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A Theoretical and Theological Reframing of Trauma

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Abstract
Racism, eco-violence, and myriad sociopolitical and interpersonal injustices continuously injure individuals, communities, and the globe, thereby challenging the human capacity to endure. The prevailing biomedical model of trauma, with its emphasis on pathology, fails to acknowledge the traumatic nature of these diffuse and pervasive injuries. The disciplines of spiritual and pastoral psychology are uniquely poised to reconceptualize trauma and reframe it as part of a stress-trauma continuum, given the way trauma can engender great suffering as well as resistance and the possibility of transformation. This perspective eschews the sentiment, ubiquitous in popular culture, that everything stressful is traumatic as well as the notion that "true" trauma is delimited by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR). This article posits a strength-based approach to trauma that contextualizes our societal negativity bias within spiritual values of hope, (post-traumatic) growth, and (possibly) resilience while not diminishing the very real suffering, even despair, that emerge from trauma of all kinds.

Keywords Trauma · Distress · Stress-trauma continuum · Theologies of trauma

Trauma has many types, and it is variously defined according to differences in discipline and context. Definitions of trauma are intended to describe a phenomenon or lived experience, yet they also inform how humans experience the self, relationships, events, and the world. The American Psychological Association defines trauma, in a general sense, as "an emotional response to a terrible event such as an accident, rape, or natural disaster" (APA, n.d.-c). All aspects of creation, including but not limited to humans, endure terrible events. The pervasiveness of such terrible events seemingly supports the attitude, rather ubiquitous in the United States, that everything stressful is traumatic. Yet, not every terrible event is

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traumatic simply because it is distressing. Many medical and mental health professionals argue that only experiences that entail "actual or threatened death, serious injury, or sexual violence" constitute *real* trauma (American Psychiatric Association, 2022). Racism, eco-violence, and myriad sociopolitical and interpersonal injustices continuously injure individuals, communities, and the planet, thereby challenging existence. Even so, the biomedical model of trauma put forth in the DSM-5-TR (APA, 2022), with its emphasis on pathology, fails to acknowledge the traumatic nature of these many diffuse and persistent injuries humans endure. Amid the varying conceptualizations of trauma, the disciplines of spiritual and pastoral psychology are uniquely poised to reconceptualize trauma and reframe it as part of a stress-trauma continuum (Dulmus & Hilarski, 2003), particularly given the way trauma can engender great suffering as well as resistance and even the possibility of transformation.

It is important to acknowledge some of the tensions faced in endeavoring to reconceptualize and reframe trauma. At its core, this is an epistemological enterprise that requires more holistic understandings of "how we know what we know" (hooks, 1994, p. 174). It requires thinking more broadly as well as more narrowly about how trauma is defined, but most importantly, thinking *differently*. Most essential is that we value ways of knowing that are central to non-Western, Black, and Indigenous people and people of color (BIPOC), even if those ways of knowing are in tension with the medicalization of trauma privileged in the United States. While biomedical definitions of trauma are essential for diagnosis and treatment, they are necessarily narrow, limited, and designed to serve the larger biomedical system. Our aim is not to alter how trauma is defined in the DSM-5-TR. Nonetheless, we find it imperative to push against definitions of trauma that fail to acknowledge insidious "terrible events" such as those stemming from racism in the United States or the resilience via resistance that so often co-occurs. The effort to reframe understandings of trauma and push beyond the medical model is rooted in theoretical research as well as empirical research (Bonanno & Mancini, 2012; Frueh et al., 2005; Krupnik, 2019; Marsella et al., 1996; Spoont et al., 2009; van der Kolk et al., 2005).

Method and Positionality

Pastoral psychology is inherently interdisciplinary. Theorists and practitioners in the field aim to be "bilingual" in the "languages" of psychology and theology/religious studies (Doehring, 2015; Snodgrass, 2015). Questions of how these disciplines are integrated have endured for decades and present epistemological challenges (Townsend, 2009; Barbour, 1990) posited four common methods for managing the epistemic tension between science and religion: conflict, independence, dialogue, and integration. In seeking to reconceptualize and reframe trauma, we employ an integrative method wherein we view psychology and theology/religious studies as allied, mutually informing disciplines. Coherence between the two is possible because knowledge is always both constructed and revealed. The psychological sciences, and some may argue theology, aim for objectivity and neutrality, yet both are culturally informed and constructed. Therefore, we do not place primacy upon biomedical/psychological, nor upon theological/religious wisdom. Rather, we aim to understand how the wisdom from each can be integrated toward a coherent conception of trauma that is both culturally relevant and liberative.

