as a theological concept. The focus is on the faith of the traumatised person as the transforming power. This approach by Erasmus however does not addresses the existentiality of the traumatised. In the 1980's South African National Defence Force Chaplains were trained to handle crisis counselling and the debriefing of soldiers in combat. A section in the training manual distinguishes between the approaches of the pastor and other professionals. It states: "The main aim of crisis counselling is spiritual growth, a more ma-

ture relationship with God. The pastor must not replace the role of the psychologist – psychological insights can, however, be of some help".

Sinclair (1993:113), an Episcopal priest and licensed therapist, contributed a spiritual approach by stating that PTSD – "is first and foremost a spiritual disorder and healing must come from within spiritual context". He gives a Biblical approach based on hope, trust and relationships to address spiritual needs ranging from loss of trust, loss of faith, loss of innocence, loss of hope, loss of purpose, loss of meaning and loss of joy.

His approach is however mainly based on his observations from counselling sessions and lack a proper theory. He says: " In addition to the psychological effects of trauma there are many other effects including spiritual losses. This experience is difficult to explain … there is no need for explanation, it is the awful rescue from pain that we need to address".

Nancy Reeves (2001: 14), a clinical psychologist specialising in the treatment of traumatised clients, and working from a Christian perspective became aware of a number of spiritual issues associated with PTSD. She says: "I treated nightmares associated with PTSD very differently than ones brought to me by clients with other concerns. It is I believe - counter therapeutic to initially look for deep meaning or psychological or spiritual issues."

Her observation leads to the confirmation that a pastor/counsellor needs to see a crisis immediately as an opportunity to address spiritual growth, but more important, it opens up the following questions:

When is the right moment to intervene?

In which way (my relationship, my scripture use, my rituals, my prayer) should it be done?

The mere presence of the pastor can convey a spiritual dimension in counselling.

Howe (1988: 230) formulates the impact of this presence as follows: "I believe that close to the very heart of pastoral work is that enlivening and encouraging pastoral presence which supports change in the face of obstacles and overwhelming anxiety".

These approaches confirm the importance of spiritual aspects in

counselling of victims of trauma but it also confirms the need for an explanatory theory to research and develop the interconnectedness of spiritual and psychological aspects.

Thayer (1985) in his discussion of spirituality in pastoral care formulates this perspective eloquently by saying –

"Although the aim of intervention for the pastor is not only the restoration and strengthening of coping abilities (ego strengths) but the utilization of the experience as a whole for deepening the person's consciousness of his or her life in its dimension of awareness of responsiveness to 'the actualization of power and meaning in unity" (1985: 65).

2.2 Approaches by behaviourists

There are at least two current theoretical models from the behaviour sciences for the conceptualisation of spiritual interventions as a result of trauma.

The first one is Logotherapy developed by V Frankl, the Swiss Psychiatrist. This approach was developed as outcome of a first –person experience of the Holocaust. Frankl (1984 , 60)focused on the concept of the Freedom of the Will (freedom of choices) of victims of trauma. He explained the concept of Logo (meaning) as a personal destiny and calling: " Life ultimately means taking the responsibility to find the right answer to its problems and to fulfill the tasks which it constantly sets for each individual. These tasks and therefore the meaning of life , differ from man to man , and from moment to moment. Thus it is impossible to define the meaning of life in a general way. Life does not mean something vague but something very real and concrete. They form man`s destiny, which is different and unique for each individual" This approach focused on the individual mastery of trauma The validity of this approach is confirmed by Vaughan (1985) who asserts that that feelings of helplessness and inability to change occur when the external environment is seen as the primary cause of events.

A new sense of meaning is however the result of the discovery of an internal reality, independent of but capable of interacting with the external environment.

The second model is the well known Twelve Steps Recovery Program for Survivors of Traumatic Experience developed by Jo Brende (1995). He says that the aspects of guilt, shame, demoralization and spiritual alienation associated with PTSD symptoms are neglected in traditional treatments which focus on resolving of primary symptoms of intrusive recollections, emotions and numbing.

He develops a recovery approach based on the concepts of belief / faith and surrender to God and acceptance of forgiveness.

The concept of surrender is developed as a core concept and the aim is freedom from the bondage of victimization for PTSD victims .The Twelve Steps evolve around twelve core values. One of the twelve is –Seeking Meaning. Adressing this aspect includes =sharing of trauma with others , accepting support and understanding ,listening to others who found meaning in trauma . Clear steps are described –

Seeking – support, understanding and direction from God and others

Acknowledging – that it is difficult to find meaning

Surrendering – your despair , confusion and meaninglessness

Taking action - to seek answers from God , friends and listening to stories of survival .

Daily prayers- for the courage to seek clarity rather than to remain a prisoner of confusion , despair and selfpity .

