

Accessing Post-Traumatic Stress Disorder Care as a Resource for Pastoral Grief Counseling

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Contemporary counseling research and techniques pulse through the publications, conferences, seminars and networks of the clinical Christian counseling community. However, local pastors, who frequently function as analyst-therapists are not part of these special-interest networks. The local pastor serves as leader, preacher, administrator, mentor, building maintenance person, and counselor. This multitasking limits the pastor's ability to undertake a comprehensive study in any single discipline. Simultaneously, professional Christian counselors continue to become more specialized and effective. The result is a polarization between local pastors and professional Christian counselors, creating a counseling proficiency gap.¹

Although long-term Christian psychological care should be done at the clinical level, the bulk of daily Christian counseling is practiced by the local pastor. Preserving and perfecting pastoral counseling skills is crucial to local church health. Prudent pastors must seek to continue their training and education by all possible means. The intention of this article is to demonstrate how pastors can easily access proficiency by translating well-researched secular disciplines for applications in Christian ministry. As an example, the following study aligns some techniques

1. In the 1960's Seward Hiltner, a patriarch of the pastoral care movement, foresaw this growing counseling gap. Although a major proponent for pastoral care, Hiltner resisted the establishment of the American Association of Pastoral Counselors in 1963. He regarded the AAPC's formation as a threat to the pastor-counselor's competence, a separation between pastors and other Christian help professionals. Subject to this separation, local pastors would become less likely to access counseling resources at levels commensurate with the pastoral task. Today the AAPC defines itself as supporting a form of psychotherapy that is Christian-specific; but only upholding theology and spirituality as perspectives in a wider range of care. Rodney J. Hunter, "Spiritual Counsel," *The Christian Century*, October 17, 2001, 20.

of grief counseling with Post-Traumatic Stress Disorder (PTSD) therapy to revise contemporary pastoral grief care.

Grief

Classic Grief Stages, Symptoms, and Care

Grief work is not a disassociated series of stages. Rather, it is a progression of interrelated periods moving semi-successively (evolving but sometimes reverting to earlier phases) until recovery is attained. When grieving for a significant other, the griever (transitioner) moves from an old method of relating to life into new emotions, new thoughts, and new ways—i.e., a new life. This transition is accented by stages of utter numbness, denial, anger, and depression.² However, the healthy transitioner ultimately rests in recovery. The term “recovery” is actually a clinical misnomer. Recovery is not a return to a previous state of normalcy. Recovery is not “re” anything. The loss of a significant other is a life-altering event, literally changing the contents and dimensions of personal reality. Everything is new, and recovery marks the beginning of a new way of life not a return to the norms of the old life. Grief transitioner Steven Curtis Chapman described this type of recovery as the “new normal” lifestyle.³

Over the past four decades, psychologists and researchers expanded or modified Kübler-Ross’ catastrophic loss stages into multiple categories of symptoms and manifestations.⁴ However, her oft-quoted research

2. Rosemary A. Thompson, *Counseling Techniques: Improving Relationships with Others, Ourselves, Our Families, and Our Environment* (New York: Brunner-Routledge, 2003), 357.

3. Chapman has won five Grammy awards and 56 Gospel Music Association Dove Awards, more than any other artist in history. He lost his adopted daughter in an accident involving his teenaged son in 2008. *Steven Curtis Chapman Honors Daughter at the Doves* <http://www.theboot.com/2009/04/24/steven-curtis-chapman-remembers-daughter-at-the-doves/?icid=main|main|dl2|link1|http://:3A%2F%2Fwww.theboot.com%2F2009%2F04%2F24%2Fsteven-curtis-chapman-remembers-daughter-at-the-doves%2F> (accessed April, 25 2009).

4. Dr. Kübler-Ross, an early professional in the field of thanatology, first introduced the idea of the five stages of dealing with death: denial and isolation, anger, bargaining, depression, and acceptance. A famous psychological study of the late twentieth century, *On Death and Dying* grew out of extensive interviews with terminally ill patients. This produced an interdisciplinary seminar on death by Dr. Elisabeth Kübler-Ross and ultimately her influential work, *On Death and Dying*. Today, Kübler-Ross’ findings on grief care continue to be recognized as clinical standards. Counselors and other authors still cite Kübler-Ross’ original five stages when defining grief processes. Kübler-Ross’ grieving circle includes family, friends, and caregivers (attending physicians, nurses, hospice person-

remains, in its simple form, a foundation for understanding grief in the twenty-first century. Briefly, these five stages, their symptoms, and some care issues are listed below. The symptoms are coded for later correlations.