Although we take an integrative approach, our religious locations (Greider, 2019), and other aspects of our social identities and lived experience, dispose us to view the psychological with a hermeneutic of hope. As two White, cisgender, heterosexual females, we each experience myriad privileges in the United States. We are both ordained in Christian denominations (Jan in the United Methodist Church and Jill in the United Church of Christ), which biases us toward making deliberative meaning from affliction and seeking hope, practices most surely facilitated in part by our privileges.

My (Jan's) worldview is strongly impacted, personally and professionally, by my research over the years in refugee camps and conflict areas (South Sudan and the Democratic Republic of the Congo) with persons who have experienced war, famine, and violence in many forms. From them I have learned much about what we would call trauma as well as the many ways that people are resilient in the face of circumstances that cause despair. I am resolute in the inclusion of a cultural (and intercultural) lens through which to ask questions of God, faith, and the human predicament. I attempt, though imperfectly to be sure, to live into a vigilant stance of practicing and building social empathy in the world I inhabit. My (Jill's) perspectives on trauma are influenced, in part, by my own experiences of distress that are often classified in U.S. culture, accurately or not, as traumatic (one example being miscarriage and infertility). My experience teaching undergraduate students amid the COVID-19 pandemic has shown me that the mental health crisis facing youth and emerging adults in the United States is indisputable (U.S. Department of Health & Human Services, 2021), yet students frequently consider their distress to be symptomatic of trauma. Certainly, their psycho-social-emotional development impacts how they appraise and construct their experiences. But culture also seems to support distorted appraisals of distress and coping.

Current Cultural Constructions of Trauma

Language Matters

The use of the term "trauma" to describe personal distress has become so ubiquitous as to cause a recent *New York Times* opinion editor to ask: If everything is trauma, is anything? (Bennett, 2022). Trauma, much like depression and anxiety, has become a catch-all term for distress. We find ourselves in a vocabulary desert when it comes to words that describe difficult events and the feelings they evoke. What most people today do know, put simply, is that posttraumatic stress disorder (PTSD) is caused by terrible events that the mind cannot wrap itself around. Of course, the clinical language for PTSD and other stressors in the DSM-5-TR is much more complex. Nonetheless, in this current era when extraordinary events seem to be outcompeting themselves, colloquial practice has come to depend heavily on the use of the term trauma to describe these distressing experiences. Our "idioms of distress" have narrowed to the point that any distress can be labeled traumatic (Nichter, 1981).

While it is easy to blame the dearth of linguistic agility on popular culture, the truth is much more complicated. Our cultural dependency on trauma language to describe psychological distress has been shaped by decades of increasing dependence on biomedical models for mental illness. In any given culture a variety of ways exist to express distress. Expressive modes are culturally constituted in the sense that they initiate particular types of interaction

and are associated with culturally pervasive values, norms, generative themes, and health concerns (Nichter, 1981, p. 379).

In the United States, and arguably in most Western societies, we depend on the formula of medical diagnosis, treatment, and cure to address our modern ills, be they physical or mental. The popular perception of and language with which we describe mental disorders have been shaped by these clinical models to such a degree that we have lost our ability to describe them otherwise (Davis, 2020). This trauma language serves to validate suffering of all kinds, particularly that over which we have little control (Fassin & Rechtman, 2009). Yet when our sole language for understanding trauma is bound by this biomedical model, we unnecessarily limit our understanding of which experiences are considered traumatic, what the effects of that trauma might look like in the lived experience, and even to whom (or to what creatures) we may apply the notion of trauma in the first place.

Language informs how we construct, narrate, and understand our experiences. bell hooks (1994) noted that "shifting how we think about language and how we use it, necessarily alters how we know what we know" (p. 174). If what we come to know in the context of distressing experiences, especially in uncertain times when one seems to have no control, is consistently constructed as traumatic, it reduces the propensity toward resilience and growth. Naming all our experiences as traumatic can be life-limiting. Paradoxically, biomedical constructions of trauma delimited to events that entail "actual or threatened death, serious injury, or sexual violence" can invalidate the enduring distress that some humans experience in the face of systemic oppression or multiple stresses stemming from ongoing planetary devastation (APA, 2022). In these and other situations, naming such experiences as traumatic can be a life-giving witness to the damage and strain endured. Practicing "language care" is essential to reconceptualizing trauma and reframing it as part of a stress-trauma continuum (Bueckert & Schipani, 2006). Caring for the language we employ and taking care to define that language precisely can be both a pastoral practice (or discipline) and a pastoral intervention.

