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Sophia is a 38-year-old divorced computer programmer living in San Francisco. Her life changed after a business trip to a nonprofit organization. She felt a spiritual connection with the CEO whose vision for founding the nonprofit resonated with her deepest values. When she went with him to his condo after eating out together, he sexually assaulted her and then threatened to discredit her if she told anyone what had happened. She blamed herself for drinking too much and using poor judgment. She thought that she could put this horrible experience behind her after a negative test for pregnancy and STDs. However, she has had difficulty sleeping and feels anxious when she is alone with male colleagues. She had a panic attack when she was offered another work-related travel opportunity. She used her employee assistance program to request a female therapist who would respect her Germanic-American Roman Catholic faith.

Sam is a 20-year-old African American Army reservist from Atlanta. During a deployment in Afghanistan his unit came under attack. Sam provided immediate emergency medical care to his buddy because they were cut off from ordinary medical supplies. While the makeshift tourniquet he used on his buddy's leg saved his life by stopping blood loss, improvising with a bootlace caused secondary damage, requiring amputation below the knee. He was tormented by guilt that he didn't provide the best emergency care under fire that he could have and regretted not thinking of using his uniform web belt as a tourniquet. When he returned home with his unit, he met with his Baptist minister to talk about struggles with guilt that surface when he talks to his buddy and encounters him and his family at the church they all attend. After

several conversations, his minister suggested that Sam meet with a colleague, a pastoral counselor who could help with his trauma-related symptoms.

The clients in these fictional scenarios are seeking help from counselors who will respect their religious beliefs and spiritual practices. Pastoral counselors bring expertise in psychology and theology that helps clients discern whether particular beliefs, values, and spiritual practices alleviate or exacerbate posttraumatic stress. The purpose of this chapter is to introduce key theories and concepts from psychological, theological, and religious studies related to posttraumatic stress disorder (PTSD), religious coping, meaning making, and spiritual struggles. I will use the following step-by-step approach to describe how an interdisciplinary approach can be implemented in pastoral counseling with trauma survivors.

1. **Building a relationship of trust** through intercultural compassion and respect for the individual nature of religious beliefs and spiritual practices, and how they shape and are shaped by trauma and trauma-related moral distress and spiritual struggles (Drescher et al., 2011; Kinghorn, 2012; Litz et al., 2009; Murray-Swank & Waelde, 2013; Pargament, 2007).
2. **Enhancing life-giving coping** with trauma-related symptoms by exploring and intentionally using religious and spiritual practices that help clients experience safety and self-compassion when traumatic memories are triggered so that they can stay relationally engaged with goodness—their own goodness and the goodness of others and life in general. Using these coping strategies consistently will able clients to explore traumatic memories in terms of values and beliefs called into question by the threat and violation of trauma.

3. **Assessing trauma-related symptoms** in terms of intensity, duration, and impact on the client's physical, emotional, relational, spiritual and behavioral well-being.
4. **Fostering spiritual integration by identifying life-giving beliefs and values about suffering associated with spiritual practices of compassion,** which can be used to counteract the automatic beliefs and values generated by trauma-related emotions like fear and shame (Doehring, 2014, 2015).

A Compassionate Reminder about Self Care

Readers can reflect upon their own process of spiritual integration by paying attention to any traumatic memories evoked by this chapter. Use religious and spiritual practices that help you feel safe and connected with the goodness of your lives. Remember the values and beliefs that anchor you. Use spiritual practices that help you integrate your core values and beliefs into coping with trauma-related emotions and memories, so that they become an invaluable resource and not a roadblock in working with trauma survivors. By using spiritual practices that enhance compassion you will be more likely to experience compassion rather than distress when listening to trauma stories (Klimecki, Leiberg, Lamm, & Singer, 2013).

Building Trust

When clients bring the most sacred aspects of their lives into counseling−their religious and spiritual beliefs, values, and practices−they need pastoral counselors skilled in intercultural care, who use a *hermeneutic of searching for differences* in order to appreciate the alterity or otherness of their clients' religious and spiritual beliefs and practices (Doehring, 2015; Lartey, 2006). A hermeneutic of searching counteracts the tendency to universalize and look for one God (Moyaert, 2012; Prothero, 2010), a tendency that makes counselors more likely to impose their

religious beliefs onto the client. Without formal religious and theological education, counselors risk being theologically naïve: not able to distinguish their embedded religious beliefs and values from those of their clients (Doehring, 2009).