Denial

Denial is usually a partial or complete departure from facts in evidence. Because denial requires mental processing antithetical to the reality of the processor, denial can only be maintained temporarily. It is an immediate defense mechanism. Specific symptoms include avoiding (a) particular conversations, (b) familiar places, (c) people, and (d) practices. Caregivers should gently guide clients toward the reality of their loss.

Anger

Because denial is not sustainable, anger has a rapid onset. Anger is volatile and can shift focal point such as (e) being angry at the lost one, (f) God, (g) the counselor, or (h) anyone who demonstrates life and vitality. At this stage, administering care is difficult. Questioning occurs most vehemently here: (i) Why? How? Who? These are the questions that are posed but cannot be satisfactorily answered. Other symptoms include (j) sleep difficulties, (k) mental preoccupation, and (l) hypersensitivity. Caregivers should not attempt to answer their questions or negotiate with grievors at this stage.

Bargaining

In Kübler-Ross' original research, the bargaining stage was a re-visitation to denial at a more cognitively stable level. Denial departs

nel, clergy, and anyone in contact with terminal patients in a significant way). Multiple publications 2008-2009 cite Kübler Ross's stages: Melissa Allen Heath and others, "Coping with Grief: Guidelines and Resources for Assisting Children," *Intervention in School & Clinic* 43 (2008); C.A. Leaver, Y. Perreault, and A. Demetrakopoulos, "Understanding AIDS-Related Bereavement and Multiple Loss among Long-Term Survivors of HIV in Ontario," *The Canadian Journal of Human Sexuality* 17 (2008); and "Beyond the Fifth Stage of Grief: Passion and the Obama Speech," *The Washington Times*, September 1, 2008, A04 [database on-line]; <http://www.questia.com/PM.qst?a=o&d=5028887461> (accessed May 11, 2009). Livia Kohn, "Cecilia Lai Wan Chan and Amy Yin Man Chow, Editors. Death, Dying and Bereavement: A Hong Kong Chinese Experience," *China Review International* 13 (2006); available from <http://www.questia.com/PM.qst?a=o&d=5024605876> (accessed May 27, 2009).

from reality. Bargaining hopes to merely amend reality's probabilities. Bargaining restates the questions of anger. Unlike the anger stage, (m) discussion of questions is more rational and profitable. Caregivers may want to carefully engage questions.

Depression

Once denial, anger, and bargaining are initially processed, the griever concentrates on (n) the loss, (o) the change, and (p) a diminished future. The individual may become (q) silent, (r) isolated, (s) morose, and (t) tearful. Encouraging or cheering up the griever is contraindicated. Depression allows the griever to disconnect from the loss. The process is valid and takes time. Symptoms also include (u) sleeplessness, (v) bad dreams, (w) waves of memories, (x) emotional thoughts, (y) suppressing feelings of sorrow or happiness (all overt expressions of emotion), and (z) feeling alone. Caregivers should spend time with the griever without interaction, a ministry of presence.

Acceptance

This final stage is the reception of a new normal. The emphasis here is life and not death. The new normal is not devoid of loss. The loss is incorporated into a revitalization of the dynamics of life. Caregivers should reinforce positive aspects of this life's new normal.

Possible Grief Care from Post-Traumatic Stress Disorder Research

Since Kübler-Ross' original study, research targeting grief care has continued to be substantial. However, research into PTSD surpasses grief studies. The term PTSD was first used in third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) of the American Psychiatric Association (1980).⁵ Since the introduction of PTSD as a separate diagnostic category, the U.S. government social and health services interests in the disorder have continually increased.⁶ Originally

5. "The advent of PTSD as a separate diagnostic category (American Psychiatric Association, 1980) was a distinct and critical turning point in the advancement of knowledge." John P. Wilson, Matthew J. Friedman, and Jacob D. Lindy, eds., *Treating Psychological Trauma and PTSD* (New York: Guilford, 2001), 3.

