

**A PASTORAL APPROACH TOWARDS TRAUMA,
WITH SPECIAL REFERENCE TO THE DYNAMICS OF PRAYER
AS A VITAL COMPONENT OF THE HEALING PROCESS**

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Trauma has the power to shake people to their very core, impacting their beliefs about themselves, the world, and often God. Even those of great faith may question His existence and love for them. In an article by Nigel Mumford (2012:14) he refers to some horrific incidents regarding the impact of trauma. One man whom he knew was in WWII and was fine until the newspaper headlines of September 11th “Three Thousand Killed.” This set him into full post-traumatic stress disorder (PTSD), as he had reckoned he had killed about three thousand people as he called in artillery fire. He was fine for 45 years until triggered by that horrific news. Mumford also knew a Sargent who was snoozing while on leave. His five-year-old daughter went “Boo” to dad. He was startled and swung out in self-defence and killed his child with his fist! They never saw him again - he was shipped off to a mental institution.

In his discussion of the theme of a pastoral response to PTSD, Duncan Sinclair (1993:66) has a very thought provoking viewpoint in stating that PTSD is basically a spiritual condition that has a vast impact at the level of our spiritual understanding – yet it is no less important in terms of its physical impact on the physical nature of the person. According to him PTSD is a spiritual disorder not because the “person is not right with God” but because the person who experiences the full impact of PTSD has been impoverished by the loss of a series of vital spiritual attributes that are essential to living a full life. If we agree with Sinclair that PTSD is first and foremost a spiritual disorder then at least a part of the healing must necessarily come from within a spiritual context and that is where prayer can play such an important role.

From the point of view of the pastoral counsellor, both the disorder and the healing can be conceptualized Biblically – a Biblical perspective gives particular insight into the trauma, the response to it, its lifelong effect, and the healing from the trauma. According to Sinclair (1993:113) PTSD involves *inter alia* the loss of hope, trust and relationships, and this of course is the Biblical story: Hope given, hope lost, and hope regained.

“The Incarnational truth of the New Testament restores hope – the hope that is realized when God Himself crawls down into the pit of despair with us to lift us out and carry us to safety” (Sinclair, 1993:115).

In the following discussion I now would like to focus on trauma from different angles and in each case, firstly give some theoretical background, and then illustrate the principle with a practical example that I personally encountered over the years in my counselling practice with traumatised persons. I just now quoted Sinclair who said that God is the one who is giving hope to the traumatised person when He crawls down into the pit of despair with us to lift us out and carry us to safety. With regard to each of the following practical examples I can surely say that this was indeed the result, and in each case the transformation away from despair and a feeling of hopelessness towards hope took place especially during the prayer session.

- **The use of prayer as a form of memorialization**

In an article by Brown and Goodman (2005:255) on the theme of childhood traumatic grief they point out that in certain cases where children lost loved ones, thoughts and images of a traumatic nature could be so terrifying, horrific and anxiety provoking that they cause the child to avoid and shut out also those thoughts and images that would be comforting reminders of the person who died. In contrast, a child who does not have intrusive reminders, or who did not experience the death as traumatic, is able to access the person in memory in a manner that is positive and beneficial to integrating the death into his or her total life experience. Communicating about, remembering, and maintaining a “connection” to the person who died, are thought to be helpful strategies for the bereaved, and consistent with normative bereavement (Brown & Goodman, 2005:258; Silberman, 2000:73). According to Brown and Goodman (2005:258) prayer can effectively be used as a form of memorialization and maintaining an on-going “presence” and positive memory of the deceased (especially during the first phase after the death). The ability to conceptualize and utilize the belief of an everlasting life may be one way of understanding the comfort provided by prayer. In addition, prayer may generate a feeling of closeness to the deceased and allow a vehicle for constructing a framework for “accessing” the person, according to Brown and Goodman.

In this regard I would personally want to add to the phrase “*accessing the person*”, by saying that through prayer we can also access all possible bad memories connected to the relationship with this person as well as any negative circumstances surrounding the death of this person – and then pray for healing of all such negative emotions and memories.