The Seeming Pervasiveness of Trauma

In many ways, the COVID-19 pandemic represents a turning point in the human experience of terrible events. Though not experienced on an equal level by all globally, the awareness of the potential for illness, the ever-increasing death toll, and the accompanying deleterious racial, economic, and political repercussions are unparalleled in recent memory, if not beyond. Concurrently, the media and popular culture has magnified the traumatic potential of myriad life experiences, including identifying as LGBTQ+ (LA Blade Digital Staff, 2022), running while Black (Streeter, 2020), gun violence and school shootings (Blake, 2022), interpersonal violence (Hillstrom, 2022), and other terrible events. The traumatic potential of everyday life has, some argue, shaped an entire generation. Maxwell Alejandro Frost, a 25-year-old running for Congress in Florida's 10th congressional district, told an NPR interviewer, "Our generation [Gen Z] has been born into a lot of trauma and a lot of civil unrest around people being frustrated with things. And I think because of that, our generation naturally thinks about things in a bit of a different way" (Moore, 2022). Assertions such as these are often attempts to witness and honor suffering, but an unintended consequence can be the medicalization or the pathologizing of distress.

Over 20 years ago, psychiatrist and philosopher Patrick Bracken (2002) argued against the "trauma industry." According to Bracken, biomedical conceptualizations of trauma erroneously reify universal truths about terrible events by positing that the mind, regardless of whose mind, will process such events in the same general way. Yet, not all humans' autonomic nervous systems function the same, and meaning-making is highly subjective and contextual. Humans most often make meaning of distressing events in community, not in isolation. Individuals, families, and communities conceptualize experiences of distress as traumatic in part because such conceptualizations are culturally supported in cultures where distress has been medicalized (White et al., 2017).

Individually and collectively, many in the United States, particularly in this current time, seem to be struggling to cope with and manage their emotions of distress. Yet paradoxically, the medicalization of distress contributes to and supports a low tolerance of distress, which ultimately impedes our ability to cope. This is particularly problematic given that "low tolerance to distress is an important predictor of psychopathology and maladaptive health behaviors, including anxiety, depression, substance abuse, eating disorders, and borderline personality disorder," the experience of which can contribute to our self-appraisal as being "traumatized" (McIntosh et al., 2021, p. 2).

The Movement for Global Mental Health (White et al., 2017) and contemporary psychological aid to refugees exemplify the problems Bracken (2002) raised regarding the medicalization of distress. Humanitarian psychiatry has over the last 20 years exported the Western medical model of PTSD and the consequent dependence on trauma language to refugee and internal displacement camps, disaster zones, and conflict areas around the world (Bracken, 2002; Fassin & Rechtman, 2009; Summerfield 1999). Interestingly there is very often a notable absence of an indigenous word for trauma, or even some of the common responses to the effects of traumatic events, in these other cultures. For example, there is no indigenous word for trauma in South Sudan even though they have been engaged in some level of conflict for many decades or longer (Holton, 2011). Rather, as with Arabic words and cultural concepts subsumed into tribal languages, PTSD has likewise been imported to describe the specific clinical symptoms of trauma. It is difficult to believe that a people at war for decades would not have their own words to describe what are considered in the biomedical model to be universal emotions and behaviors associated with the effects of war. Some have made the argument that the South Sudanese were simply unaware of what responses one might expect from the trauma of war, a perspective that negates the wisdom of the culture and fails to embrace the concept that the meaning of such experiences is constructed rather than a foregone outcome of a terrible event like war.

The medicalization of distress and the proliferation of the trauma industry are also evident in the qualifications for refugees seeking asylum in the United States. Refugees are required to show evidence of trauma, particularly by means of a psychiatric assessment but also through photographs of wounds and other sources of documentation (Fassin & Rechtman, 2009). This demonstrates not only the medicalization of distress but also its politicization. It is not without some degree of irony that while asylum-seekers are required to be trauma victims to receive asylum, the experiences of many BIPOC, who have endured arguably the greatest degree of racism, violence, and ongoing uncertainty in the United States, do not satisfy cultural or biomedical conceptions of trauma. Whose suffering will be legitimated by being granted or denied the arguable privilege of being deemed trauma

induced? What authorities exercise this power, and why is it that everyone is so eager to have their experience validated and thereby be designated a trauma survivor?