This approach focuses on the support of peergroups and interaction. These approaches confirm the importance of spiritual aspects in counselling of victims of trauma but it also confirms the need for an explanatory theory to research and develop the interconnectedness of spiritual and psychological aspects .

Pastoral counselling for people in trauma also requires an intervention model that can touch the needs of the people in a holistic way. In his comprehensive work on Christian counselling Collins (1988:78) links trauma to a life-long legacy of anxiety by stating: "For years after the trauma some people have nightmares, irrational fears, depression, worry and loss of interest in activities that once were pleasant". He however does not develop a model but offer only some guidelines for psychological first aid.

In the search for a pastoral counselling approach to address the

challenges of Post Traumatic Stress it was imperative that the approach need to be "real, logical and purposeful". ("Wilson and Moran 1998) and that the approach must allow for continuity and unity in a counselee`s faith (Decker, 1995). Decker makes a case for the incorporation of spiritual counselling into therapeutic schemata devised by clinicians. He verbalises a concern that counsellors are not catechists and that proselytising during therapy is not appropriate. He also warns that the use of abstract concepts and metaphysical hypotheses are ineffective. In a similar way he says that different theologies offer different articulations of the theology of suffering. He mentions redemptive suffering, altruistic suffering and submission to the divine will – but that "may be counterproductive concepts in trauma therapy".Wilson and Moran (1998: 173) are of the opinion that "an integrated and holistic plan of treatment would benefit spiritually those who suffer from grave psychological trauma and PTSD. An integrated model greatly enhances the ability of the therapist to understand and treat the whole person". Psychological trauma and PTSD constitute a grave threat to the spirituality and faith for the believer. Faith and spirituality lead to confidence in the congruency of life and the orderliness of the world. Faith also offers meaning, relevance and coherence in life (Meissner 1987, quoted by Wilson & Moran 1998). However, once faith is shattered because of trauma then a person loses his/her sense of coherence and confidence. An astute incorporation of spiritual counselling into various therapeutic schemata devised by clinicians will contribute greatly to securing a "why" for which victims of psychological trauma and PTSD can live" (Wilson & Moran 1998:176).Brende (in Everly & Lating 1995) mentions the lack of contributions in the literature on trauma counselling on the treatment of aspects like self–esteem , spiritual integrity and sense of purpose .The search for an intervention approach which addresses beliefs, values and finding meaning is the challenge of this article.

3. IMPACT OF TRAUMA ON BELIEFS ,VALUES AND MEANING

3.1 The impact of neurologic hypersensitivity :insecurity and withdrawal

Research by Van den Blink (1998) mentions "emotional hijacking" and "pre-cognitive emotion" as the results of trauma . He refers to research by Joseph le Deux, (1996) a researcher at the Center for Neural Science at New York University.This research confirms that the sequence of transmissions in the neural pathways of the brain are different when a person is traumatized. Le Deux explains his theory as follows:

"The prevailing view is that some kind of cognitive activity always precedes the activation of emotions. More precisely – the thalamus which receives inputs from all senses was always thought to transmit these stimuli to the neo-cortex, the thinking area, and especially to the hippocampus which is the focal point for cognition , decoding,and organising of perceptions and to make sense out of the stimuli. After hypothesizing and attributing meaning, the neo cortex in turn signals the amygdala which registers and emits emotions. The sequence of transmissions was believed to follow the neural pathways from thalamus to neo-cortex to amygdala. (Le Deux, 1996, p154-158).

Le Deux proved convincingly that this prevailing view is not always the case. He has found that "pre- cognitive emotion" results from various bits of sensory stimuli coming from within and from without which have not being sorted out by the neo- cortex and are not in conscious awareness. And these "pre-cognitive emotions impacts on behaviour. He mentions anxiety, panic states, chronic depressions and amongst others post-traumatic stress syndromes.

Van den Blink`s (1998, 32)) comments on the complexity of these psycho systems are – "research has shown that the mind does have many parts capable of encoding and storing memories and that only a fraction of all that activity is available to our conscious awareness. Our therapeutic models have not even begin to take into account the complexity of this multi levelled and multi factional mental activity."

Jensma (1999), a specialist in the field of integration of theology and psychology ,confirms in her research that almost all physical, emotional, cognitive, behavioural and spiritual effects emanate from neuro-chemical and physiological changes.

She refers to research by the neuro – science division of the National Center for PTSD at West Haven Connecticut. This research confirms that trauma leads to abnormal brain lateralization resulting in "scared speechless". It helps to explain why sometimes a person is not able to put a traumatic experience in words. The "shutting" down of the left hemisphere of the brain makes debriefing or "talk therapy" difficult and ineffective.