❖ **Example**

I counselled a young woman whose brother died in his sleep unexpectedly a year previously. During our session she still struggled tremendously to come to terms with his death. The worse memory that kept coming back, even in her dreams, was connected to the few minutes that she had spent in the state mortuary shortly after his death to identify his body. That specific day when she stood beside his body she literally had the physical sensation of somebody pouring a bucket of cold water out on her. Since then, each time that a negative memory or emotion connected to her brother’s death was triggered, she immediately had that same physical sensation, and indirectly the message: “I am back in the mortuary!” This is because unresolved trauma is always functioning in the present tense until it is resolved. It is thus based on a lie. [Therefore so important for instance a Christian cognitive-behaviour therapeutical approach: assessing, identifying and renouncing faulty thinking – exposing the lies counselees still live by and exchanging them with the truths of Scripture – this will lead to a changed thinking > and this will lead to a changed heart > and this will lead to changed behaviour (Jones, Clinton & Ohlslager, 2005:49)]

During the prayer session we focussed our prayer specifically on those few minutes in the mortuary when she was standing next to her brother’s body. In my prayer I basically asked the Lord to take her back right into that same situation and then to make her aware of His own presence with her in that place through His Holy Spirit. When she opened her eyes after a minute or two she told me that this was precisely what she experienced. She was back in the mortuary standing next to her brother’s body and she was aware of Jesus standing beside her, putting His arm around her shoulder in support. And during those few seconds she also had the experience of that strange sensation - of cold water being poured out on her - this sensation then disappeared and instead there was peace and calmness. After this session we still had contact with her for quite some time until she finished her studies and started

with a career in another part of the country – her testimony was the same throughout: that strange trigger effect was resolved and she could move forward with her life.

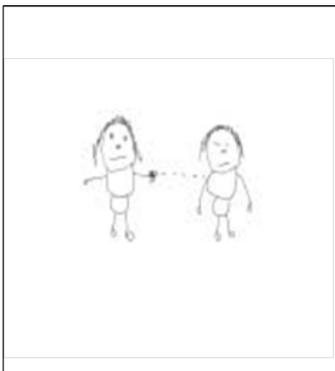
- **The importance of the body and body memories**

In an article by Cathy Malchiodi (2001:24) with the title, *Using drawing as intervention with traumatized children*, she points out that for many years it was believed that children who witnessed traumatic events should not be asked to talk about these traumatic memories for fear of re-traumatization. However, it is now known that it is important to the recovery process to provide children with ways to express their apprehension and worries and to provide sensory experiences that mobilize the expression of these feelings in a structured manner.

In this regard Malchiodi then lists several drawing tasks as particularly useful, including:

- **Drawing ‘what happened’**

When an individual experiences a trauma, drawing ‘what happened’ is essential. In order to successfully resolve and master a traumatic event, children must have the opportunity to recount the experience in detail. A structured interview is proposed along with drawing to facilitate this process. While it is a difficult task to recreate an image on paper of the traumatic event, most children find a degree of relief in finally being asked to describe what happened



“A man being shot”; drawing of what happened by 7 year old.

- **Drawing of self in relation to the trauma experience**

It is helpful to have the child ‘draw a picture of him/herself when the trauma happened,’ especially if the child did not include him- or herself in the previous

drawing of 'what happened.' A self-image gives additional information about how children see themselves and how they see themselves in relation to the traumatic event.

- **Drawing of the body of the victim**

In cases of violent crime, accidents, or death from natural causes such as cancer, heart attack, or illness, at some point it is often helpful to ask the child to 'draw the body of the victim.' This task, when presented in a sensitive and supportive manner, can be helpful in resolution of not only stress-related symptoms, but also in identifying any intrusive or recurrent memories that the child may have about the traumatic event.



"What my dad looked like after the accident"; drawing by a 6 year old of his father who died in a car accident.

- **Completing a pre-structured 'body outline'**

This task basically involves the use of a pre-structured body outline which the child may colour in a variety of ways. The therapist may take several approaches to this task with the child, depending on the child's needs and experience of trauma. For example, a therapist might say:

"We can have many different kinds of feelings when a bad experience occurs. Sometimes when something bad happens, we feel it in our stomachs like a tummy ache and other times we can get a headache. I want you to colour the body outline in the places where you felt the traumatic event in your body when you first heard about it (or witnessed it, if that is the case)."