6. Tara Mckelvey, "Combat Fatigue: As Returning Veterans Suffer Post-Traumatic Stress Disorder In Record Numbers, A Controversial New Drug Is Being Tested That Would Dampen Their Memories," *The American Prospect*, July-August 2008.

PTSD was associated highly with combat-stressed Vietnam War veterans.⁷ After the declaration of the Global War on Terror, U.S. soldiers deployed into war zones that were tactically and stressfully reminiscent of Vietnam's guerilla warfare. Following the 9/11 attacks, U.S. public support of military servicemembers and their post-battlefield care catapulted to a patriotic zenith.⁸ Military spending and subsequent veteran care are at their highest since the end of World War II.⁹ Federal and local funding for research on PTSD is also at an apex.¹⁰ The current wealth of research on PTSD is valuable beyond care for returning veterans. PTSD symptoms demonstrate parallels with some characteristics of grief. Therefore, the wealth of studies relating to PTSD care is important for grief counseling.

PTSD is regarded by the DSM-IV-TR as an anxiety disorder. In the simplest terms, post-traumatic stress is defined as the psychological aftermath of "severe, repeated, or prolonged trauma."¹¹ Grief includes all three of these criteria. Death-loss trauma is *severe*. There is no imaginable greater emotional impact. There is no recourse or reversal. Death-loss trauma is permanent and, therefore, *prolonged*. Death-loss trauma is also *repeated*, reinforced by the continued absence of the lost one and the momentary recurring realizations that death has occurred. Such realizations refresh the initial traumatic experience repeatedly. These reminders are often referred to as waves of grief and mourning.¹² Further, PTSD is

7. Psychologists labeled postwar psychological reactions as Post-Vietnam Syndrome (PVS) or Post-Traumatic Stress Disorder (PTSD). In PTSD/PVS, soldiers experience adjustment problems upon rapid transitioning from chaotic civilian-entangled battlefields to routine civilian life. The abrupt nature of this process (as short as 24 hours) added to feelings of guilt and isolation. Tobey C. Herzog, *Vietnam War Stories: Innocence Lost* (New York: Routledge, 1992), 56.

8. Piers Robinson, "5 Researching U.S. Media-State Relations and Twenty-First Century Wars," in *Reporting War: Journalism in Wartime*, eds. Stuart Allan and Barbie Zelizer (New York: Routledge, 2004), 98.

9. Brian D. McLaren, *Everything Must Change: Jesus, Global Crises, and a Revolution of Hope* (Nashville: Thomas Nelson, 2007), 162.

10. Ilona Meagler, *Moving a Nation to Care*, (Brooklyn: Ig Publishing, 2007), 49.

11. Post-traumatic stress disorder is a "disruption in central psychological assumption (cognitive schema) and memory processing" due to intensive trauma. M. Nicholas and A. Forrester, "Advantages of Heterogeneous Therapy Groups in the Psychotherapy of the Traumatically Abused: Treating the problem as well as the person," *International Journal of Group Psychotherapy* 49 (1999): 323.

12. "Each time something is done for the first time that would have been shared with the other, the bereaved mourns a little more. Birthdays, anniversaries, special holidays may painfully reawaken the full extent of the loss, bringing

deemed acute if the duration of its symptoms is less than three months. The disorder becomes chronic if symptoms persist for three months or longer or symptoms are delayed in the onset.¹³ If the stress is left unprocessed, the victim can develop unhealthy adaptations in perception, interpersonal relationships, and basic need-meeting skills.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder Symptoms

There are 17 PTSD symptoms that are listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR). The Davidson Trauma Scale (DTS) (1997) consists of an equal number of 17 items that correspond to the DSM-IV-TR criteria. Further, the DTS is grouped into three subcategories that address the following experiences: intrusive re-experiencing, avoidance or numbness, and hyper-arousal. Many PTSD diagnostics are based in the DSM-IV-TR 17-symptom standard. This study utilizes the 17-symptom standard.¹⁴ For later correlations with grief therapies, the 17 symptoms are organized under Davidson's three trauma subcategories:

Re-Experiencing Symptoms

- (1) Frequently having upset thoughts or memories about a traumatic event.
- (2) Having recurrent nightmares.
- (3) Acting or feeling as though the traumatic event was happening again, sometimes called a "flashback."
- (4) Having very strong feelings of distress when reminded of the traumatic event.
- (5) Being physically responsive, such as sweating or experiencing a surge in your heart rate, when reminded of the traumatic event.

fresh waves of grief and mourning. Beverley Raphael, *The Anatomy of Bereavement: A Handbook for the Caring Professions* (London: Routledge, 1996), 47.

13. Wilson, Friedman, and Lindy, eds., *Treating Psychological Trauma*, 209.

14. Similar 17 symptom standards are found in the Clinician-Administered PTSD Scale (CAPS), the Composite International Diagnostic Interview (CIDI), the Anxiety Disorders Interview Schedule (ADIS), the Structured Clinical Interview for the DSM-III-R or DSM-IV (SCID), and the Diagnostic Interview Schedule (DIS). The DIS was developed by the U.S. National Institute of Mental Health. William J. Koch, Kevin S. Douglas, Tonia L. Nicholls, and Melanie L. O'Neill, *Psychological Injuries: Forensic Assessment, Treatment, and Law* (New York: Oxford University Press, 2006), 63-65.

Avoidance Symptoms

- (6) Making an effort to avoid thoughts, feelings, or conversations about the traumatic event.
- (7) Making an effort to avoid people or places that remind the victim of the traumatic event.
- (8) Having a difficult time remembering important parts of the traumatic event.
- (9) A loss of interest in important, once positive, activities.
- (10) Feeling distant from others.
- (11) Difficulties in experiencing positive feelings, such as happiness or love.
- (12) Feeling as though one's life may be cut short.

Hyper-Arousal Symptoms

- (13) Having a difficult time falling or staying asleep.
- (14) Feeling more irritable or having outbursts of anger.
- (15) Having difficulty concentrating.
- (16) Feeling constantly "on guard" or as if danger is lurking around every corner.
- (17) Being "jumpy" or easily startled.¹⁵

Post-Traumatic Stress Disorder Symptoms and Grief

Pastor-counselors may recognize many parallels to grief symptoms within PTSD's 17 symptoms. In fact, most PTSD indicators have many directly corresponding grief symptoms. To help observe these parallels, PTSD symptoms are correlated to Kübler-Ross' grief symptoms in parenthetical coding below (coding previously stated). Davidson's categories function to simplify the aligning process.

In the PTSD/DTS, re-experiencing symptoms consist of (j) nightmares, (s, t, x) dynamic emotions, and (w) waves of memories. Avoidance symptoms are evading (a) particular subjects in conversation, (b) familiar places, (c) people, or (d) practices. In addition, the avoidance category includes: (y) disallowing feelings of sorrow or happiness, (q, r, z) feeling isolated and insulated. Finally, the hyper-arousal category contains (u, v) sleep difficulties, (e, f, g, h) anger, (k, n, o, p) mental preoccupation, and (l) hypersensitivity. Grief also fulfills each PTSD diagnostic criterion of *severe*, *repeated*, and *prolonged* trauma. Accordingly, pastor-counselors can look to a wealth of PTSD research to find alternative counseling methodologies addressing grief.

15. Victoria Lemle Beckner and John B. Arden, *Conquering Post-Traumatic Stress Disorder: The Newest Techniques for Overcoming Symptoms, Regaining Hope, and Getting Your Life Back* (Beverly: Fair Winds Press, 2008), 9-11.