A counselor might assume, for example, that Sophia, as a Roman Catholic, associates sin with sexual contact, which exacerbates her guilt about being sexually assaulted; further, the remedy is belief in the compassionate God at the core of all theistic religions of the world. This counselor's tendency to universalize and make theological assumptions about Sophia's religious upbringing will make her less attuned to Sophia's Germanic-American Roman Catholic upbringing and her college education at a liberal arts Roman Catholic college. Her Germanic-American self-reliance and formation as a Roman Catholic feminist shape her guilt that she should have known about the risks of date rape. A counselor attuned to the unique features Sophia's religious formation will gain Sophia's trust. Within this relationship of trust clients like Sophia will become more able to articulate and elaborate deeply personal and intrinsically meaningful religious and spiritual beliefs and practices, especially those related to trauma experiences. These clients will, in turn, be more likely to share this spiritual dimension of themselves with trusted others, enhancing posttraumatic growth by deepening their capacity for spiritual self-reflection and spiritual intimacy within their relational network.

Coping that Enhances a Sense of Safety and Goodness

Using an intercultural approach that attends to the client's unique ways of coping, pastoral counselors will not assume that religious and spiritual practices always help clients experience a sense of safety and goodness. Indeed, psychological research on religious coping has found that religion and spirituality are multidimensional, "made up of a myriad of thoughts, feelings,

actions, experiences, relationships, and physiological responses" and, hence, related to acute stress and trauma in a variety of life-enhancing, life-limiting, and destructive ways. "The critical question isn't *whether* religion and spirituality are good or bad, but *when, how,* and *why* they take constructive or destructive forms [in the aftermath of trauma]" (Pargament, Mahoney, Exline, Jones, & Shafranske, 2013, p. 7). Psychological studies on religious coping and trauma have demonstrated that many victims experience *transitory religious and spiritual struggles* that often involve questioning and searching for spiritual and religious practices and meanings. They may conserve practices and beliefs that have helped them in the past and also discover new beliefs and practices that become integrated into their lives. Many clients will experience psycho-spiritual growth when they use *positive religious coping* that includes (for those in theistic religious traditions) (1) believing in and experiencing God as benevolent, (2) collaborating with God in problem solving rather than deferring to God or being self-directing, and (3) seeking spiritual support in their communities of faith. Extensive research demonstrates that positive religious coping decreases psychological and spiritual distress (e.g., anxiety, depression) and increases posttraumatic psychological and spiritual growth. Those who end up experiencing *chronic religious struggle often use negative religious coping*, which, for those in theistic traditions, involves (1) believing in and experiencing God as punitive and abandoning, (2) questioning God's love, and (3) being discontented with their religious communities (Pargament, Murray-Swank, Magyar, Murray, & Ano, 2005). Ongoing struggles and negative coping are associated with increased psychological and spiritual distress. Some clients will experience a transitory or chronic sense of *spiritual violation* and *desecration* of that which is sacred (e.g., one's body), which can threaten clients' spiritual well-being (Murray-Swank & Pargament, 2005; Pargament, 2007; Pargament, Magyar, Benore, & Mahoney, 2005). Without

any explicitly religious education about sexual violence, someone like Sophia might assume that her community of faith would shun her if she were to disclose what happened (Leslie, 2002). This life-limiting theology contains many spiritual "sticking-points"—conflicts between pre-trauma beliefs/values and trauma-related doubts and questions, like "How could a loving God allow this to happen to me?" (Murray-Swank & Waelde, 2013, pp. 344-347).

When clients intentionally engage in religious and spiritual practices in order to help them feel safe when they re-experience traumatic memories, they will be more able to stay relationally engaged with goodness: their own goodness, and the goodness of others and life in general. Identifying which ways of coping with traumatic memories are life-giving or life-limiting will enhance a client's sense of safety and well-being. After initially exploring and keeping track of their habitual coping strategies, clients can become more intentional about using specific spiritual coping strategies in response to trauma-related symptoms and related automatic negative thoughts about self, others, God, and life general. They can keep notes on how effective these strategies are in helping them experience safety and goodness (inner, relational, and cosmic). Psycho-spiritual approaches to fear- and shame-based trauma focus on helping survivors use spiritual practices to experience of the goodness of life (Harris et al., 2011; Whitehead, 2010). Spiritual practices that foster self-compassion can uncover and alleviate the shame that often is part of privatized religious meaning-making (Doehring, 2015; Herman, 2011). Such practices help survivors compassionately counteract hyper-arousal, intrusive memories, and avoidant coping when they begin to explore traumatic memories. Emerging research on trauma and moral distress suggests that, in addition to issues of fear, shame and guilt also need to be considered at the outset of psycho-spiritual care (Herman, 2011). Spiritual caregivers are uniquely equipped to help morally-distressed trauma survivors find spiritual