The victim of a crime or accident may also be addressed through this activity, and you might ask the child to consider

“where did your friend (parent, brother, etc.) feel the trauma (accident, crime) when it occurred. I want you to colour the body outline in the places that you think the person felt pain when it happened.”

This aspect is also important with regard to the prayer session with the victim. Over the years I became used to ask the counselee (depending on the history of the specific case) at the beginning of the prayer session, to indicate to me whenever there is a sudden physical reaction - such a reaction could be an indication of where this person initially felt the physical pain when the trauma happened.

❖ **Example**

Years ago when I was still in full time ministry I visited at some stage a friend in hospital who had been in a car hijack trauma – the hijacker shot him in the face. His wife was also with him during my visit and she then mentioned the fact that she suddenly had this strange pain in one of her legs the last couple of days since the drama surrounding his hijacking trauma. When asking her about some more detail she started to remember that it was the same leg where she had been bitten by a big dog years ago when she was 16. I explained to her that there could be a connection between the physical pain and the unresolved trauma of that bad experience years ago. I also explained the fact that there could be a body memory that could have been triggered by the same emotions that she experienced during the hijacking of her husband. We talked through the detail of the trauma of the 16 year old girl and then we prayed about it and when we said amen, she told me that the pain was gone. A couple of days later I met her again at the side of her husband's bed in the hospital. At this occasion she was a bit more distressed: that morning when she reversed out of the garage she bumped into a tree on their premises, with a lot of damage to their new car. Shortly after this new trauma the pain in her leg was back again. I explained to her that this new trauma probably triggered the previous trauma again. We then talked through the trauma of that morning and prayed through it and then also prayed again for the trauma of the 16 year old girl bitten by a dog – after the prayer all the physical pain was gone and she experienced much more inner calm and peace.

- **The body remembers**

Regarding the aspect of body memories the well-known trauma specialist, dr. Bessel van der Kolk (Professor of psychiatry), did extensive work with Vietnam veterans suffering post-traumatic stress. Dr. Van der Kolk observed how horrific experiences are stored physically, but forgotten mentally. Some of these memories then later return in flashbacks or recurring physical symptoms (actually as *body memories*). In his well-known article, *The body keeps the score* (1994), he discusses this issue and emphasizes the fact that it is actually our *bodies* and not our *minds* that control how we respond to trauma. Ten years later Mary Sykes Wylie wrote an article, *The limits of talk. Bessel van der Kolk wants to transform the treatment of trauma* (2004). Wylie refers to neuroimaging studies that Van der Kolk has collaborated on, that showed that the executive functions of the brain become impaired when traumatized people try to access their trauma. The imprint of trauma doesn't "sit" in the verbal, understanding, part of the brain, but in much deeper regions - amygdala, hippocampus, hypothalamus and brain stem - which are only marginally affected by thinking and cognition. These studies showed that people process their trauma from the bottom up - body to mind - not top down. But if trauma is situated in these subcortical areas, then to do effective therapy, we need to do things that change the way people regulate these core functions, which probably can't be done by words and language alone. This is where aspects like play therapy, music, drama, art and drawing tasks can make a tremendous difference – and I would indeed add the action of *prayer* here as well.

In an article by Steele and Raider (*Structured sensory intervention for traumatized children, adolescents, and parents*, 2001:21) they also elaborate on this aspect of the insufficiency of words to really express inner emotions after being traumatized. They say that when a terrifying incident such as trauma is experienced and does not fit into a contextual memory, a new memory or dissociation is established. When that memory cannot be linked linguistically in a contextual framework, it remains at a symbolic level for which there are no words to describe it. Maybe there could be some link to what Rom 8:26 is referring to: "*When we don't know what to pray for, the Spirit prays for us in ways that cannot be put into words*" (CEV).

In this regard an action like drawing could also provide children an impetus to tell their story - it provides the child the ability to translate his/her traumatic experience into a narrative.