From Adverse Childhood Experience to Trauma Informed

Before presenting psychological and theological conceptions of trauma, it is important to briefly reflect upon how trauma came from the margins to the center of cultural discourse. In 1966, the National Academy of Sciences identified trauma as the most "neglected disease of our society," rendering trauma a central focal point for research across disciplines (Committee on Trauma and Committee on Shock, 1966). This sentiment set the groundwork for the Adverse Childhood Experiences study, a seminal study conducted from 1995 to 1997 by the Center for Disease Control and Prevention and Kaiser Permanente Health System that resulted in pivotal information about the correlation between the effects of various early life stressors and outcomes later in life. The study has proven indispensable for large-scale public health planning and policy even today. Over the last 20 years, however, the results of the ACE study also have been pushed to the frontlines in medical, social work, and other contexts on an individual level through the use of the ACE-10 questionnaire, a 10-question assessment that attempts to measure the number of specific stressors in childhood. In doing so, advocates for its use imply a causal relationship between early trauma and detrimental effects later in life. Public health researchers have strongly criticized these ACEs screenings, the algorithms used to assess risk, and how they are utilized, saying:

> [P]rojecting the risk of health or social outcomes based on any individual's ACE score by applying grouped (or average) risk observed in epidemiologic studies can lead to significant underestimation or overestimation of actual risk; thus, the ACE score is not suitable for screening individuals and assessing risk for use in decision making about need for services or treatment [and further,] although the health conditions listed within the [ACE score] algorithm have been associated with ACEs in epidemiologic studies, most occurrences of many listed conditions are caused by factors other than ACEs. (Anda et al., 2020, pp. 293–294)

The ACE study has also raised the question of how to train professionals to be aware of significant stressors, including trauma, in the lives of those to whom they offer services. From this has emerged a trauma-informed paradigm that now shapes the training of professionals across multiple disciplines, including healthcare, social work, church, and education, to name a few. Harris and Fallot (2001), early leaders in trauma informed mental health practice, advocate for "administrators [to] declare their intent to make an understanding of the impact of violence and victimization an integral part of the mission of their agencies" (p. 6). It would be difficult to argue that methods of improving the understanding of people's lives and the events that shape them is not a good thing, but, like the use of ACE-testing, the push for trauma-informed services has frequently become overly reductive as it has spread beyond the mental health context.

Ultimately, the over-popularization of the ACE study, ACE scoring, and trauma-informed paradigms, especially through social media during the recent years of the pandemic, make us aware of the tension always at play when discerning the value and use of large-scale studies and all that trickles down from them. Surely, professionals of all sorts and the citizens

they serve benefit alike from being better informed. We must stay vigilant, however, for the increasing and unhelpful ways that distortions and unexamined overuse of these same tools shape and misshape trauma discourse among the general public.

Theologies of Trauma

The medicalization of distress, a cultural phenomenon, both influences and is influenced by Christian theological anthropology as well as understandings of God and Jesus. Whether we heard it from a grandmother or a seminary professor, many of us have been deeply shaped by the notions of humankind's fallen, sinful nature and the idea that were it not for human disobedience, human existence would be perfect, immortal, and, most importantly, free of suffering and distress. This theology makes suffering not just unfortunate but a punishment to be avoided at all costs. It is a de facto theology of distress in which we can easily become perpetually caught between what should be and what is. The theological narrative we hear less often is one in which we are created by God as the finite creatures that we are and are celebrated as good, even within all of our limitedness (Farley, 1990; Tillich, 1951). In this view suffering, while not something to be celebrated, is still an experience of the human condition but one that comes to us without an implicit moral failing. This perspective does not mean that we do not also recognize the ways that humans always fail (in our finitude) to perfectly live into the love, expectations, and unlimited possibilities offered to us by a redeeming, loving, and grace-filled God. These are not just abstract philosophical musings. Our understanding of who we are in our naked creatureliness has practical consequences in feet-on-the-ground everyday living and particular consequences in how we shape a theology of trauma.

The emphasis on humanity's fallen nature also contributes to the Christian tradition's focus on the woundedness and suffering of Christ and his followers. Paul attributed his own woundedness, a "thorn in the flesh," to God that he might be "made perfect in weakness" (2 Corinthians 12:9). The belief that wounds are a conduit to faith pervaded the life of the early church, particularly when many endured persecution. In much of Christian theology, woundedness not only binds humans with one another in a common experience but connects humans to the suffering Christ and God. Historically, connection with the suffering Christ emboldened Christians to cope with life in a fallen world. For those who have suffered at the hands of others, the notion of living in the woundedness of Christ can draw one closer to God.