practices that help them experience a sense of self-compassion and/or a transcendent experience of the compassion of God or the goodness of creation (Doehring, 2015; Kinghorn, 2012). When shame is compassionately addressed at the outset of spiritual care relationships, allowing morally-distressed trauma survivors to experience compassion through spiritual practices, they will be able to compassionately explore intrusive memories involving moral distress.

Empathically Assessing Trauma-Related Symptoms

Sophia experienced the violation of a sexual assault with someone she admired who seemed to share many of her values. Sam faced death when his patrol came under attack He witnessed his buddy being seriously injured and tried to keep him alive until medics arrived. These clients experienced existential and physical danger. In the weeks following these life-threatening events, they reacted with symptoms of acute stress: re-experiencing the horror of what happened in flashbacks and dreams, being on alert for danger, having sleep problems, feeling numb, and avoiding trauma-related cues and reminders.

These reactions to intensely fearful events, while upsetting and disruptive, are the way people grapple with and adjust to life-threatening experiences. Fear is an evolved and adaptive response to threats that helps people like Sophia and Sam survive the initial trauma and cope in its aftermath. Their fear-based neurophysiological alarm system alerts them to danger and triggers cognitive, emotional, and motor responses designed to help them survive during the traumatic event and as they adjust to having survived. Pastoral theologian Jason Whitehead (2010) argues that that the hope of survival is part of how fear works as a neurophysiological survival mechanism. Hope of survival is the undercurrent of fear that pulls Sophia and Sam out of danger. Trauma-related symptoms (re-experiencing fear in flashbacks and dreams, hyper-vigilance, and avoidance) are all ways that human beings automatically try to protect themselves

from further life-threatening stressors. For example, when Sophia is alone with male colleagues her fear-related shortness of breath and racing heart function like an alarm system warning of danger, as Figure 1 illustrates.