With regard to Bessel van der Kolk's article 'The body keeps the score,' and his basic premise on this issue, the trauma expert and psychotherapist, Babette Rothschild said:

"For the first time, a traditional, mainstream psychiatrist and neurobiology researcher was legitimizing the importance of understanding the effects of psycho-logical disturbance on the body. It was very exciting to have him confirm what many practitioners had believed for a long time - that there's something called somatic memory" (as quoted by Wylie, 2004).

Rothschild is also the author of the very interesting book, *The body remembers. The psycho-physiology of trauma and trauma treatment* (2000).

With regard to the aspect of body memories my own experience over many years in counselling traumatized persons is that very often there can be body memories, especially if there had been physical trauma. If we are sensitive to these and take them into consideration (especially during the prayer session with the counselee) they can very often guide us in a certain sense to some spiritual and emotional breakthroughs.

❖ **Example**

A couple of years ago I counselled a guy who fought in the SA/Angola war 35 years ago. His wife first came because overnight out of the blue, he confronted her with a divorce letter, and according to her there had been no indication whatsoever of a divorce before that. This happened during the last week of August that year. She also told me that since they were married about six years previously, every year round about that same time (beginning of Sept) he acts very strangely for a couple of months – emotionally very unstable - and then eventually round about December/January he settles down and is back to normal again. The previous year for instance he just disappeared for three weeks. When he arrived back home again, he told her that he hitchhiked to Cape Town without any extra clothing or baggage or money and he couldn't give any reasonable explanation for his behaviour. This year suddenly he got the idea of a divorce. When I interviewed him I asked him to tell me his story. During his youth he had two or three traumatic experiences – the worse of these: his grandfather, who was for him like his own father because he raised him, died in his arms. But then the most traumatic experience: 35 years before, while

fighting on the border of Namibia there was this big battle that year on 1 September. On that day four of his best friends died while fighting next to him. One of these four was a step-brother of his with whom he grew up. During the battle he decided that he was not going to allow the enemy taking possession of the bodies of his four friends – so, while the battle was still raging on, he decided to retrieve the bodies one by one. He told me that some of those bodies were so mutilated that when picking them up his fingers could touch their bare ribs, stripped of all flesh. Since then, for the following 35 years the 1st of September has been a crisis for him year after year. Up till our conversation he had been through a lot of treatment and a couple of times taken up in institutions, but I don't think the deeper root of these body memories connected to the specific date of 1 September had been identified – consequently there was no progress.

He also told me that since that traumatic experience he had the strange sensation of something like an iron grid around his breast that caused breathing problems for 35 years – he had been for medical examinations specifically for this problem but without any results.

We then started with our prayer session in which we focussed specifically on all the emotions and the memories and the detail and the trauma of that day in September that were indelibly edged in his mind for 35 years. As we prayed through the events of that day this guy told me at one stage that this 'iron grid' round his waste was starting to relax – at the end of the prayer session he told me that this strange feeling was totally gone and for the first time in 35 years it felt as if his lungs were open and he could freely breathe in and out. My interpretation of this sensation of an 'iron grid' around his breast was that it had all to do with body memories and the effect of trauma on his body and consequently also on his emotions, his way of thinking and behaviour.

- **Praying for physical ailments as a result of adverse experiences/trauma**

In an article in 2005 on the theme of *Developmental trauma disorder*, dr. Bessel van der Kolk made the statement that childhood trauma, including abuse and neglect, is probably the single most important public health challenge in the United States. [We can add that this statement probably not only apply to the USA but also to all other countries.] According to dr. Van der Kolk the traumatic stress field has adopted the term '*complex trauma*' to describe the experience of multiple, chronic and prolonged,

developmentally adverse traumatic events, most often of an interpersonal nature (eg, sexual or physical abuse, war, and community violence) and early-life onset. These exposures often occur within the child's caregiving system and include physical, emotional, and educational neglect and child maltreatment beginning in early childhood.

In this same regard John Bradshaw (1996:138) argues that numbed out emotional pain can be expressed in several ways. One way is to convert the emotional pain to somatic disorders, or chronic sickness. Someone who is sick a lot of the time without an identifiable disease or organic disability is often converting the painful feelings of sexual or emotional abuse into somatic disorders, according to Bradshaw.