Jensma (1999) refers to research by Vincent (1990) and Butler (1996) experts on the neurochemical effects of changes in brain physiology to explain memory loss due to traumatic exposure. Atrophy of the hippocampus (the focal point for cognition in the brain) is the result of the release of cortisol by the adrenal glands when stress is encountered. The result appears to be the destruction of neurons in the hippocampus. Butler (1996) adds to this view and refers to the role of epinephrine and non epinephrine which results in memory loss, increased emotional reactivity, generating of heightened startle response, hyper vigilance and vulnerability to emotional regression. Trauma results not only in memory loss but also in the loss of activity in the left hemisphere of the brain which controls most verbal functions. New trauma seems to follow the pathways of the old thus" shutting down" the left hemisphere of the brain.

The impact of PTSD on the rational choice making ability of the neocortex is confirmed by Smith and Jones (1993) in their research at the Biofeedback Institute for counselling of veterans of war . Their research confirms that when there is insufficient cortical guidance, traumatized people revert to a primitive form of sub- cortical learning named neophobia meaning fear of the new. Neophobia means that people keep making familiar choices and resent in pain rather then making an alternative choice to end pain. Smith and Jones (1993) propose that this neophobic learning ,results in fundamental ontological insecurity. Ontological insecurity means that a traumatized person sees only the possibility of being terro-

rized, engulfed or invaded and that they fear other people as continuous threats to their existence. These observations mean that reason and insight are far less influential in counselling than often are thought to be. The shutting down of the verbal capacity of the brain makes it not unusual to experience withdrawal from God , inability to read or pray , difficulty attending church meetings or engaging in various forms of fellowship and the questioning of spiritual values and even doctrines . Much of the distorted thinking in the wake of trauma including thinking about spiritual aspects is a result of the neurobiological abnormalities induced by trauma .

PTSD however does not only results in insecurity, withdrawal and questioning of values but also in a distorted worldview .

3.2 The impact of psychological hypersensitivity on worldview .

James Ashbrook (1996) suggests an affinity between left and right brain cognitive processes and patterns of belief. He associates the right brain with a "sense of wonder, and belief in the locus of manifestation, with savouring the goodness of creation, opening ourselves to the goodness within us and around us". He associates in a similar way the left brain with a "belief in the locus of the holy being known in definite commandments and imperatives". His double brain view focuses on the role of beliefs for a secure worldview . Ashbrooks' double brain view links with the two factor model developed by Everly and Lating (2004). They developed a synergistic personality guided approach to PTSD treatment. In stages 4 and 5 of their approach they confirm the importance of the challenges to assumptive worldviews , adversely impinged on by the traumatic event. They focus on three primary assumptions useful in restoring the functional utility of core worldviews or beliefs.

The three core assumptions or beliefs are:

- The world is benevolent
- Events in the world are meaningfull
- The self is positive and worthy (Everly and Lating 1995: 77)

These core beliefs are influenced by the combined contribution of both hemispheres of the brain. All complex activities of the brain are integrated functions enabled by the Corpus Callosium, a great

fibre which enables coordination of both sides of the brain.
These core beliefs or assumptions are grounded in the early preverbal experiences of the child and are disrupted by trauma . Decker (1993) refers to research with survivors of horrific trauma who truly managed to experience the trauma without developing the difficulties associated with PTSD.

He says the majority of theoretical explanations of how beliefs influence responses to trauma are based on the concept that beliefs are the result of interaction with the environment (Interaction –Based Beliefs) This view which is developed by Janoff -Bullman, Wilson, McCann and Pearlman, Catherall and Benyahar (Decker,1993) supports the conceptualisation by Everly and Lating of PTSD as "shattered worldviews and beliefs" based on experiences of the external world and external events in life .

Decker (1993: 21) says that PTSD has its greatest impact if belief systems – "have been developed primarily based on consequences of behaviour, personal identity based on external roles and existential meaning dependent on external success". Decker refers to a second development of belief systems named the Internal-Based Belief System.

"If our development of beliefs has included existential questions of freedom, isolation and death that demand authentic answers ,a genuine sense of self may be available when trauma occurs and demands an expanded depth of awareness." (Decker, 1993: 25).

This discovery of an internal reality, independent of the environment ,demands a modification of one's self and of the emotional investment in the original beliefs based on the external reality. He refers to extensive interactions with individual survivors of the Vietnam conflict and he concludes that there is one main reason why some survivors did not display or develop the symptoms of PTSD.

That reason is not that the survivors are in denial or using defence mechanisms to create superficial appearances but that their beliefs are founded on inner realisations which are less disrupted by trauma than are beliefs formed from interaction with the environment.

In this paragraph it became clear that the impact of PTSD on beliefs depends on the factors of interaction- based beliefs or on

internal-based beliefs . How beliefs developed and are maintained in pre-trauma life is a crucial factor determining how trauma is perceived.