Post-Traumatic Stress Disorder Care

Medication and psychotherapy have proven helpful in PTSD. However, the most effective approaches seem to be “cognitive-behavioral.” This methodology may be more successful because the focal point of treatment is the epicenter of the traumatic event, the client’s perceptions of the trauma. Traumatized people are re-exposed to their view of the trauma and their resultant behavior. Exposure therapy includes systematic desensitization (learning composure in the face of incidents that remind the traumatized of the stressful event).¹⁶ Similarly, psychological flooding (re-submerging the client into the original trauma through rapid, multiple, vivid verbal and visual imagery) is used. Results increase behavioral management abilities. Other anxiety management strategies are also employed, including Rational Emotive Behavior Therapy (modifying belief/worldview). Other PTSD therapies include, but are not limited to, relaxation training, stress inoculation training, cognitive restructuring, breathing retraining, biofeedback, social skills training, and distraction therapy.¹⁷

Delineated below is the work of Harvard medical PTSD researcher and author Lester Grinspoon, M.D.¹⁸ Grinspoon provided 17 comprehensive counseling suggestions for counselors dealing with PTSD clients. Though these therapies do not directly parallel the PTSD symptoms, Grinspoon’s counseling directions create an effective environment for the confrontational and behavioral therapy indicated for PTSD.¹⁹

Grinspoon’s PTSD Therapy

- (1) Provide a safe environment to confront the trauma.
- (2) Link events emotionally and intellectually to the symptoms.
- (3) Restore identity and personality.
- (4) Remain calm while listening to horrifying stories
- (5) As the caregiver, anticipate one’s own feelings and coping with dread, disgust, and anger at clients or persons who had hurt them, guilt, or anxiety about providing enough help.

16. Dianne L. Chambless, and Thomas H. Ollendick, “Empirically Supported Psychological Interventions: Controversies and Evidence,” *Annual Review of Psychology* (2001): 685.

17. Thompson, *Counseling Techniques*, 361.

18. Lester Grinspoon, M.D., is a professor of psychiatry at Harvard Medical School and has authored several books that target the PTSD generation of Vietnam veterans. Among these are: *The Long Darkness: Psychological and Moral Perspectives on Nuclear Winter* (1986) and *Marijuana the Forbidden Medicine* (1997).

19. L. Grinspoon, ed., “Post-traumatic Stress: Part I. *Harvard Mental Health Letter* 7 (Feb/March 1991),” in Thompson, *Counseling Techniques*, 1-4.

- (6) Avoid over-commitment and detachment.
- (7) Avoid identifying with the client or seeing oneself as a rescuer.
- (8) Tell the client that change may take some time.
- (9) Introduce the subject of trauma to ask about terrifying experiences and about specific symptoms.
- (10) Moderate extremes of reliving and denial while the client works through memories of trauma.
- (11) Provide sympathy, encouragement, and reassurance.
- (12) Try to limit external demands on the client.
- (13) During periods of client numbing and withdrawal, pay more attention to the traumatic event itself.
- (14) Help the client bring memories to light by any means possible including dreams, associations, or fantasies.
- (15) Examine photographs and old medical records; for children, employ play therapy, dolls, coloring books, and drawings.
- (16) Employ special techniques including systematic desensitization and implosion to eliminate conditioned fear of situations evoking memories and achieving catharsis.
- (17) Facilitate group therapy.

Organizing PTSD Therapy for Grief Counseling

When Grinspoon's therapy is stated in narrative and organized within Davidson's categories (re-experiencing, avoiding, and hyperarousal), a readable, accessible, categorized therapy is defined. Grinspoon's 17 therapies are parenthetically coded for cross referencing. General Counseling Protocol (not in the DTS) are: (1) Offer a confidential, non-threatening setting for counseling. (6) Remember that the victim nature of PTSD may cause counselors to become over-committed, spending psychological and emotional energy to their own detriment.²⁰ (7) Counselors must avoid over identifying with the client or seeing themselves as a rescuer.²¹ Conversely, peritraumatic dissociation (detachment from the trauma of counseling) is also a risk for counselors

20. The state of over-commitment refers to extreme identification with and involvement in the counseling task so that personal psychological health is threatened. Rodney L. Lowman, *Counseling and Psychotherapy of Work Dysfunctions* (Washington: American Psychological Association, 1993), 55.