With regard to the theme of unresolved emotional baggage there is also the very interesting research called the *Adverse Childhood Experiences Study (ACE)* (Van der Kolk also refers to this study in his article). The ACE Study is a decade-long and on-going collaboration between Kaiser Permanente's Department of Preventive Medicine in San Diego and the Centres for Disease Control and Prevention (Kaiser Permanente is an integrated managed care consortium). However, some of the concepts for this ACE Study had their beginnings already in 1985 when, as a specialist in Preventive Medicine, Dr. Vincent Felitti initially set out to help obese people lose weight through the so called *Positive Choice Programs* (Felitti, 2003:1). To his amazement, those people most likely to drop out of the weight loss program were those who were successfully losing weight!

On digging more deeply, in a careful study of 286 such patients, Dr. Felitti learned that many had been unconsciously using obesity as a shield against unwanted sexual attention, or as a form of defence against physical attack, and that many of them had been sexually and/or physically abused as children. That is to say, although obesity was conventionally viewed as the problem, it was often found to be the unconscious solution to other, far more concealed, problems. The prevalence and severity of these problems was totally unexpected. Many, like childhood sexual abuse or suicidality, were shielded by social taboos against freely discussing these topics, even in medical settings.

The ACE Study is the largest study of its kind ever conducted (more than 17,000 study participants) and the range of adverse childhood experiences and health related outcomes studied was unprecedented. The study determined that an unexpectedly high number of these people - adults who came to the Department of

Preventive Medicine for comprehensive medical screening – had experienced significant abuse or household dysfunction during their childhoods. For the purposes of the ACE Study, adverse childhood experiences were defined as:

- Emotional, physical, or sexual abuse
- Emotional or physical neglect
- Growing up in a household where someone was an:
 - Alcoholic
 - A drug user
 - Mentally ill
 - Suicidal
 - Where the mother was treated violently
 - Or where a household member had been imprisoned during the patient’s childhood.

The Study found the following burden of individual adverse childhood experiences:

Abuse:

| | |
|-----------|-----|
| Emotional | 10% |
| Physical | 26% |
| Sexual | 21% |

Neglect:

| | |
|-----------|-----|
| Emotional | 15% |
| Physical | 10% |

Household Dysfunction

| | |
|--------------------------------|-----|
| Mother treated violently | 13% |
| Mental illness | 20% |
| Substance abuse | 28% |
| Parental separation or divorce | 24% |
| Household member imprisoned | 6% |

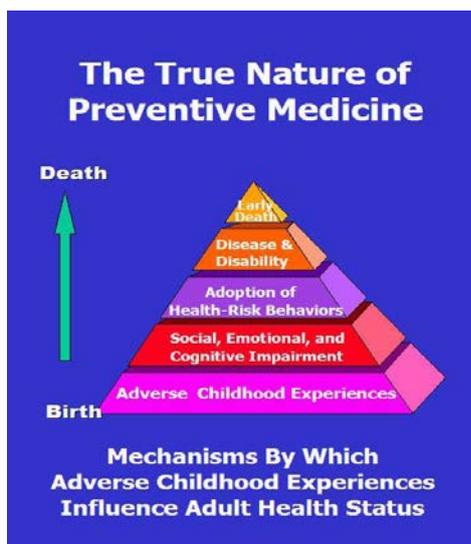
Because the ACE Study research team found that in most cases, not just one, but several, of these ACE’s existed in the child’s home, a simple scoring system was

used (called the ACE score), in which each participant was attributed one point for each category of adverse childhood experience occurring prior to age 18 (Felliti, 2007:3). The percentage of Kaiser members with each ACE score is shown below. Note that only 1/3 of persons reported no adverse childhood experiences:

ACE score:

| | |
|---|-----|
| 0 | 33% |
| 1 | 26% |
| 2 | 16% |
| 3 | 10% |
| 4 | 6% |
| 5 | 5% |
| 6 | 6% |

Using the ACE score as a measure of the burden of traumatic childhood exposures, the ACE Study team found that as the ACE score increased, the chances of being a user of street drugs, tobacco or having problems with alcohol abuse increased in a stepwise fashion. Thus, adverse childhood experiences were not only unexpectedly common, but their effects were found to be cumulative (Felliti, 2003:3).



