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# A Sense of Trust: Somatic Spiritual Practices as a Path to Wholeness in Spiritually Integrated Trauma Care

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**Abstract**

A traumatic event holds the power to rupture one's world, generating lingering effects on embodied existence. Research has demonstrated that overwhelmingly stressful events often call into question deeply held values and beliefs and that spiritual struggles "tend to be partially responsible for the distress experienced" (Pomerleau et al., 2020, pp. 456–457). Similarly, research with veterans has demonstrated that religious and spiritual struggles mediate the relationship between a potentially morally injurious event and both anxiety and PTSD (Evans et al., 2018), often intensifying trauma and moral injury symptoms as well as opening a pathway for spiritual integration and growth (Pargament & Exline, 2022). In this dissertation, I focus on the role of intrinsically meaningful somatic spiritual practices in helping trauma survivors reclaim embodied trust, lament loss, and seek wholeness. I use an interreligious approach, based on a revised correlational method from practical theology (Bennett et al., 2018; Marshall, 2004; Miller-McLemore, 2010). This approach brings lived experiences of intrinsically meaningful somatic spiritual practices into dialogue with interdisciplinary research, scholarship, and clinical approaches to propose a spiritually oriented trauma care praxis.

Existential–phenomenological therapies—notably, gestalt therapy and Eugene Gendlin's focusing-oriented therapy—as well as interoception research support my argument that embodiment is an important integrative process that can occur in four stages. After summarizing the somatic impact of moral injury and trauma, I highlight

three evidence-based somatic therapies for trauma integration that utilize interoception. I argue for the incorporation of relational trust and cocreativity in trauma care by utilizing (a) developmental psychologist Edward Tronick's (2007; Tronick & Beeghly, 2011) *mutual regulation model,* (b) the dialogically derived cocreativity of field theory, (c) polyvagal theory regarding socially enhanced *alert ease*, and (d) Heart Rate Variability (HRV) research on coherence and synchrony. I propose a spiritually oriented, interreligious, trauma care praxis for cocreating intrinsically meaningful somatic spiritual practices that enable an abiding *sense of trust*. Such trust facilitates lament and spiritual wholeness in survivors of trauma and moral injury. An extended case study illustrates this praxis. The end goal is to help mental health and spiritual care practitioners develop competencies for spiritually oriented trauma care that integrate research and relational mystery by exploring somatic spiritual practices as a path to wholeness.

## Acknowledgments

Every day that I worked on this dissertation, I started with a somatic spiritual practice and prayed in gratitude, in this order, for their influence upon my writing: for the Divine; for my sons, Lucian and Leon; for my *two mothers*, Angela and Emma-Shivani (see Dedication in appendix); for Joshua and Amariee, both beautiful gift-givers; for my partner Jon, for sanity in pandemic madness; for the care of my children, Amy at BMS, Loes, Nayan, and Lenise; for my spiritual family (group #9), whose influence is throughout these pages; for my physical family, both living and deceased, in Ireland and America; to and for the unseen Spiritual Teachers; for mentors and colleagues, particularly Arielle, Betty, Wolf group, and the Gestalt Institute of the Rockies; for new and old friends Alyson, Lana, Joy, Zach, Ryan, and RPS; for my clients (and Josie); for the MDiv Integration Lab, 2020-2022; for Mt. Hope Lutheran Church and Pastor Sarah at the Longmont UCC, for your hospitality; and for the scholars in these pages.

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## Table of Contents

**Chapter One: The *Sense* of this Dissertation**

**Rationale and Thesis**

This dissertation addresses the interdisciplinary nature of competent spiritually integrated trauma care by constructing an intercultural and interreligious, evidence-based understanding of the bodily dimensions of traumatic experience and a care praxis that facilitates spiritual integration of traumatic distress toward dynamic spiritual wholeness. This interdisciplinary project facilitates a dialogue between neurophysiologically sophisticated psychotherapeutic treatment based, in part, upon neuropsychologist and researcher Stephen Porges's (2011) polyvagal theory and theologically sophisticated psychological and spiritual care, especially with regard to moral, spiritual, and religious struggles arising from trauma.