21. In traumatic abuse with a history from childhood, Christiane Sanderson states, "Such fantasies must be acknowledged, understood and contained in order to ensure that boundaries do not collapse. Common indicators that the therapeutic boundaries are becoming unstable include the counsellor offering the client extra time, increased contact between sessions and contact during holidays." Christiane Sanderson, *Counselling Adult Survivors of Child Sexual Abuse*, 3rd ed. (London: Jessica Kingsley, 2006), 131.

who treat PTSD.²² (3) Identify the client's pre-trauma self and the post-trauma self to discover the griever's core identity and personality. Again, the above do not fall within the DTS categories.

Re-Experiencing

As early as the numbness-disbelief stage, when (13) first focusing on the trauma, (2) connect specific trauma events with the presenting symptoms. It is important to (9) ask pointed questions about specific terrors, while (10) moderating the extremes of emotional responses.

Hyper-Arousal

(4, 5) Prepare to remain calm, notwithstanding personal dread, disgust, or anger toward the client as a perpetrator or toward the circumstances surrounding the client's victimization. (11) Pacify hyper-arousal with sympathy, compassion, encouragement, and reassurance. (12) Limit any admonitions to calm down or other external demands as they exacerbate arousal.

Avoidance

(14) Interview client about dreams and fantasies or use association to liberate areas of avoidance from subconscious management toward deliberate management. (15) Employ memorabilia such as photos, letters, and records from their schools, military, or other institutions to reinforce the reality of trauma. (16) Introduce similar trauma from the news, movies, and stories to desensitize the conditioned fear response for situations similar to the original trauma. Employ other systematic desensitizations, implosions, or flooding techniques to eliminate conditioned responses, evoking memories for catharsis.²³ (17) Group therapy also serves a desensitizing therapy and expands interpersonal support structures.

Accessing PTSD Therapy for Grief Counseling

After aligning all of Grinspoon's PTSD therapies within the DTS groupings, counseling therapies can be clearly delineated. However,

22. "Peritraumatic dissociation (detachment at the time of the event) Rachel M. MacNair, *Perpetration-Induced Traumatic Stress: The Psychological Consequences of Killing* (Westport: Praeger, 2002), 33.

23. "Implosion or flooding focuses on the repeated presentation of intense phobic stimuli to eradicate the problematic responses connected to them." See. Thompson, *Counseling Techniques*, 176.

rather than using the negative categories for grouping of the Davidson scale, pastoral grief counseling can be correlated in categories antithetical to DTS but more palatable for positive therapies: *positive re-experiencing* (good grief), *non-avoidance* (new normalization), and *anti-hyper-arousal* (pursuing peace). These are coded with Grinspoon's numbering below.

Good Grief (Positive Re-Experiencing)

Good grief validates a level of re-experiencing that creates movement toward a new normalization. As early as (13) the initial impact and immediate denial, pastors may (2) direct a client's thinking toward the specifics of loss, the loss of; security, companionship, identity, and so on. Pastors should (9) limit conversation about the loss in positive directions (what will be best remembered), while being sensitive to the extremes of emotional responses. Pastors should (1) validate the extreme emotions of the griever without facilitating those extremes. The irrational nature of the moment, symbolized by denial, gives opportunity for the proper use of the ministry of presence. The extreme rational nature of the theology may be contraindicated at this juncture.

Shortly after the death of a loved one, pastors serve as navigators to conduct grievers through the treacherous moments directly following their loss. Pastors must appreciate that grief is functional. They should move with the griever in pain, encourage positive remembering, and resist making explanations for the loss. A ministry of presence that also places limits on despair is the pastoral task.

Pursuing Peace (Anti Hyper-Arousal)

Above all, pastors must represent the love and serenity of Christ in a chaotic moment in time. Though the transitioner's focal point of anger may be the pastor, the church, or even God, the pastor-counselor must maintain a peace that surpasses logic. (4, 5) Clergy should remain calm in the face anger. Overwhelming grief is not an opportunity to defend God's methods. Pastors are present first as shepherd-counselors and second as theologians. Use the Scripture as a balm. The Psalms yield many verses of comfort (Psalms 34:18, 119:28). Pauline letters can assist grievers (1 Thessalonians 4:13, 1 Corinthians 15:54). Although the Scripture brings the greatest solace, (12) it is not intended to suppress authentic emotion. Let the grieving question God. Don't answer for Him. (11) Pacify hyper-arousal with agreement where possible and with sympathy, compassion, encouragement, engagement, reassurance, and the aching love of shared grief. Often a simple touch is indicated, a connection of emotion that requires no words. Pursuing peace is another instance for the ministry of presence.