The first publication from the ACE Study examined the relationship of the ACE Score to many of the leading causes of death in the United States. Major risk factors for these causes of death - such as smoking, alcohol abuse, obesity, physical inactivity, use of illicit drugs, promiscuity, and suicide attempts - were all increased by adverse childhood experiences.

Among the more notable findings were that, compared to persons with an ACE score of 0,

those with an ACE score of 4 or more were twice as likely to be smokers, 12 times more likely to have attempted suicide, 7 times more likely to be alcoholic, and 10 times more likely to have injected street drugs. This illustrates to some extent the

devastating effect of emotional baggage and unresolved pain since childhood.

In many, if not most, cases the behaviours such as alcohol or drug abuse, smoking, or sexual promiscuity may act to alleviate the emotional or social distress that results from adverse childhood experiences. Thus, these behaviours, typically considered to be problems, continue because they function as short-term solutions, even though they have detrimental, long-term effects.

The ACE Study also showed that as the ACE score increased, the number of risk factors for the leading causes of death increased. Thus, persons with high ACE scores are later at much higher risk for health and medical conditions resulting from their choice of remedies for their pain. While these approaches are effective in the short term, they often have dire long-term consequences such as serious chronic health and social problems.

In addition, the underlying causes of these problems, namely adverse childhood experiences, would typically go undetected because of shame, secrecy and social taboo, which prevent people from talking about such things. These same social taboos prevent physicians and other health care providers - those best poised to help victims of child abuse - from asking the very questions that would help identify these underlying causes of major impediments to a whole country's health and wellbeing.

In combination, the fallout from various forms of child abuse and household dysfunction is monumental, costing all countries untold sums of money because of the health risks such as the use of street drugs, tobacco, alcohol, overeating and sexual promiscuity. Not the least of these high-ticket medical costs is due to cardiovascular disease, cancer, AIDS and other sexually transmitted diseases, unwanted often-high-risk pregnancies, chronic obstructive pulmonary disease, and a legacy of self-perpetuating child abuse (Felliti, 2003:3).

To quote Van der Kolk (2005:402) again:

“The ACE study showed that adverse childhood experiences are vastly more common than recognized or acknowledged and that they have a powerful relationship to adult health a half-century later. The study confirmed earlier investigations that found a highly significant relationship between adverse childhood experiences and depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, cigarette smoking, obesity, physical inactivity, and sexually transmitted diseases. In addition, the more adverse childhood

experiences reported, the more likely a person was to develop heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease.”

Against this background as well as a number of other similar studies with similar results I became more and more inclined over the last couple of years in counselling to insist with every counselee to hear his/her whole story, with special emphasis on all adverse childhood experiences. My first question with each one is usually: Tell me your story right from the beginning – tell me about every bad incident and every bad memory. And then very important: Tell me about any physical problem that could have developed after a specific traumatic experience – a physical problem that you didn't have before.

❖ **Example**

With regard to the aspect of physical problems as a result of adverse experiences, I counselled a lady who had been in a car accident about 12 years previously with her two pre-school children. The accident was a very traumatic experience because the car overturned and ended up in a dam. Very quickly the level of the water started to rise in the car as it was sinking and she had quite a struggle in trying to get the two children, who couldn't swim, out of the car through the back window that had been shattered during the crash. Shortly after this traumatic accident she developed a physical problem with her sight and had to get a pair of glasses for reading and when doing needle work – before the accident she didn't have this problem with her eyes. Since then she also had the strange feeling as if always looking through a fishbowl to the world around her – this was obviously because of the effect of the water associated with the accident and the trauma – it was as if some effect of the trauma literally got stuck in her eyes and in her sight. After working through and praying through all the detail of this experience she told me something interesting a week or two later during a following counselling session. She said that a few days before, she wanted to do some sewing work with her machine and she asked her husband to fetch her glasses in one of the other rooms. While he was gone fetching the glasses she started working with her machine in the meantime and then discovered that she could see clearly and didn't need the glasses any more – she then also realized that the strange 'fishbowl-effect', when looking at the world around her, had also disappeared. The interesting fact here is that in our counselling and in our prayer

session we didn't actually focus on the problem with her eyes or her sight but we only focussed on the effect of the trauma and the memory of the traumatic experience in general.