In her still groundbreaking, now classic text, *Trauma and Recovery*, psychiatrist and trauma specialist Judith Herman (1992) has explained that the first step of recovery from trauma is to establish a sense of psychological safety through emotional regulation. The Victims of Violence treatment program established by Herman and leading trauma specialist Bessel van der Kolk has helped survivors find age-old practices that calm the body as a prerequisite for remembering and mourning the often-irrevocable losses incurred by trauma. Van der Kolk (2014) and others who have been conducting research on yoga in the treatment of posttraumatic stress have found that body-centered (spiritual) practices help to regulate arousal states.

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Although diverse kinds of yoga, meditation, prayer, and ritual are being found effective in regulating intense trauma-related arousal in psychotherapeutic trauma care, there is no consensus among trauma specialists about the need for accountable, respectful engagement with the actual spiritual or religious context of the care seeker while prescribing these once spiritual technologies (Doehring, 2015b). Somatically oriented trauma specialists are likely to reduce complex centuries-old religious and spiritual practices to medical prescriptions if they do not draw upon current research and standards of competent care in spiritually integrated psychotherapy (e.g., Pargament, 2007, Pargament et al., 2006; Pargament et al., 2013; Vieten et al., 2013). This dissertation argues for an interdisciplinary approach to trauma care that draws upon relevant neurophysiological research on and treatment of trauma (Craig, 2015; Porges, 2011; van der Kolk, 2014), psychology of religion research on religious coping and spiritual struggles and competent spiritually integrated approaches in both psychotherapy (Greider, 2012, 2015; Pargament et al., 2006; Sandage et al., 2008; Vieten & Lukof, 2021), and intercultural spiritual care (Doehring, 2015b; Doehring & Kestenbaum, 2022b) for respectful religious and spiritual engagement.

The role of embodiment in somatically oriented trauma care is complex and evolving. Positive experiences of embodiment through interoceptive awareness have been shown to lead to a greater sense of empowerment and confidence (Craig, 2008, 2015; Park & Thayer, 2014; Pinna & Edwards, 2020). When a process of embodiment is included in the aim of spiritual wholeness, it may well become a source of "experiential and theological disclosure" (E. Graham, 1999, p. 119) and restorative (spiritual) trust, integrative wisdom, and potential revelation (C. Doehring, personal communication,

2019). In *Trauma Sensitive Theology*, theologian and therapist Jennifer Baldwin (2018) has argued that spiritual and religious practices have the power to heal and that these practices, when tied with embodiment, reveal somatic wisdom. This dissertation project culminates in a praxis that offers an intercultural and interreligious route to an embodied experience of *a sense of trust* that can facilitate lament and reveal spiritual wholeness.

I have attempted to address three issues through this project and the culminating praxis. First, body-centered, spiritually oriented therapies are too often prescriptive in their use of spiritual practices (e.g., yoga, meditation, animist ritual practices) with limited theological sensitivity or cocreative methodology that explores a range of possible *intrinsically* meaningful body practices. Second, theologically sensitive pastoral and spiritual care of trauma can be enriched by distinct evidence-based, body-centered praxis that serves to cultivate spiritual trust and further advance spiritual wholeness. Third, both body-centered psychotherapy and pastoral/spiritual care tend to utilize processes of embodiment as a means to self-regulation and restored sense of safety yet, this dissertation proposes that processes of embodiment, when coupled with intrinsically meaningful spiritual practices, can be a path to holistic integration enriched by somatic wisdom for trauma survivors. One must simply engage the possibility that embodiment is not merely a means to other ends but a richly revelatory end in itself.

This dissertation proposes that a starting place for theologically and neurophysiologically sophisticated trauma care is a trustworthy process of embodiment and respect for the religious, spiritual, and moral worlds of the trauma survivor. With these components in place, calming spiritual practices can offer unique resources for both restoring self-regulation and developing intrinsically meaningful ways of lamenting and

eventually integrating the irrevocable losses incurred by trauma. Interculturally sensitive cocreative spiritual practice offers a site for spiritually integrated trauma care that is empowering, honors the religious/spiritual world of the other, and includes embodiment in wholeness. The central assertion of this dissertation is that reclaiming embodied trust through intrinsically meaningful somatic spiritual practice helps trauma survivors lament loss and seek wholeness.