4 INTERVENTIONS FOR TRAUMA

From the ABCD model to a Two Factor Integrative Model. The search for a proper intervention approach starts with the well known ABCD model and lead to a neuropsychological approach

4.1 The ABCD Model

A model, which occurs commonly in books on crisis counselling written for pastors, is named the ABCD model and was originally developed by a psychiatrist Warren L Jones. The model is used amongst others by H J Clinebell (1966, 1984),D K Switzer (1974, 1986) and H Stone (1976).

ABCD is an acronym for four stages, namely:

A- Achieve a relationship
B- Boil down the problem (to its major parts)
C- Cope actively with the problem and challenge the clients to take constructive actions
D- Develop an ongoing growth-action plan.

The model includes several elements that are part of the first-aid plan as well, since the pastor may have been involved from the onset of the crisis.

Relevance for the case study

With reference to the case study the counsellor could only addresses specific faith issues in a second session a month after the robbery. A proper understanding of the stress levels of the people involved is not properly addressed in the ABCD model. This approach does not address the experience of hyper-arousal due to trauma or the disturbed worldviews . It only refers to “consensual formulation” to reduce the stress levels.

4.2 The 132-RAP model of PTSD

Weaver (1993) developed a model for clergy based on a quick reference guide from the comprehensive Diagnostic and statistical manual of mental disorder (DSM-R) - Revised (1994). From his research it is clear that, in the USA, clergy are extensively involved in the care of persons who have been exposed to traumatic stress.

Weaver developed a 132 RAP model. The model aims primarily to sharpen the skills of clergy to recognise and evaluate PTSD.

PTSD may be understood by grouping the symptoms into three types, namely re-experiencing (intrusive), avoiding, and physical hyper arousal (RAP) as set forth in the American Psychiatric Association's Diagnostic and statistical manual of mental disorders - Revised, 1994.

Re-experiencing takes the following forms, namely:

- recurrent and intrusive, distressing recollections of events (in young children, repetitive play in which themes or aspects of trauma are re-enacted)
- recurrent distressing dreams of the events
- sudden acting or feeling as if the traumatic event were recurring
- intense psychological distress at exposure to the events that symbolise or resemble an aspect of the trauma, including anniversaries of the experience (eg Vietnam veterans re-experience combat trauma at hearing the sound of a helicopter flying overhead).

Avoiding may take the following forms, namely:

- efforts to avoid thoughts or feelings associated with the trauma
- efforts to avoid activities or situations that arouse recollection of the trauma
- inability to recall an important aspect of the trauma (psychogenic amnesia)
- markedly diminished interest in significant activities, also very common in depression (in young children, loss of recently acquired developmental skills such as toilet training)
- a feeling of detachment or estrangement from others
- a restricted range of affect (commonly the loss of feelings associated with intimacy, tenderness and sexuality)

- a sense of a foreshortened future, especially in children (e.g., gang members who take life-threatening risks because they have lost faith in the future).

Physical hyperarousal may appear in the following ways:

- difficulty in falling or staying asleep
- irritability or outbursts of anger
- difficulty in concentrating
- hyper vigilance/hyper alertness (always "on guard" and forever vigilant)
- exaggerated startle response ("very jumpy behaviour")
- physiological reactivity upon exposure to events that symbolise or resemble an aspect of the traumatic event (e.g., a woman who was raped in a church breaks out in a sweat when entering a church).

In order to meet the criteria for the diagnosis of PTSD, an individual must have one Re-experience symptom, three Avoiding symptoms, and two Physical hyper arousal features (RAP-132). These symptoms must be present for a minimum period of one month, although not necessarily all at the same time. They must stem from an event outside ordinary human experience, which would be distressful to almost anyone. In some cases, PTSD can be delayed and first manifest itself six months or more after the traumatic stressor.

Relevance for the case studies

Weaver's model is of value because it is based on the DSM diagnostic criteria. His model empowers counsellors in terms of their evaluative skills. He summarises the diagnostic criteria to focus on three clusters of criteria:

Cluster 1: A pattern of intrusive re-experiencing of the events as if they relive the traumatic experience over and over.

Cluster 2: Robot-like numbness and appearing distant, cold, unfeeling and uncaring.

Cluster 3: Sleep disturbance which may involve nightmares.

In terms of the case study all the personnel fitted the criteria although in different degrees of severity. After a month some people recorded intruding nightmares as well as re-experiencing of the events. Only a few people recorded numbness and labile affect.

Weaver's model based on the DSM-III-R however lacks in terms of the importance of contextuality of victims of trauma .and he did not address the impact of trauma on the spirituality and meaningfulness of trauma on survivors of trauma.