The notion that suffering and trauma are inherent to the Christian journey is part of many Christians' embedded theology.[1] Regrettably, such theological perspectives are often used to normalize distress and trauma among contemporary Christians. Similar to the way that trauma language can validate our suffering, the enduring of suffering can be used to validate our faithfulness as Christians. Identifying with the suffering Christ in such a manner can be helpful but in the long term can also leave sufferers stalled in victimhood and unable to envision horizons of hope. Life-limiting theological perspectives on suffering have been

[1] Drawing on the work of Stone and Duke (1996/2013), Carrie Doehring (2014) defined embedded theology as the "beliefs and values instilled throughout childhood, which exert an unconscious influence and surface under stress. Embedded theologies are those pre-critical and often unexamined beliefs and practices that have become a habitual part of one's worldview and practices" (para. 8).

employed to justify violence, abuse, and oppression. Conversely, the medicalization of distress has contributed to both implicit and explicit encouragement to take pride in the "privilege to suffer as Christians. . [for such] trials and tribulations in connection with the r are honorable and profitable" (Walker, 2020, paras. 2–3).

The valorization of trauma is problematic, especially when emphasized over and above God's transforming power in a manner that leads Christians to seek suffering (Dyer, 2010–2011). "That Jesus suffered and died for others to bring about salvation models behavior that Christians seek to follow," thus communicating the message that "suffering is redemptive" (Dyer, 2010–2011, p. 181). Rather than focusing on the uniqueness of Jesus' suffering, some Christians are misguidedly emboldened to "take up their cross and follow" Jesus (Matthew 16:24), sanctifying their own suffering and trauma and, in some cases, colluding with the abusive acts of perpetrators and transgressors. In contrast, exhortations on suffering such as those found in Hebrews were meant to help Christians resist evil, not to condone it (Stevenson-Moessner, 2003). Rather than perpetuating evil via life-limiting theologies, Christians can act with compassion toward the transformation of trauma and suffering (Swinton, 2007). Shifting problematic, embedded theologies of trauma to more deliberative, life-giving theologies is necessary but can be tremendously difficult. Nonetheless, Scripture and the Christian tradition offer profound wisdom for engaging in this task.

Reframing Theologies of Trauma

Too often trauma and resilience are framed as dichotomous constructs and experiences; resilience is considered the defeat of trauma (i.e., an outcome) when, according to both scriptural and psychological wisdom, resilience is also a process that co-occurs alongside adversity (Werdel & Wicks, 2012). Scriptural examples of this abound, but given the scope of this article we highlight just three. First, consider how Jacob wrestled with the "angel" as recounted in Genesis. Jacob wrestled the angel, physically toiling throughout the night, until the angel departed at daybreak. Jacob received a blow to the hip that wounded him, crippling him for the rest of his life. But, in spite of the scars, Jacob also received a new name, "Israel," meaning "one who struggles with God." Amid the trauma of his battle, a metaphorical and literal confrontation with his own growing edges and with God, Jacob was simultaneously wounded and blessed by the struggle.

Second, the New Testament portrays Jesus, time and time again, with his "back against the wall" (Thurman, 1949/1996). In *Jesus and the Disinherited*, Howard Thurman reminds us of the essential fact that Jesus grew up and lived as a dark-skinned Jew under the oppression of empire. Among all the interpretations of Jesus' life and death, the most important speak "to those who stand, at a moment in human history, with their backs against the wall" (Thurman, 1949/1996, p. 11). God did not take on human form as a Roman elite but as a poor Jew. Jesus lived as an outcast facing injustice daily. But Jesus' life is ultimately one that demonstrates resilience amid oppression. He exercised power by choosing his response to the distresses of this world. Jesus taught that the alleviation of distress, or the eradication of injustice, would not be enacted by laws but by the ethical practice of love grounded in love of God, other, and self.

Finally, although Jesus did not call Christians to seek trauma and suffering, the Scriptures offer numerous examples of Jesus speaking transparently about the simultaneously arduous and blessed nature of discipleship. Consider, for example, the Beatitudes recounted in Mat-

thew. When Jesus stated, "Blessed are those who hunger and thirst for righteousness, for they will be filled" (Matthew 5:6 NRSV), he was not foreshadowing an eschatological, otherworldly blessing. It was not that the hungry *will be* blessed; they already are. The struggle for right relationship and justice is both inherently distressing and generative.