- **The power of prayer not fully utilized**

Although prayer is a powerful instrument available to pastoral counselors, the dynamic influence of it is not always fully utilized. Because of this reason so often we get stuck with the detail of some therapeutical model without a breakthrough and we become discouraged.

In his discussion of the topics of prayer and inner healing within the practice of pastoral counseling the Christian psychiatrist, dr William Wilson (2003) makes the statement that there is no ideal childhood. There is only a childhood with greater or lesser amounts of trauma. Some may suffer illnesses, others may be born with or acquire stigmas that make them different. Others may be physically, emotionally, sexually or verbally abused, while others may be rejected or neglected. In most instances we humans are able to adapt to these traumas, but they leave scars on our souls. It is these scars that have to be healed if we are to live without symptoms and have an abundant life.

Dr. Wilson then very interestingly states that dynamic psychiatry has always promoted the belief that our psychological problems have their origin in these childhood traumas. He is convinced that there is no doubt that such a formulation has verity. As a result they developed methods to uncover the traumatic memories and the emotional component of the memories uncovered is of importance to them if it can be identified or experienced again. In ordinary dynamic practice, according to dr. Wilson, little else is done about the recovered memory. It is believed that the realization of how the memory has influenced subsequent thinking and behavior will result in the development of insight. With insight the patient's behavior will change - understanding is thus supposed to be the key ingredient in therapy.

Notwithstanding this type of approach by secular therapists the ideal results are apparently not always achieved with regard to unresolved emotional pain as well as trauma that has been to a certain extend engraved on the victim's subconscious. In this regard dr. Wilson makes the following important remark:

“There is no technique in the armamentarium of dynamic therapists to bring about decathexis (withdrawal) of the emotion that was attached

to the remembered event. It is assumed by many therapists that abreaction (catharsis/emotional ventilation) brings about decathexis. This is true only in rare instances. Although inner healing is the goal of secular therapy it is seldom the result.”

Dr. Wilson then indicates how the Pastorate can indeed address this pain and trauma that is often embedded on a very deep level – it can address it through prayer and in this way achieve breakthroughs that are not always necessarily the result of some secular therapeutical approaches. This probably relates to the fact that a pastoral approach is much more sensitive towards the spiritual dimension of human experience - a dimension that is usually influenced by unresolved pain and trauma.

In my introductory remarks I referred to Duncan Sinclair’s viewpoint that PTSD is basically a spiritual disorder and that part of the healing must be from a spiritual context. Measured against my own experience of 35 years with hundreds of trauma victims I want to venture the opinion that overwhelming trauma that got stuck on a very deep level can in many cases eventually only be resolved and healed through prayer (although I realise that I am on thin ice with a statement like this).

- **Conclusion**

Where there is only hopelessness and despair in the lives of post traumatic victims, God made the restoration of hope possible through the incarnational truth of the New Testament. And we as Christian workers, whatever the specific discipline may be that we represent here today, can facilitate this hope in a very concrete and tangible way through prayer.

Just to recap very briefly:

We said that in and through our prayers with the traumatized victim we can focus especially on aspects like the following:

- ***Using our prayers as a form of memorialization***

In this regard we said that through prayer we can also access all possible bad memories connected to the relationship with the person who died as well as any negative circumstances surrounding the death of this person – and then also pray for healing of all such negative emotions and memories.

- **Looking out for patterns of recurring physical symptoms**
Maybe prayer is necessary after the deeper root of these symptoms has been identified – maybe after focussed prayer the recurring pattern will clear up.
- **To be sensitive to body memories and take them into consideration, especially during prayer sessions with counselees.**
Very often these body memories can guide us to spiritual and emotional breakthroughs.
- **Always keeping in mind the fact that physical ailments could be the result of adverse childhood experiences (trauma).**
As part of a multidisciplinary-holistic approach where emphasis is put on the emotional, the physical and the spiritual dimensions, prayer can be a catalyst towards deep inner healing of emotions and memories.
- **Up till now the dynamic influence of prayer as a transforming power has not been utilized nor realized to its fullest extent.**
As Christian workers and pastoral counsellors we have one of the most powerful tools available and we must utilize it to its fullest extent.

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