In view of the evaluation of the two above-mentioned approaches, an integrative two-factor neuropsychological model is proposed.for use by pastoral counsellors The aim is to address the limitations of the two mentioned approaches. The ABCD approach does not address the factor of hyperarousal appropriately and the 132-RAP model does not address the issue of the meaningfulness and of spirituality in trauma counselling .

4.3 A Two-factor Neuropsychological Integrative Model

To address the need for an integrated model to enable pastoral counsellors to counsel traumatised people holistically a two factor integrated model is proposed. An integrated approach can empower counsellors and pastors with both an explanatory theory for the effects of trauma and with a model to intervene. Everly Jr (1995) developed a two-factor integrated neurological model. Motivated by Kardiner (1941) who viewed PTSD as a "physioneurosis", the APA (American Psychiatric Association) operationalised post-traumatic stress as a form of anxiety disorder blending more primitive physiological elements with higher order cognitive and affective processes (Everly & Lating 1995: 28). The development of Everly's model is represented in two figures (Refer to Figures 1 -2). Everly intended to bring more "phenomenological order" to the DSM criteria of PTSD. The three clusters of symptoms of the DSM are blended into one psychophysiological construct.

Figure 1: A model of post-traumatic stress disorder

Figure 1 explains the model with reference to three aspects:

Aspect one - immediately after the traumatic shock a person suffers an acute hypothalamically numbing reaction

Aspect two - this is followed by a cognitive interpretation by the victim of the event.

Building on the pioneering work of Pierre Janet, Everly confirms that, "it is the cognitive appraisal of the traumatic event, in combination with the resultant emotion, that ultimately determines the intensity of the traumatic stressors' overall impact upon psychological functioning and whether the reaction is pathological" (Everly & Lating 1995: 29).

Aspect three -neurological arousal and intrusive cognitive recollections are the two core constituents emanating in , avoidance and withdrawal behaviour. From the epiphenomological construction a two-factor neurocognitive process model is revealed (figure 2).

Figure 2: A two-factor formulation of post-traumatic stress

Factor one - A neurological hypersensitivity - a propensity for neurological arousal existing in the limbic circuity and its newal effectors (amygdaloid and hippocampus).

Kardiner (1941) coined the term "physioneurosis" referring to a combination of five biological and psychological phenomena, namely:

- an exaggerated startle reflex and irritability
- atypical dream experiences
- a propensity for explosive and aggressive reactions
- psychic fixation upon the trauma
- constriction of personality functioning.

PTSD is viewed as a pathological inability to modulate arousal of the central nervous system.

The person suffering from PTSD is neurologically sensitised resulting from:

- an augmentation of neurotransmitters e.g. norepinephrine, dopamine, glutamate
- decrease in inhibitory neurochemicals eg gonna aminobutyric acid
- changes in neuronal structure, a decrease in inhibitory receptors.

Intense stimulation can create permanent change in the limbic system of the brain. The over stimulation of neural cells by lactic acid may lead to neural cell death. The toxicity within the hippocampus

and corpus callosum cells explains aspects of memory and concentration disfunctioning, aggressive behaviour, diminished social or family bonding and diminished affiliative behaviour.

Factor two - A psychological hypersensitivity. This psychotraumatogenic process may be viewed as some form of violation of the person's worldview (Weltanschauung) regarding safety, security or overall sense of self causing difficulties to assimilate the trauma in the person's idiosyncratic worldview. A person's worldview refers to safety and security as well as to aspects of his/her self-perception.

The achievement of any predetermined life goal rests on a functional environmental model interacting with an organismic model (self). Trauma causes a contradiction of extant environmental and organismic models and the reintegration of the image of the trauma into some meaningful context. Trauma is the antithesis of order, safety and security because it challenges previously constructed assumptions.

"Victimisation is not readily assimilated into his or her conceptual system" (Janoff Bulman, in Everly & Lating 1995: 77).

Traumatised people need to re-establish an integrated organised set of these basic assumptions. The trauma must be assimilated into the victim's world. The need for an integrated stable conceptual system is so urgent that people are able to even view victimisation as "positive" (eg defending bank robbers in Stockholm – "Stockholm Syndrome" in an attempt to maintain a belief in a benevolent world in which safety and security are maximised).

A trauma intervention which is based on the two factor approach is the Synergistic Personality Guided Approach developed by Everly GS & Lating JM. (See Addendum for a framework). Based on the Two-Factor Integrative Model of Everly & Lating (2004) the approach focused on (a) desentization and stress management stage and on (b) the restoring of functional core assumptive worldviews.

The two factors determine specific interventions with the traumatised people. In terms of the first factor (neurological hypersensitivity) the use of relaxation response proved to be the ideal strategy for the treatment of PTSD.

Weil (Everly & Lating 1995: 162) discussed four mechanisms by which the limbic system in the brain may be relaxed and restored, namely.