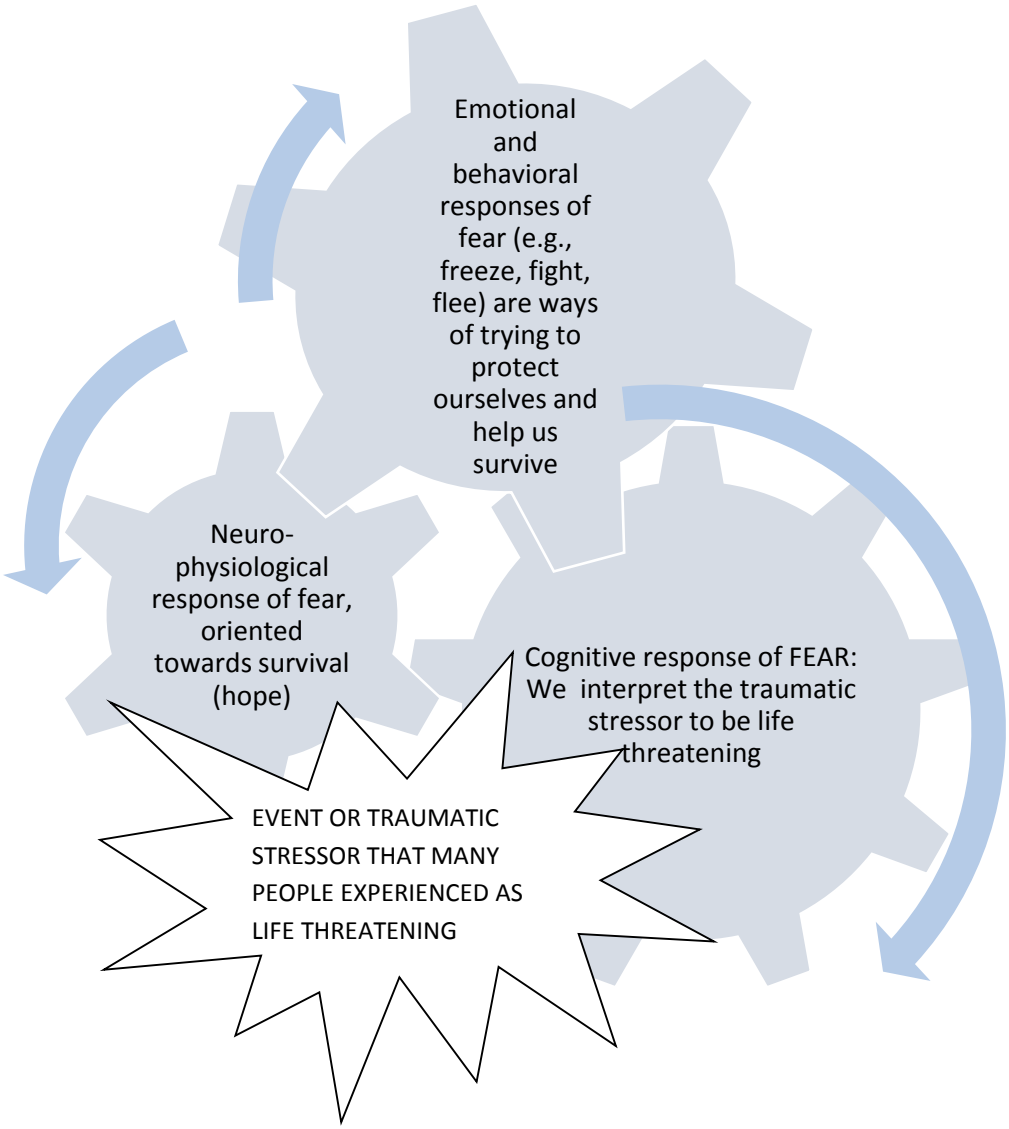

Figure 1. A life-threatening stressor triggers an immediate cognitive assessment that we are in danger, which almost instantaneously sets off a neurophysiological fear response (fright) followed by emotional and behavior responses (i.e., flight/freeze)

Usually trauma-related symptoms subside in three to six months, as survivors cognitively process these fear-based responses to threat, experience social support, and gradually learn to manage the lingering effects of their traumatic experiences. At least half of all trauma survivors are resilient.[1] When symptoms remain intense and persist past a month, people may develop acute PTSD; symptoms that persist beyond three months may indicate chronic PTSD. Chronic trauma-related symptoms often negatively affect the survivor's moods and thoughts about themselves and others, sometimes resulting in shame, guilt, blaming, and unhappiness with life in general. Sophia, for example, used to enjoy work relationships and felt confident exploring interests with men to whom she was attracted. Now she questions and blames herself, is fearful around male colleagues, and takes no pleasure in work or work-related travel. These trauma-related emotions are linked with values and beliefs based on rape myths that support the "cultural scaffolding of rape" (Gavey, 2005)—"an underlay of contradictory values, norms, ideas and practices [forming] a matrix of rape-supportive discourses" (Gavey & Senn, 2014, p. 347). Social systems like sexism, heterosexism, racism, and classism intersect to form specific rape myths that Sophia has internalized (Ramsay, 2013). She would benefit from a safe and trusting counseling relationship that helps her compassionately understand persistent trauma-related symptoms, find ways to experience safety and goodness, identify life-limiting beliefs and practices that exacerbate PTSD, and claim life-giving beliefs and practices that connect her with goodness.

PTSD is more likely when the threat of death or violation is severe (like combat and sexual assault) and especially when there are injuries and powerlessness. PTSD is also more common among people without support systems and relationships where they can process what

[1] "Resilience is a multidimensional construct that includes genetic, neurohormonal, cognitive, personality, and social factors" (Friedman, Resick, & Keane, 2007, p. 11).

has happened. Sophia's shame and fears about retaliation from her assailant prevented her from telling anyone what had happened. She tried to cope on her own. Without being able to rely on a compassionate and affirming circle of supporters, she was more vulnerable to negative moods, shame, and self-blaming. Another contributor to PTSD is a history of trauma and/or psychological vulnerabilities (i.e., anxiety, depression, addictions). In summary, PTSD will be more likely when there is

- a severe sense of threat and injury
- a lack of social support—the most important posttraumatic factor in whether people recover (Brewin, Andrews, & Valentine, 2000).

Pre-traumatic risk factors include

- a history of trauma
- a history of mental illness
- being girls and women, and thus more likely to experience sexual abuse, sexual assault and intimate partner violence—particularly toxic kinds of trauma
- being young
- being in a minority race
- being in a lower socio-economic status and educational level (Brewin, et al., 2000).