Despite these scriptural examples of co-occurring resilience and adversity, many Christian theologies of trauma focus most closely, if not entirely, on how the suffering associated with PTSD is reflected in the wounds of Jesus at the end of his life as he hung on a cross. This can undoubtedly be a great comfort to victims of PTSD, especially those just recognizing themselves as such, who feel alone, abandoned, and misunderstood. To stay in this place of woundedness, though, risks condemning victims of trauma to a life of victimhood and undermines the power of ongoing resurrection that recognizes moments of growth amid suffering. Identifying solely with Christ's wounded nature prevents one from becoming a victim-survivor.

The cross is only one end of a continuum of suffering and stresses for Jesus and for all those who live under the thumb of oppression. A theology of trauma cannot overlook the ways that Jesus speaks into the lives of all who live on a continuum of traumatic injuries. In the secular context we as a western culture have held to the particular diagnostic truth that PTSD is the ultimate plumb line by which real trauma is determined. It is true that any theology of trauma must acknowledge that not all distress is traumatic; our finitude ensures that struggle is a part of life. A reframed pastoral theology of trauma, however, must recognize that the life spirit of those with their backs against the wall is a spirit that is denied its freedom and dignity and carries a trauma no less wounding than biomedically sanctioned PTSD. From his earliest days as a refugee through his life as a dark-skinned man living under the foot of empire, Jesus' life reflects the suffering of people the world over who face injustice and oppression as their daily reality. His life and ministry offer a way of knowing about the world and the struggle it brings. A Christian trauma theology must be inclusive of Jesus' life as a continuum in which persons of color, those living in poverty, and others see and find hope for their own traumatic struggle, even if it is not reflected in the DSM-5-TR diagnostic criteria for PTSD.

Psychological Theories of Trauma

Let us begin by noting that contemporary psychological wisdom is heavily informed by the DSM, first created by the American Psychiatric Association in the early 1950s to establish a common nomenclature around psychological pathology and distress that located its origins in biological causes. The advantages of a biomedical diagnostic model for the treatment and care of persons with mental disorders, including PTSD, has been substantial but is not without cost. Locating clinical psychology and diagnosis within a medical framework has legitimized mental illness not only for treatment purposes but also for healthcare reimbursement, pharmaceutical intervention (though dependence on pharmaceuticals may also tip over into a harmful trend), and, importantly, as areas of concern in the eyes of the general public. This deductive model, however, also narrows how we conceive of illness and diagnoses, thereby employing a deficit-based approach that eschews other important social influences that shape life experiences, health and unhealth, and the resourcefulness of individuals. It is

these aspects that are especially relevant to expanding our understanding of trauma and that we bring into focus in this article.

A history of psychological theories of trauma is beyond the scope of this project; however, it is important to note several touchstones along the way to a developed psychology of what today is termed trauma. Trauma, called in more recent decades shell shock, war neurosis, or combat fatigue, has been well recognized over the centuries as a response to the experiences of war and combat (Crocq & Crocq, 2000). The psychiatric treatment of "post-Vietnam syndrome" in Vietnam War veterans arguably served as an entryway into what became the DSM diagnosis of PTSD (Fassin & Rechtman, 2009). The focus then broadened in subsequent years to include the traumatic experiences of children and eventually of women; perhaps most notable in this regard was the seminal work of Judith Herman (1992). Regardless of the era or the population, psychological theories of trauma reflect and are embedded in the sociocultural context.

The United States is unique among other countries in its use of the DSM-5-TR as the diagnostic tool for mental health conditions, including PTSD. Although Australia is rapidly also switching to its use, other member states of the World Health Organization adhere to the International Classification of Diseases (ICD) system, now in its eleventh version, for the centralized classification of all diseases, including mental illnesses. Although our purpose here is not to run a full comparison between the two classification systems, it is helpful to consider how the diagnosis of mental health disorders such as PTSD has been framed in this country and globally.