- reduction of the intensity of stimuli
- reduction of the rate of stimuli
- deep tactile pressure (e.g., massage)
- shift from stimuli specificity to stimuli nonspecificity.

There is however no research to demonstrate a best technique but every case should determine a specific intervention for stress reduction.

Psychotropic medications may serve a valuable function for desensitisation eg benzodiazepines, anti-depressants and anti-convulsants.

Interventions in terms of the second factor (the psychological hypersensitivity) focus mainly on the contradictions in terms of the worldview of traumatised people - the shattered sense of safety/ security and the self-perception.

The main aim is formulated by Janoff Bulman (Everly & Lating 1995:165): "From a cognitive perspective the key to the victim's recovery process is the re-establishment of an integrated, organised set of basic assumptions.... The traumatic event must be assimilated into the victim's assumptive world, or the assumptive world must accommodate the new data". This world incorporates the world of God and of faith.

The goals of intervention in terms of the second factor can be summarised as follows. Methods for cognitive change entails two aspects namely a worldview and self-perception. The counsellor needs to assist the person to integrate trauma into his/her extant Weltanschauung (worldview), to create a parallel Weltanschauung, and to create a new Weltanschauung. In terms of the second factor the person needs guidance to achieve enactive attainment, vicarious learning, verbal persuasion and physiological self-regulation.

The neuropsychological two factor approach opened possibilities to address the beliefs , values and meaning-finding by victims of trauma.

In this approach three primary strategies are usefull in restoring the assumptive worldviews –

An integration of trauma into a person's existing worldview to understand an assumptive event as consistent with the person's worldview.

Allowing the traumatic event to be understood as an exception to an existing worldview which does not invalidate the overall utility of the general assumptive worldview.

Acknowledging the disconfirming invalidating nature of the traumatic event on the assumptive worldview which necessitates the creation of a new worldview to accommodates a new worldview.

This process implicates six cognitive reinterpretations –

- Reinterpreting the traumatic event as considered a personal success and not a failure.
- Reinterpreting the role of the patient played in the etiologic of the trauma. (E.g. self blame).
- Reinterpretation of the trauma as an event possessing some positive or redeeming aspects. (E.g. you can learn from it, it could have been worse).
- Reinterpretation of the overall importance of the event eg it is less important as determinant form happiness.
- Comparison of oneself with other victims of trauma.
- Recognizing the rate of personal recovery.

Healing is determined by the sense of safety within the therapeutic relationship and on the moment when the victim can extend into the world outside of therapy.

This approach is well described by the greatest endocrinologist of his time and founder of the "stress" concept Hans Selye – who said- "It is not what happens to you that matters, but how you take it". A subjective interpretation of traumatic events was incorporated in the DSM-IV in 1994. The use of concepts like "fear, helplessness or horror" are clearly states of subjective interpretation. Until that time the DSM-IV focussed on objective symptoms. Based on a review of relevant literature there appears to be at least five core assumptive explanatory worldviews (Everly & Lating, 2004, 37).

These include the following –

- Violation to the assumption that justice and fairness must prevail.
- Abandonment, treachery, betrayal especially if perpetrated by a trusted person, organization or institution.
- Threats to or violations of the physical safety of oneself or others.

- Contradiction to the view of oneself in a positive, self-efficacious perspective. (Self-efficacy and self-esteem).

A disruption to or violation of some deeply held overarching assumptions about life and perhaps death. The belief in some overarching meaning or order in life – for example, religion, spirituality or faith in a defying order or unifying paradigm. Trauma results in a crisis of faith or of religion or an existential crisis when this worldview is isolated.

Relevance for case study 1

Trauma debriefing was requested and started with a detailed discussion between the counsellor and the Human Resources Manager to get all the relevant information. A short self-awareness session was the next step. An integrative approach to incident stress reduction was used, applying the Model of Critical Incident Stress Debriefing (CISD) of Meichenbaum (1994).

The model is a phase model consisting of the following:

- Introductory phase to provide ground rules
- Fact phase to establish what happened
- Thought (Cognition) phase to discuss thoughts about what happened
- Reaction (Feeling) phase to discuss emotions associated with the event
- Symptom phase to review signs and symptoms of distress
- Teaching (Educational) phase to emphasise "normality" along with information about useful coping strategies
- Re-entry (Wind-down) phase to discuss outstanding issues, and to offer summary statements and any additional advice.

Personnel were asked individually to give a detailed account of the incident. They were encouraged to give as many accounts of the incident as possible. The aim was to encourage them to express their experiences in detail. This intervention is based on the Trauma Desensitisation Technique (TDT) developed by Nancy Reeves in the 1980's. TDT relies on the principle that it is impossible to maintain anxiety when you are concentrating deeply (poor concentration is common in PTSD). The autogenic method was also used.