Pastoral counselors can help clients track trauma-related symptoms, and whether they continue to be intense and disruptive a month or more after a traumatic event. They can also assess risk factors that make PTSD more likely (listed above).

Emerging research on trauma and moral distress suggests that, in addition to issues of fear, shame and guilt also need to be considered at the outset of psycho-spiritual care (Herman, 2011). Spiritual caregivers are uniquely equipped to help morally-distressed trauma survivors find spiritual practices that help them experience a sense of self-compassion and/or a transcendent experience of the compassion of God or the goodness of creation. Many military service members and veterans deployed to Iraq or Afghanistan faced morally questionable or ethically ambiguous situations that are typical of counter-insurgency, guerilla warfare (Litz, et al., 2009, p. 696). Sam's experience illustrates a combat-related event in which he tried to do his best but still felt like he had failed. His moral distress arises from the interacting values and beliefs of his religious and military cultures.

In the spiritual domain clients experiencing spiritual and moral struggles may feel disillusioned and hopeless. They may have difficulties feeling thankful and not be able to access practices or routines that foster self-compassion, or connect with God or a sense of the sacred. These *spiritual* struggles have a ripple effect in the following domains. In the *physical domain*, clients may experience trauma-related startle responses, hyper vigilance, headaches, stress-related health problems, stress-related pain, and sleep problems. In the *emotional domain*, they may experience numbness, emotional shut down, worry, anxiety, depression, anger, distraction, difficulties calming down, being on an emotional rollercoaster, and craving an adrenaline rush. In the *cognitive domain*, they may experience trauma-related automatic thoughts that reinforce negative beliefs about self and others. In the *behavioral domain*, they may struggle with impulsive behavioral ways of coping like using addictive substances, overeating, excessive use of internet (like social networking or cybersex), and gambling. In the *relational domain* they may end up withdrawing from or avoiding others, experiencing social anxiety and isolation, and

impatience/displeasure with more superficial socializing. They may also have difficulties with intimacy and use coercive and violent ways of handling relational stress.

Twenty-year old Sam, for example, has a recurrent nightmare of not being able to find his emergency medical supplies while his buddy bleeds and cries for help. He wakes up shaking and then is tormented by guilt that makes it hard for him to fall asleep again (a physiological effect of PTSD). He is tempted to use a prescription painkiller to dull his psychological torment. He knows that getting up and starting his morning routine of exercise would help (a life-giving behavioral and physiological way of coping) but instead he lies in bed, ruminating about how tired he's going to be all day, generating more negative thoughts. He feels totally alone and misses the physical comfort and release of tension he experienced in a previous partnership that ended when he was deployed. He's tempted to go online to a pornographic website (another life-limiting behavioral way of coping). He tries to use a meditative prayer that he practiced with the chaplain. As he focuses on the prayer, he can hear his minister's voice coaching him. He is finally able to physically relax and starts to have more positive thoughts about himself and his life. The more he can intentionally use this kind of spiritual practice that evokes positive thoughts and memories, the more he will experience beneficial ripple effects.

When clients access spiritual ways of fostering self-compassion, these spiritual practices can lead to post-traumatic/spiritual growth and resilience to traumatic stressors, which include increased self-compassion, feeling connected with God/ a sense of the sacred/the beauty of life, finding supportive spiritual communities, and experiencing a sense of purpose. Spiritual integration will in turn have ripple effects in the following domains. In the *physical domain* signs of post-traumatic/spiritual growth and resilience include better health overall, the ability to relax and cope with startle responses and hyper vigilance, and healthy and efficient sleep patterns. In

the *emotional domain* signs of post-traumatic/spiritual growth include calmness, peacefulness, feeling confident, being fully present in the here and now, and growing emotionally through stress. In the *cognitive domain*, clients will be able to draw upon life-enhancing religious and spiritual beliefs and values energized that can counteract automatic negative thoughts. In the *behavioral domain* signs of post-traumatic/spiritual growth will manifest in a healthy life style and habits, like exercise, nutritious eating, moderate use of pleasure-inducing substances and routines. In the *relational domain* clients will find relational ways of coping with stress that deepen intimacy, and increased enjoyment of quality time with partners, family, and friends.