Trauma neurosis, the experience of psychological and physical distress stemming from disasters and other experiences, has had a global presence in the treatment of psychiatric conditions for more than a century and in Japan as early as the 1870s (Goto & Wilson, 2003). The tragic event and consequence of the atomic bombings at Hiroshima and Nagasaki in 1945 were unprecedented in every way, including that of understanding the psychological response to catastrophic traumas. Interestingly, it was not until after the training of Japanese mental health professionals by the U.S. Community Crisis Response Team (CCRT) in response to the 1995 earthquake that PTSD became well known and ultimately the primary frame for understanding the effects of traumatic experience in Japan (Goto & Wilson, 2003).

Indigenous and traditional ways of understanding distress are generally disregarded within contemporary psychological theories of trauma. The violence and cultural degradation experienced within many indigenous communities, and among marginalized peoples throughout history and the world, has an intergenerational impact (Danieli, 1998; Menakem, 2017; Pinderhughes, 2004). Distress and trauma do not result from cognitive appraisals made by disembodied organisms, nor are they primarily emotional responses. Distress and trauma are passed among people, including from one generation to the next. The DSM-5-TR diagnostic criteria for PTSD do not reflect this indigenous/traditional wisdom.

In authoring the DSM-5, the American Psychiatric Association (2013) did attempt to acknowledge how distress and trauma are cultural constructions and, to aid clinicians in considering the impact of culture when diagnosing clients, they added a "Glossary of Cultural Concepts of Distress" in an appendix. The glossary lists nine common cultural syndromes of distress. For example, *khyal cap*, or a *wind attack*, "is a syndrome found among Cambodians in the United States and Cambodia" that includes symptoms of "dizziness, palpitations, shortness of breath, and cold extremities, as well as other symptoms of anxiety and autonomic arousal" (Thornton, 2017, p. 55). The belief that wind may arise within the

body and blood, thus causing such symptoms, is acknowledged as a culturally distinctive manifestation of distress. However, *khyal cap* is then linked back to disorders in the main body of the DSM-5, including distinctly Western perceptions of distress such as panic attack and panic disorders. Therefore, while recent editions of the DSM have given a nod to the impact of social and cultural influences, these have been far outpaced by the rise of neuroscience and the search for neurological evidence of mental health pathology. The failure to integrate various social stressors such as racism, persecution of LGBTQ+persons, economic oppression, and other such factors into the diagnostic model means we often dismiss the severity and impact of having to endure these lifelong threats.

Contemporary means of conceptualizing trauma, both clinical and popular, also fail to acknowledge the human tendency to focus on the negative. We "display a negativity bias, or the propensity to attend to, learn from, and use negative information far more than positive information" (Vaish et al., 2008, p. 383). Humans' negativity bias serves adaptive purposes from an evolutionary perspective, but it also means that negative events have greater psychological, and arguably spiritual, impact than positive events. Conceptualizing all stressful events as traumatic is both an outgrowth of, and fuel for, our negativity bias. The pathology-focused clinical diagnostic frame only further reinforces both. Overemphasizing the negative to the point of normalizing trauma disposes us to minimize our ability to cope and supports deficit- rather than strength-based self-assessments. Consider, for example, the way violence and mass shootings have been normalized within U.S. culture. The widespread nature of such events caused the American Psychological Association to publish a cover story in *Monitor on Psychology* entitled "Stress of Mass Shootings Causing Cascade of Collective Traumas" (Abrams, 2022). Is the United States, as a nation, collectively traumatized by mass shootings? Though they are tragic events to be sure, Lowe and Galea (2015) reviewed 49 studies on the impact of mass shootings on mental health and found that PTSD prevalence was as low as 3% and as high as 91%, raising significant methodological concerns. Perhaps it is our negativity bias that causes us to conflate stress and trauma and fear in ways that diminish our ability to cope with distressing events.

The Stress-Trauma Continuum

Dulmus and Hilarski (2003) sought to aid researchers and practitioners in accurately defining the terms "stress," "trauma," and "crisis" with the goal of improved assessment and intervention. Toward this end they conceptualized the stress-trauma-crisis continuum to explain the uniqueness of and relationship among these constructs, each of which results from the perception of an event, not the event itself. Although crisis is outside the focus of this special issue of *Pastoral Psychology*, reconceptualizing a pastoral psychology of trauma is founded upon the stress-trauma continuum. To reiterate, we are not suggesting a continuum that reflects progressive phases of stress that ends at its ultimate, and thus most clinically legitimate, form of PTSD.