New Normalization (Non-Avoidance)

Later in the grief process, pastors should interview griever to ascertain progress. (14) Conversations should serve movement toward deliberate management. If possible, discuss mutual experiences with the deceased. (15) Ask to share photos or stories that reinforce the reality of loss. When the loss is not being processed well, an increased number of pastoral visits is indicated. (16) These visits should help desensitize any conditioned fear response surrounding discussions of the loss. Visits will continually evoke memories and help achieve a natural catharsis. (17) Group therapy also serves as a desensitizing tool while increasing support structures. This is a process of delicate remembrances; gentle reminders that memories will not die. Through remembering conversations, the pastor helps to demonstrate that the deceased is most alive in the griever's life when memories are shared openly. The pastoral task is to facilitate movement from painful grief and avoidance toward pleasant reminiscing.

Conclusion

The local pastor is the first-line counselor in grief trauma. The pastor, not the clinician, is most often called to infuse hope, stability, and solace into the chaos and anxiety of loss through death. The pastor is also the most likely professional to have consistent contact with the griever over the full course of recovery. Extensive, government-funded clinical studies in PTSD and resultant therapies provide many effective therapies for grief counseling. Unfortunately, some of these therapies may seem counterintuitive to Christian pastors. Seminary-educated pastors are trained to be theologians but are less equipped to deal effectively with extreme or crisis counseling.²⁴ Accordingly, pastors may attempt to use a *therapy of theologizing*²⁵ to comfort the traumatized.²⁶ Those who recognize the danger of speaking for God during intense grief may counsel with a *ministry of presence* approach, restricting their counsel to a sympathetic listening ear.²⁷ Each of these applications has value at appropriate times.

24. Prominent U.S. seminaries MDiv curricula require only 2 or 3 credit hours of counseling studies: Concordia (3), Denver (2), Gordon-Conwell (3), Trinity Evangelical Divinity School (3) as of 2008 published electronic catalogs.

25. Term by the author meaning: counseling with from only Scripture and theology.

26. Many internet resources offer Scripture without clinical application. *Bible Scriptures to Comfort Grieving People*; <http://nitewriter.net/BibleScripturestoComfort.htm> (accessed April 29, 2009).

27. Robert C. Sterling writes on hospice and hospital care for alcohol-

However, the impact of Scripture and the comfort of pastoral presence may not be comprehensive. Scripture and comfort therapy are suspiciously familiar. Providing personal presence and theology are what pastors do well. Pastors are comfortable with fellowship and faith. Pastors may see their role as directing counselees away from pain and toward God. However, directing clients only toward God (as ultimately good) or to themselves (as sympathetically good) counters what has been learned in PTSD research. Although pastors may be resistant to guide the traumatized back into their trauma, research demonstrates that this is where they must go at first.

The repeated journey back into both destructive and *good grief* allows the transitioner to recognize the better of the two. As navigators in the process, pastors guide counselees to *pursue peace* through moments of hyper-arousal and waves of grief. The result is not a return to the old, normal life but an incorporation of the life and the loss of a loved one into a *new normalization*. The confrontational essence of PTSD-type grief counseling may seem discomforting to pastor-counselors. However, pastors are responsible to use every resource to guide grievers safely into and through grief toward emotional and spiritual well-being.

Local pastors can benefit from secular information in the area of grief counseling. PTSD therapy provides a model that easily translates for grief counseling. This type of counseling is a valuable addition to the ministry of presence and the appropriate use of Scripture, and it is an effective multiplier for the multitasking pastor.

ism. He says that chaplains “provide informal individual spiritual counseling and guidance to patients through the *Ministry of Presence*.” Historically, the U.S. military chaplaincy used this posture in lieu of training to be more effective than merely present. Robert C. Sterling and others, “Levels of Spirituality and Treatment Outcome: A Preliminary Examination,” *Journal of Studies on Alcohol* 67 (2006).