Psycho-spiritual education about trauma, along with journaling that tracks various aspects of trauma-related symptoms, are strategies used in cognitive behavioral therapy (CBT), one of the best evidence-based treatments (Resick, Monson, & Rizvi, 2008). Spiritually-integrated approaches to PTSD are showing promise (Murray-Swank & Pargament, 2005, 2008; Murray-Swank & Waelde, 2013). Throughout my description of intercultural pastoral counseling I incorporate (1) spiritual practices that foster compassion and (2) cognitive behavioral treatment strategies that focus on the client's trauma-related emotions and thoughts.[2]

Specific features of CBT incorporated into this chapter's description of pastoral counseling for PTSD are the use of journaling and psycho-spiritual education about trauma, trauma-related symptoms, and their impact on all aspects of well-being, especially spiritual well-being. Clients use journaling in order to track trauma-related symptoms and their associated thoughts, feelings, and behaviors, along with coping strategies (what works and what doesn't). Journaling helps clients identify and break the associations between trauma-related automatic

[2] Pastoral counselors will need specialized training and supervision in order to use CBT treatment strategies like exposure treatment (graduated levels of prolonged exposure to imaginal and *in vivo* trauma-related stimuli using the client's hierarchy of anxiety-provoking situations/memories), Eye Movement Desensitization and Reprocessing (EMDR) and Dialectical Behavioral Therapy (DBT).

thoughts and their effects on emotions/physical sensations, and behaviors, and all aspects of well-being—spiritual, physical, emotional, cognitive, behavioral, and relational.

Clients, for example, can keep a daily record of when they experience trauma-related symptoms, how disruptive they are (on a 10-point scale), what seems to have triggered symptoms, and how they coped. These journal entries help counselors and clients track type, frequency and severity of trauma-related symptoms and the initial ways clients cope. As pastoral counseling moves from the assessment and psycho-educational phase into a psycho-spiritual focus on coping, clients can use journaling to track whether the spiritual and religious ways they cope enhance or undermine a sense of safety.

Identify, Evaluate and Integrate the Client's Lived Theology

Once clients have identified and evaluated habitual coping strategies and tested life-giving spiritual practices, they will be ready for the final phase of counseling: exploring their lived theology. Lived theologies and spiritual orienting systems consist of the emotionally-charged constellations of beliefs and values that clients put into practice in coping behaviors. Journal entries about trauma-related emotions and automatic thoughts provide clients with data for exploring the underlying beliefs and values of their lived theologies and spiritual orienting systems. Clients will have the opportunity to assess whether these orienting systems are congruent with their espoused or intentional theology (what they say they believe in).

Many trauma survivors find that traumatic events and memories tap into lived theologies formed in childhood. Clients can be invited to think about their lived theology as multi-layered:

- pre-critical childhood beliefs and values shaped by family and experienced as literally and absolutely true; one could say in a pre-modern sense.

- values and beliefs formed in adolescence and young adulthood, using critical perspectives gained developmentally and through mentoring and higher education. Often these values and beliefs draw upon more modern ways of thinking.
- maturing values and beliefs shaped through ongoing formative experiences and relationships. These beliefs and values are usually intrinsically meaningful in terms of a more contextual post-modern approaches to knowledge (Doehring, 2015).

Metaphorically speaking, trauma is like an earthquake that exposes beliefs and values formed in childhood that may be buried but still exerting an influence in the form of emotionally-charged automatic thoughts. Pastoral counselors can help clients assess this embedded childhood theology in terms of whether it is still relevant and life-giving to them in adulthood, especially as they cope with trauma-related symptoms. As clients keep track in their journals of trauma-related emotions and automatic thoughts, they can note whether such thoughts are rooted in life-giving or life-limiting embedded values and beliefs from various phases in their lives. They can also test whether trauma-related symptoms are alleviated by intentional use of spiritual practices that reflect enduring life-giving core values and beliefs.

Over time, this journaling and use of intentional practices will help clients identify and set aside life-limiting values and beliefs triggered by automatic thoughts, countering them with life-giving values and beliefs that anchor their sense of who they are. The more these anchoring values and beliefs are claimed and intentionally put into practice, the more clients will experience trauma-related spiritual and psychological growth and the integration of traumatic memories into life-giving self-narratives. Clients will then be able to remember without being overwhelmed and will slowly be able to ‘digest’ the horror of what happened and incorporate traumatic experiences in life-giving ways into their life narratives.