This method is a stress reduction intervention in which stress is gradually reduced in short steps. Everyone participated. Three people were absent - L because of her pregnancy, R left the bank earlier in the day and A was on leave. Their stress levels were measured by means of the Subjective Unit of Disturbance Scales (SUDS). SUDS is a measurement of stress on a scale of one to ten. Personnel were then issued with a comprehensive questionnaire - the Violent Crime Victim Interview Schedule to be completed before the next session in July 2002. From the questionnaire it was possible to evaluate the post-traumatic stress symptoms, the neurological hypersensitivity as well as the psychological hypersensitivity of each person.

During the second session personnel were once more given the opportunity to recall their memories of the incident. The whole group then participated in a stress reduction exercise, "Healing negative memories", in which the brain waves are reduced to alpha rhythm to enhance concentration.

This was followed up with individual counselling sessions with every person. In the sessions the outcomes of the questionnaire were discussed. From the reports it was clear that everyone was shocked and reacted in disbelief that the incident could have happened in their bank. What was also clear is that the trauma triggered past traumatic experiences in some of the personnel. They could then in counselling talk about it. Some expressed a wish to be transferred while others talked about marriage problems. Some had faith questions. The interviewed personnel however were emotionally in control. Their stress levels were again measured with the SUDS (Subjective Units of Disturbance Scale). All SUDS measured below four out of ten with the exception of three persons. More individual counselling sessions were conducted with these three people. The counselling was based on the Synergistic Personality Guided Approach. The outcome was that they accepted what happened and decided to be more careful in future. It was only in the individual sessions that the counsellor could address religious, worldview, self-perception and relational issues depending on the specific needs of people.

DISCUSSION OF RESULTS

This research confirms that clergymen /pastors and counsellors who are conversant with knowledge about the Two-Factor Neurocognitive Model are better equipped to counsel people suffering from PTS. The Everly Model not only explains the psychological hypersensitivity factor but also the neurological hypersensitivity factor. The discussion of the case study makes it clear that both factors need to be addressed in counselling. It is confirmed that spiritual and meaning-making issues can only be addressed after traumatised people are neurologically desensitised. Pastoral counsellors need to be trained to:

- use a comprehensive assessment instrument
- intervene with techniques for stress reduction
- conduct a spiritual recovery programme.

In view of the above-mentioned model, the ABCD Model and the 132 RAP Model are evaluated as of limited use for pastoral counselling.

6. CONCLUSION

More people than we are aware of live with the symptoms of PTSD. Reeves (2001:16) quotes a lady suffering from PTSD for 20 years, who said: "I came to talk to become more effective in helping others. I realise now that I've had PTSD for twenty years due to one physically abusive contact with a relative. I knew it had affected me and have done therapy around it. I've never been desensitised though to my aversion to bald men. I think this is one reason I went into youth ministry. I don't flee from the room when I see a bald man; but I definitely feel anxiety and would never turn my back on him. I think I need to be desensitised. So many of my male friends are starting to lose their hair!"

There is a lack of competently trained counsellors who can integrate spiritual and psychological needs. The proposed model is a contribution to this field.

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ADDENDUM A: POST TRAUMATIC STRESS DSM-IV POST-TRAUMATIC STRESS DISORDER CRITERIA

A The person has been exposed to a traumatic event in which both of the following were present:

1 the person has experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others;

2 the person=s response involved intense dear, helplessness, or horror (in children, disorganized or agitated behavior).

B The traumatic event is persistently re experienced in at least one (or more) of the following ways:

1 recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions (in young children, repetitive play may occur in which themes or aspects of the trauma are expressed)

2 recurrent distressing dreams of the event (in children, there may be frightening dreams without recognizable content)

3 acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated) (in young children, trauma-specific reenactment may occur)

4 intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

5 physiologic reactivity1 on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three (or more) of the following:

1 efforts to avoid thoughts, feelings or conversations associated with the trauma

2 efforts to avoid activities, places, or people that arouse recollections of the trauma

3 inability to recall an important aspect of the trauma
4 markedly diminished interest or participation in significant activities
5 feeling of detachment or estrangement from others
6 restricted range of affect (e.g., unable to have feelings)
7 sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two (or more) of the following:
1 difficulty falling or staying asleep
2 irritability or outbursts of anger
3 difficulty concentrating
4 hyper vigilance
5 exaggerated startle response

E Duration of the disturbance (symptoms in Criteria B, C and D) is more than one month

F The disturbance causes clinically significant distress or marked impairment in social, occupational or other important areas of functioning

Specify if:
With Delayed Onset: onset of symptoms is at least six months have passed between the traumatic event and the onset of the symptoms
III Partial PTSD
1 Meeting criterion A (stressor) and criterion E (symptoms evident for a least one month)
2 Five or fewer of the symptoms from criterion B, C and D (re-experiencing, avoidance, and hyper arousal); whereas PTSD requires 6 or more symptoms

ADDENDUM B: A SYNERGISTIC PERSONALITY GUIDED APPROACH

In line with the abovementioned explanatory model for PTSD Everly and Lating (2004) developed a synergistic, personality guided therapeutic approach. This approach entails five stages.