First, it is essential to remember that not all stress is distress. Eustress is a positive stress response that is not only helpful but necessary for optimal performance. Eustress is "a type of stress that results from challenging but attainable and enjoyable or worthwhile tasks (e.g., participating in an athletic event, giving a speech)" (American Psychological Association, n.d.-b). Eustress differs from distress that is a negative stress response and involves "negative affect and physiological reactivity: a type of stress that results from being overwhelmed

by demands, losses, or perceived threats. It has a detrimental effect by generating physical and psychological maladaptation and posing serious health risks for individuals" (American Psychological Association, n.d.-a). The same event—for example, giving a major speech—can cause one person eustress and another distress based upon their perception. Like eustress and distress, trauma also results from perception. "The bomb dropped on Hiroshima may be a trauma-producing event, a military victory, or a divine retribution depending on the individual's. . attribution and perception of the occurrence" (Dulmus & Hilarski, 2003, p. 29). While distress and trauma can produce the same physiological responses (e.g., hypertension, migraines), the acute and long-term neurological impact of trauma is distinct. Because personality and culture influence our perceptions and appraisals of events, and because our spiritual and religious beliefs and practices influence our perceptions, religious leaders and practitioners of spiritually integrated psychotherapy should utilize the stress-trauma continuum in assessing any and every care receiver's or client's presentation of distress.

Reframing a Spiritual and Pastoral Psychology of Trauma

The above exploration of theological and psychological conceptions of trauma evidences why pastoral psychology as a discipline should be invested in reconceptualizing and reframing understandings of trauma. Our strengths-based, reframed understanding of trauma is built upon the following four working principles:

- Not all distress is trauma, nor should all distress be avoided.
- PTSD, as defined in the DSM-5-TR, does not encompass all categories of traumatic distress.
- Stress and trauma can co-occur with growth and resilience, as evidenced in the wisdom of Scripture and tradition.
- Stress and trauma exist on a continuum, not a hierarchy, and both are deserving of care.

Centering and privileging Jesus' crucifixion as the Christian example of trauma is a disservice to all those whose own experiences along the stress-trauma continuum leaves them longing to see their own life reflected in the life of Jesus. A deliberative Christian theology recognizes that the cross is only one end of a continuum of suffering reflected in the life of Jesus. Further, life for Jesus began on the margins of society, much as it does for many today living under the thumb of oppression. We ought not rush too quickly to resurrection, yet we must honor the resilience many enact in the face of traumatic experience that leads them to find hope, meaning, and even new life in a post-crucifixion world.[2]

Jesus' ministry reflects the complex tensions of living in the unpredictable world of empire with hope constantly under threat. God's grace revealed in Jesus Christ shows us that it is never either/or but always both/and. The wounds of the world are real, and yet a faith built upon the promise of an always faithful God opens the possibility to choose hope even while experiencing our woundedness. Built upon the promises of God, we are always living in the potential for being simultaneously broken and redeemed. Our distress

[2] Socially and historically, the trauma of being Black in the United States is unique. Oppressions quite often compound, making it even more challenging to cope, and yet people keep going. People learn to struggle well, and often it is in resisting that people become resilient.

and traumas alike offer the potential for resilience and, at times, posttraumatic growth. This reconceptualized and reframed spiritual and pastoral psychology of trauma is evident in contemporary examples of distress across myriad cultures, as is shown in the other articles in this special issue.

Implications for Spiritual and Pastoral Psychology and Caregiving

Religious leaders, spiritual caregivers, and clinicians offering spiritually integrated psychotherapy and care can benefit from grounding their perceptions, assessments, and interventions in a reframed pastoral psychology of trauma. This framework invites professionals to:

- Recognize the broad range of care receivers' and clients' need, whether their experience is most aptly termed distress or trauma. Both necessitate intervention and care.
- Assist care receivers and clients in identifying language that accurately reflects their distress beyond the biases and fixed terminology of trauma culture.
- Acknowledge that oppression can, but does not always, have a traumatic effect and that we need to create space for naming and experiencing it as such when relevant.
- Avoid exporting Western, biomedical conceptions of trauma and colonizing them within other cultures and contexts. We would do well to be mindful of this in our everyday discourse, in how we talk about events occurring in other contexts/cultures and also within intercultural relationships.
- Provide care receivers and clients with space to shift embedded theological understandings of trauma that center distress to the exclusion of hope, as well as understandings that center hope to the exclusion of distress, and help guide them in constructing more deliberative theologies of trauma.

The work of reconceptualizing and reframing understandings of trauma is imperative. But, theories and theologies must be practiced and enacted in order to foster resistance and the possibility of transformation.

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