Theologically Reflecting on the Benefits and Liabilities of Lived Theologies of Trauma

Counselors trained in pastoral theological studies[3] can draw upon their theological expertise in helping clients assess the consequences of the theologies of trauma inherent in their values and beliefs, especially embedded theologies from childhood. Counselors' religious and theological education gives them an historical and comparative understanding of various religious and theological ways that people have tried to make sense of and live with suffering. There are, of course, innumerable philosophical and theological treatises on evil and the problem of suffering. Theologian Susan Nelson (2003) provides a helpful introductory typology of five ways of understanding suffering within Christian traditions.[4] In reviewing various ways that religious traditions have struggled to make sense of suffering, pastoral counselors can consider how such understandings may be life-giving or life-limiting in the process of coping with trauma-related symptoms, and also in the long-range meaning making process.

The most common Christian ways of understanding suffering described by Nelson are moral and redemptive theologies. Some traditional moral theologies function in life-limiting ways when people inappropriately blame themselves, believing that trauma and suffering is a consequence of their personal sin and a punishment from God. More complex moral theologies function in life-giving ways when people need to hold themselves accountable. Sam held himself accountable when he didn't provide the best emergency care he could have. He felt as though he had compromised moral ideals instilled during his military training. Sam realized that his guilt

[3] Pastoral theological studies are a form of practical theology in which pastoral praxis is brought into dialogue with relevant theoretical perspectives like religious, psychological and theological studies.

[4] Interculturally, counselors need to refrain from "translating" beliefs about suffering from other religions of the world into this Christian typology. In the end, they will be exploring how each client describes and assesses their own lived theologies. Nonetheless, summaries about theologies of suffering can orient counselors to some of the benefits and liabilities of these theologies.

was exaggerated when he and his counselor talked about Sam's commander's assessment that everyone had done the best job they could. Sam also realized that his all-or-nothing thinking and sense of over responsibility contributed to his automatic thoughts of guilt and his moral approach to suffering.

Sam also found that some of his childhood beliefs in redemption became life-limiting when he automatically thought that his anguished ruminations on his buddy's amputation were his cross to bear. He recalled his minister's counsel: tormenting himself with blame was not a cross to bear that would somehow redeem his buddy's suffering.[5] Sam found that redemptive theology was life-giving when he experienced God's compassion with him in his suffering, and later, when he looked back and saw that this compassion, especially embodied in his minister, brought forth new life (Jones, 2009; Rambo, 2010; Swain, 2011).

A third historically significant Christian theology of suffering is eschatological, focused on moments of hope that point to a future when suffering will be alleviated. Nelson makes this theology especially relevant for trauma survivors by describing the moments of hope that pierce unrelenting fear or horror and help survivor see a light beyond the darkness. Sophia remembered such a moment when she experienced the kindness of the woman at her Employee Assistance Program who helped her find a pastoral counselor. After speaking with her, Sophia felt a sense of hope amidst her lonely struggles to cope and stay engaged at work. She later wondered whether her determined self-reliance was a reaction to the way her mother endured suffering in the hope for some future justice. Her Catholic feminism made her question this kind of hope. Her self-directing way of coping was a lived theology in which her only hope was herself. When she

[5] Marie Fortune rightly argues against this kind of life-limiting redemptive theology: "Rather than *sanctification of suffering,* Jesus' crucifixion remains a witness to the horror of violence. It is not a model of how *suffering should be borne*, but a witness to God's desire that no one should suffer such violence again" (Fortune, 2005, p. 140).

realized she could trust her pastoral counselor, a more life-giving sense of hope emerged, that she would eventually regain her self-confidence and begin to enjoy work again.

Nelson also describes theologies of lament/radical suffering and theologies of ambiguous creation. Lament theologies help many trauma survivors interrogate and lament terrible suffering (Graham, 2006). Sophia lamented how much her assailant had violated her sense of trust by seeming to share her deepest values. She later sought out a spiritual director who could help her engage deeply with God, especially when she was angry.