Stage 1: Telling the "Trauma Story" and the Formation of the Therapeutic Alliance

Every traumatic incident involves a story that needs to be told and that needs to be heard. In a calm and accepting manner, the therapist encourages the patient to tell this story. The story will usually consist of four components. Although the story is not fully told until all components are described, the patient may simply not be able to fully describe all of the elements listed in the earliest stage of therapy. Nevertheless, the therapist should inquire about:

A description of the traumatic event.

A description of signs, symptoms, and any other personal reactions or changes in behavior that are a consequence of the traumatic event.

Any reactions or changes in behavior demonstrated by family members, friends, coworkers, or others that appear to be a direct, or indirect, consequence of the traumatic event.

Any anticipated changes to the patient's personal life, career, or interpersonal relationships in the future as a result of the traumatic event.

The order of the four revelations in stage 1 are of less importance than is the need to allow the patient to tell the story in a supportive, accepting, and safe setting.

Stage 2: Providing Information

Information is usually an anxiolytic. Many patients indicate that the worst part of being "ill" is not knowing what is wrong and not having prognosis of some kind. This stage is designed to remedy this concern. To the degree to which it seems appropriate, the therapist should provide hope, reassurance, and as much of a technical explanation of the patient's signs and symptoms as seems useful.

The concept of being a survivor: "Survival is an achievement" (Lifton 1988:8).

The role of human connectedness in survivors. Trauma engenders a discontinuity, a strain on interpersonal relationships, even family relationships. Recovery entails becoming reconnected.

The symptoms of dissociation represent a form of disconnectedness. Dissociation may be seen as a natural human response to

extreme stress. The vulnerability for dissociation is present in all humans in varying degrees.
PTSD is a "normal adaptive process of reaction to an abnormal situation" (Lifton 1988:9).
Survivor guilt is a common posttraumatic reaction for the perception of having failed to halt the traumatic event or the failure to help others.
Depression, even psychic numbing , is an extreme form of dissociation and represents a discontinuity of the self.
The search for meaning is intimately involved in psychological trauma. According to Lifton (1988), "Without addressing this idea of meaning ... we cannot understand post-traumatic stress disorder" (p. 10).
Psychological traumatization and recovery involves issues of the transformation of the self.

Stage 3: Neurological Desensitization and Stress Management
As soon as reasonably possible, the therapist should consider initiating efforts to neurologically desensitize the neural hypersensitivity that is a hallmark of PTSD. The more severe the PTSD, the more important direct efforts to desensitize become. Initially, we believe that behavioral techniques should be used. Should these efforts prove of no avail, or should the severity of the neurological arousal be assessed as self-sustaining, then psychotropic medication should be considered. Ultimately, we conceive of the patient with PTSD as suffering from a state of pathognomonic ergotropic tone. Efforts will usually need to be directed toward altering this neurological status in the trophotropic direction.

Stage 4: Identifying the Assumptive Worldview Most Challenged or Adversely Affected by the Traumatic Event
This stage in treatment is not necessarily a discrete stage per se but rather a process. It represents a process of discovery wherein the therapist carefully listens to the trauma story as told by the patient and attempts to identify the core assumptive worldview(s) most challenged or adversely impinged on by the traumatic event(s).

Stage 5: Restoring Functional Core Assumptive Worldviews

It may well be that the sine qua non of recovery from psychological traumatization is the restoration of adaptive functionality to the core assumptive worldviews. Certainly, we believe the greatest degree of recovery is achieved by doing so.

We believe that there are three primary strategies useful in restoring the functional utility of core assumptive worldviews (Everly 1994, 1995):

Integrating the traumatic event into the patient's existing worldview in such a way that the patient comes to understand the event as actually consistent with the worldview (i.e., the event did not in actuality violate any core assumptive worldviews).

Allowing the traumatic event to be understood as an exception to an existing worldview (i.e., and "exception to the rule"), which despite its existence represents a low probability occurrence and does not serve to invalidate the overall utility, or functionality, of the general assumptive construction; thus, life as the patient knows it goes on.

Acknowledging the disconfirming, invalidating nature of the traumatic event on the assumptive worldview, thus necessitating the creation of a new worldview wherein the trauma more readily fits. The difficulty inherent in such a process is clearly mitigated by assisting the patient to use the traumatic event to lead to a revelation of self-efficacy or to the revelation-creation of some greater good to self, family, or society that grows out of the traumatic experience.