**Location, Intention, and Audience**

I am a psychotherapist in private practice and a clinical skills teacher at a local university in Colorado. I have 20 years of direct client experience in the field of counseling psychology and have focused my training and teaching on a synthesis of cognitive, emotional, and spiritual integration through evidence-based somatic methods of care. I am from a blue-collar family of direct Irish descent that values optimism, pragmatism, and hard work. From this background and values, I find my desire to apply what I learn to practical clinical uses that benefit ordinary people's lives. Christened Catholic and then raised by an avowed agnostic, I have 25 years of active engagement in spiritual multiplicity at the boundaries of Christian, Hindu, and Buddhist traditions as a practitioner-scholar. The memory that captures my spiritual multiplicity is of floating on the sacred Ganges River outside the city of Varanasi, India. As I stared into the cloudless purple-blue sky, practicing a mindfulness-awareness practice taught by the Buddha, the bells of the Vedic sunset ritual of Arathi rang magically through my cells. I was being pulled gently through the waters by a spiritual Elder who was repeatedly whispering The Lord's Prayer. My location is as a person of faith, respectfully on the boundary of

religious traditions and an apologist for none, deeply committed to integrative, embodied wellbeing.

My intention is to share in and dialogically refine a respectful, intercultural or interreligious care praxis that can be a portable tool for care providers who seek to engage in trauma-sensitive, spiritually integrated care. My hope is that this praxis speaks to multiple audiences such as psychotherapists, pastoral care providers, spiritual directors, crisis chaplains, and social workers looking to respond more affectively to the needs of trauma survivors, especially those whose religious, spiritual, and moral struggles may contribute to suffering or integration. The end goal is to help mental health and spiritual care practitioners working with trauma survivors find respectful and cocreative somatic spiritual practices that integrate research and relational mystery into an effective tool for spiritual integration. This dissertation offers one integrated care praxis that can be a complement to spiritual care of many types. I intend this praxis to fit well into the rich tapestry of skillful clinical, pastoral, and spiritual care methods already being engaged.

**Methodology**

The central claim in this dissertation is that an evidence-based, intercultural and interreligious approach to spiritually integrated care using embodied cocreative spiritual practice leads to a higher likelihood of integration of traumatic experiences towards wholeness. I support this claim with a review of empirical research and scholarly literature from three disciplines: the clinical psychology subdiscipline of somatic psychology as informed by traumatology and neuropsychology for evidence-based trauma care, pastoral care for an intercultural approach, and psychology of religion for spiritually integrated, interreligious care competencies and empirical research on spiritual

struggles, spiritual coping, and spiritual growth. The resulting praxis is a pragmatic synthesis of these three fields, illustrated through an ongoing case study from my spiritually integrated psychotherapy practice.

I use an interreligious approach to engage a revised correlational method from practical theology (Bennett et al., 2018; Marshall, 2004; Miller-McLemore, 2010) from the perspective of a person working and living on the borders between worlds; religiously and professionally. My work as a transpersonal clinician and gestalt therapist does not fit neatly into any one psychological paradigm or mode of practice. As a spiritual practitioner shaped by multiple spiritual influences, I am not beholden or accountable to a particular religious or theological community. I experience myself, as theologian and existential philosopher Paul Tillich (1936/1966) has said, "On the Boundary" (p. 10). Although clinical psychology has been my dominant second-order language (Doehring, 2015a) for much of my professional life, the language of spirituality has been my first-order way of understanding experience. Bearing in mind pastoral theology educator Zoë Bennett and colleagues' (2018) warning that "every way of seeing is also a way of not seeing" (p. 134), I attempt to engage in third-order language, where possible, that does not favor one disciplinary perspective but rather reflects the outcome of a cocreative dialogue through four hermeneutical circles: faculty mentorship, MDiv teaching, clinical work, and clinical consultation group. The revised correlational method allows for this because of its spirit of equality among disciplinary conversation partners (Bennett et al., 2018). Because the revised correlational method values each discipline as carrying equal authority, it "allows pastoral theologians, caregivers, and counselors to attempt more constructive contributions in the field" (Marshall, 2004, p. 139). Therefore, methodology

for this research project is as much dialogic as correlational (Miller-McLemore, 2010) and aimed at a provisional synthesis for the sake of praxis.