Theologies of ambiguous creation use 20th century worldviews of creation as systemic, finite, and diverse, with human beings embedded in relational webs that inevitably result in limits and conflicted choices. Relational theistic theologies like process theology describe God's power "as persuasive and relational rather than unilateral; ordered by love and compassionate judgment" (Graham, 2006, pp. 11-12). Feminist theologian Wendy Farley (1990, p. 133) highlights the role of compassion in a process theological understanding of tragedy: "The radical love of God . . . is not overcome by evil . . . In seeing and tasting this love, human beings . . . come to burn with the incandescent compassion for the world, to feel the grief of the world without being destroyed by it… "

Theologically oriented approaches to trauma and moral distress have been proposed by Jones (2009), Kinghorn (2012), Rambo (2010), and Whitehead (2010). Kinghorn (2009, p. 2) argues for the "irreducibly moral context of the combat situation." Spiritual care is not simply a supplement to mental health care but has its own unique expertise and purpose, says Kinghorn (2009, p. 11) "Christians (and religious communities in general) must provide for combat veterans what Shelly Rambo, following Serene Jones, refers to as "morphological spaces" which

provide form and structure to experiences which, due to linguistic and conceptual impoverishment, would otherwise remain unnarratable."

Rambo's, Jones' and Swain's theologies of suffering are primarily oriented to Christian traditions, and specifically theologies of lament and redemption. Such theologies often shape how healing is understood. In an exploratory study interviewing Vietnam veterans who use Buddhist practices to cope with trauma, Doehring and Arora (2013) found that these veterans qualified the idea of healing from trauma by describing how Buddhist practices have enabled them to respond compassionately to posttraumatic stress and moral distress without the resurrectionist overtones of redemptive theologies of suffering. Such practices help them, first, recognize triggers and how they automatically respond to them, and second, help them contemplate their reactions through the lenses of self-compassion and complex understandings of suffering. Each of the veterans came to Buddhist practices after searching for ways to reconnect with some sense of goodness, especially when they re-experienced the horrors of their Vietnam experiences and tried to avoid morally distressing memories. Buddhist practices dramatically changed their experience of post traumatic suffering and, indeed, their lives.

In reflecting on these veterans' experience, Doehring and Arora (2013) explore how Buddhist approaches provide an alternative to commonly used redemptive theologies of suffering. These approaches offer (1) meaning making frameworks for understanding morally distressing memories, (2) practices for emotionally and spiritually processing disturbing memories related to moral distress, and (3) value-based commitments to helping other veterans. The role of self-compassion was central in helping the veterans no longer avoid the moral distress of their traumatic experiences. Buddhist beliefs about suffering helped them develop more complex ways of understanding their experiences, such that they could begin to

comprehend the ambiguous and interconnected relational and cultural webs in which they were caught as young soldiers. Understanding the tragic inter-related dimensions of their suffering and the suffering they may have caused helped them give voice to lament and also assume appropriate responsibility for their actions. Buddhist worldviews helped them accept their moral agency in complex ways that allowed them to incorporate distressing memories into an integrated self-narrative.

The experiences of these veterans highlight the need to monitor how embedded theologies of redemptive suffering are often used to understand trauma but are sometimes unable to hold the lament associated with moral distress within the ambiguity of such suffering. Spiritual caregivers and pastoral counselors need to draw upon their theological expertise to appreciate the radical ways some survivors live out an ambiguous theology of suffering at odds with commonly-used redemptive theologies. While Rambo (2010), Jones (2009), and Swain (2011) offer a much more sophisticated theology of suffering that makes room for lament, embedded theologies of redemption often push people beyond lament to accept resurrection as the ultimate sign of healing. In exploring the intricacies of lived theologies of healing, spiritual caregivers and counselors need theological expertise, even within the context of intercultural care that values the uniqueness of survivors' existential worlds.

In the process of exploring the benefits and liabilities of clients' lived and espoused theologies, clients and their counselors will co-construct and elaborate life-giving theologies of suffering that are deeply anchored in the client's values and beliefs. These theologies can be practiced in several ways. They can be used to counter automatic trauma-related thoughts based on embedded theologies no longer relevant and meaningful. They can also be tested in the client's spiritual and religious practices. Post traumatic growth will increase as clients develop a

well-integrated spirituality that is "broad and deep, responsive to life's situations, nurtured by the larger social context, capable of flexibility and continuity [and] large enough to encompass the full range of human potential and luminous enough to provide the individual with a powerful guiding vision" (Pargament, 2007, p. 136).

Discussion Questions

1. Do you have spiritual practices that help foster compassion, especially self-compassion if trauma is part of your story?

2. This pastoral counseling approach helps people find compassion-based spiritual practices that counteract life-limiting trauma-related lived theologies and spiritual orienting systems. What are the challenges of practicing this approach in your context of care?

3. What kinds of support would you need to practice this approach?

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