Supporting the central claim that intercultural and interreligious sensitivity is of paramount importance to a spiritually integrated approach to care is the fact that a growing portion of the U.S. population could be designated spiritually multiple as described by pastoral theologian and researcher Duane Bidwell (2018). I judiciously utilize autoethnography as a complementary method to demonstrate the prevalence and distinctiveness of spiritual multiplicity and to demonstrate self-reflexivity (Doehring & Kestenbaum, 2022b) and transparency of religious location (Greider, 2015) as part of intercultural care competency. Autoethnography "seek[s] to understand a cultural issue from the vantage point of personal experience" (Bennett et al., 2018, p. 152). An autoethnographic approach is congruent with the ways that practical theology begins and returns to practices, lived experience, and contexts of care for the cultivation of informed praxis. With this in mind, an important additional contribution to the research methodology is the weaving of a current case study throughout the chapters.

In this dissertation, I utilize a revised correlational method, judicious autoethnography, and a minimally modified case study as *living human document* (Boisen, 1955). Although any methodological approach has its limitations, the biases inherent in my perspective are tempered by the use of somatic and spiritual self-reflexivity, a lens of differential pluralism (Hedges, 2010) that humbly anticipates and welcomes alterity, and my own somatic spiritual practice as means of spiritual self-differentiation (Doehring & Kestenbaum, 2022b). As Tillich (1936/1966) has said about being on the boundary between distinct disciplines, "the boundary is the best place for

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acquiring knowledge" (p. 13). I use my reference point, the "boundary," critically and reflexively.

**Limitations**

This project has had a number of important limitations, the first of which is, of course, the limits of my own capacity to correlate, integrate, and imagine novel connections at the narrow interdisciplinary intersection I sought to engage. My location as an Irish American psychotherapist, spiritually multiple yet religiously unaffiliated, able-bodied female also holds various strengths and biases that, despite my best effort to overcome them, have inevitably influenced my perspective, choices, and emphases.

The most obvious limitation, aside from my own perspectival location, is that of scope: for instance, important current research and theory building in the areas of racial trauma, intergenerational trauma, systemic trauma, and sex distinctions in trauma responses are not covered in the scope of this dissertation. Cross-cultural exploration is also not engaged at much depth. The text also does not explicitly discuss spiritual practices for atheists or religiously conservative persons seeking care. These are all important populations deserving of rich, interculturally and interreligiously sensitive spiritual care. My hope is that the praxis of cocreating somatic spiritual practices can be explored further in various care settings and with different populations. Given that the praxis relies on self-reflexivity, respect for alterity, and broad physiology-based processes of embodiment, it is a potentially accessible tool ripe for modification and exploration.

**Chapter Overview and Key Terms**

The strength of somatic spiritual practice in care pivots on embodiment as route and wholeness as an integrative aim. In Chapter Two, I have constructed a definition of

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wholeness that correlates gestalt therapy theory's fruition or present-centered view of

wholeness with psychology of religion researcher Ken Pargament et al.'s (2016) more

developmental or lifespan description of wholeness. This definition includes a robust

understanding of spiritual wholeness as a synthesis between immediate felt experiences

of wholeness and an ever-increasing spiritual orientation toward development of

wholeness across time. Empirical research into interoceptive awareness, philosopher and

psychologist Eugene Gendlin's (1982) somatic psychology concept and technique of the

*felt sense,* and a literature review of some of the key issues in defining embodiment are

brought together in my proposal for a four-stage process of embodiment on the way to a

*felt sense* of trust. Key terms in Chapter Two are defined as follows.

*Wholeness* is twofold: it is a dynamic integration of senses, emotion, and

cognition in one's current contexts and "a dynamic process of movement toward a

higher-order organization that continuously evolves over the lifespan" (Hart et al., 2020,

p. 3). It is the immediate felt sense of dynamic wholeness and an emerging

developmental coherence that includes purpose, meaning, the paradox of brokenness, and

spiritual orienting.

*Embodiment* is a process of conscious inclusion of sensate experience into one's

awareness. The process I propose, as outlined in Chapter Two, moves through stages

from somatic awareness to somatic trust, somatic reflexivity, and somatic wisdom. This

is the experience of various dimensions of one's felt sense of existence rooted in a

material body. *Felt sense*, for the purposes of the proposed praxis, is a somatic gestalt (or

whole), where an experience is grasped viscerally in its entirety through the process of

embodiment.

Trauma ruptures trust and threatens wholeness. Chapter Three constructs a concise definition of moral injury and psychological trauma and their interconnection through correlations among emerging research in traumatology, psychology, and pastoral care. The process of integration is introduced and highlighted in three evidence-based somatic therapies for trauma that utilize interoceptive awareness, the felt sense, and various processes of embodiment. The definitions of key terms in this chapter are as follows.

*Trauma* is the result of unintegrated overwhelming stress or distress due to inadequate intersubjective or relational support that could help survivors integrate a perceived threat to (a) life, (b) psychological integrity, and/or (c) moral or spiritual identity.

*Moral injury* or *soul wound* (L. Graham, 2017) results when moral dissonance includes the life threat of traumatic stressors, where one feels responsible for or holds others responsible for a witnessed traumatic harm. This includes a sense of guilt from harm caused or a sense of betrayal that those responsible for protecting life did not fulfill their responsibilities.

*Integration* is a process of making whole by incorporating fragmented, traumatic, or simply novel and jarring experience into new understanding and an expanded sense of wholeness. The term *integration* is preferred over *healing*, *recovery*, or *resolution* because it points to the clinical and spiritual view held in this dissertation that one does not get rid of bad experiences or return to some mythical or ideal state of health but rather grows in integrity, courage, and moral complexity by expanding to include dissonant experiences.

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Cocreative relationships can repair traumatic rupture and lead to renewed wholeness. In Chapter Four, I address the role of relationships in the process of integration by describing a provisional belief in participation in a *friendly* universe expressed through relational *trust* and *cocreativity*. I attend to my claim that a process of integration of trauma is greatly advanced through experiencing relational trust and cocreativity, which I define through a synthesis of cognate contributions. Key words in this chapter are defined as follows.

*Trust* is a felt sense of goodness. It is rooted in the old Norse word for *confidence*. Some definitions of the word trust describe "belief in," whereas I and others (see Erikson, 1963) claim it to be first a somatic sense or feeling and not a belief. One can experience deepening confidence, assurance, even faith in something or someone without a cognitive "belief" of any kind, hence the important connection to be made with embodiment and a felt sense of trust.

*Cocreativity* involves a deep sense of interpersonal connection supported by alert ease, which promotes freedom to generate or access new possibilities and shared meanings.

Cocreativity and spiritual practice can enhance and be enhanced by spiritual trust fostered in spiritual care relationships. In Chapter Five, the final chapter, I address the importance of spiritual care competencies in a multicultural, interreligious world in the aftermath of trauma. Starting with current research on categories of spiritual struggles that can arise in care and a review of spiritual care best practices in therapy, I present a three-step praxis of cocreating intrinsically meaningful somatic spiritual practices that are

sensitive to spiritual struggles and aligned with spiritual care competencies that cultivate spiritual trust. Key words found in this chapter are defined below.

*Spirituality* is considered a seeking or search for (Pargament, 2007) and abiding or dwelling in (Sandage & Harden, 2011) a relationship with the sacred (Shults & Sandage, 2006), the sacred being that which one has deemed significant and marked by reverence (Taves, 2009).

*Spiritual trust* is "a relational foundation unique to spiritual care" (Doehring & Kestenbaum, 2022b, p. 135) and "goes beyond the caregiving relationship to include spiritual dimensions of relationality" (2022a, p. 129) and a "felt sense of spiritual connectedness beyond oneself" (2022a, p. 130).

*Spiritual practice* is the intentional and often ritualized or operationalized seeking or dwelling aspect of spirituality whereby one engages in traditional or personal practices that cultivate a felt relationship with the sacred.

**Commencement**

With intentionally deepening breath and lengthening exhale, and an occasionally well-focused gaze upon the page, I have endeavored to make *sense* of a long-standing intuition brought to me first in the Vedanta Temple and again on the cool marble ground of a jasmine scented, sunlit day at the Sri Aurobindo Ashram, where suffering and a felt sense of trust directed my awareness towards this project.

**Chapter Two: Wholeness and Embodiment**

At the age of 19, I entered a Hindu temple for the first time at the Vedanta Society of Southern California in Santa Barbara. The fading gold-pink light of the setting sun reflected off the Pacific Ocean and passed through carved wooden slats covering a banquet of sea-facing windows. Barefoot, I followed meticulous vacuum lines in plush pink carpet to the front of the shrine and sat cross-legged against a wooden pillar. A long exhale plunged me into an experience that would usher in a new, life-long commitment. I remember to this day the warm, salty breeze on my skin as an exhalation engulfed me in a mental silence and visceral stillness unlike anything I had ever experienced.

The silence grew effortlessly, accompanied by a pleasant vibration out of the stillness, like warm goosebumps. Every one of my senses was enlivened. I could intentionally turn my awareness toward one sense or another with distinctive clarity, without losing an experience of my body as a whole. These senses together made a meaningful composite or *felt sense* of the whole experience. It was as if the volume on my ordinary mental activity had been turned down, my sensate awareness turned up, and a new kind of clarity, a direct knowing, rooted in my body, had emerged. This trustworthy sensing, somatic in nature, slowly came with its own brand of present-centered cognition that was entirely novel to me at the time. My exhalation had breathed awareness *into* and

revealed the mind of this very body. This was a sacred entrée into trustworthy embodiment.

Over what must have been an hour, what I know now to be the ritual of *arathi* was carried out in a vibrant array of gestures, chants, and offerings. I was not a dispassionate observer. Instead, the sights, scents, and sounds passed through and moved me as waves of multitextured experience. Above me hung life-sized paintings of the Hindu sage Sri Ramakrishna, Jesus Christ, and the Buddha. I gazed at these images as though they were an old family photo album fondly rediscovered. A deep yearning, felt entirely bodily, arose in me, along with the prayerful sentence "I am here. I am right here." I repeated it inwardly, not simply to myself but also to the Sacred Presence I felt surrounding and reverberating within me.

What transpired in that temple remains at once deeply familiar, exquisitely mysterious, and more trustworthy than any other memory I have viscerally recorded. In fact, I trust that wholesome, embodied experience as deeply as I have come to trust in God. It was, for me, an experience *of* the immanent God that has shaped my personal theology ever since. That day, my spirituality became wholly entwined with my physicality. I discovered the holiness of embodied wholeness, achievable through trust in incarnation. I *felt* Divine presence, and I committed to pursuing and nurturing it. Although I have had such experiences many times since that day, remembering that initial exultation as a "*felt sense*" of trust has been integral to my understanding of the potential within somatic spiritual practices. (Author's journal, June, 2021)

This sensuous account describes my particular lived experience of a sense of embodied trust, sacred connection, and felt wholeness. What I describe here as a transformative spiritual experience has informed a longstanding personal spiritual practice as well as the spiritually integrated and somatically centered clinical pursuits that inform this dissertation. In this dissertation, I propose an intercultural approach to spiritually oriented trauma care focusing on a felt sense of sacred or spiritual trust experienced through co-creating body-based or somatic practices that are existentially, spiritually, or religiously meaningful.[1] I describe the role of such practices in helping clients experience the deeply rooted sensations of trust, such that clients literally sense trust reliably in their bodies. I argue in later chapters that this *felt sense*[2] of trust is one foundational ingredient in an ongoing process of dynamic (mind–body–spirit) wholeness, especially for those whose sense of trust has been ruptured through trauma.

Embodiment is therefore considered a core process of this particular spiritually integrated approach to trauma care. The central thesis is that reclaiming embodied trust through intrinsically meaningful somatic spiritual practice assists trauma survivors in seeking wholeness. This chapter focuses on the role of embodied trust in spiritually oriented trauma care. I build upon two existential–phenomenological therapies: gestalt

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[1] The term *religion* has, arguably, both a useful and a contentious history. I am using it here to speak primarily to the experience of lived religious life. It is important to acknowledge that *religion* is not a neutral term; for example, Tink Tinker (2020) has joined distinguished American Indian scholars in challenging the colonial notion that such a thing as "religion" is at all a universal category.

[2] The term *felt sense*, first defined by Gendlin (1982) in his popular book *Focusing,* describes a "bodily awareness" or somatic knowledge of a person, problem, or situation. It is a somatic awareness deeper and often more complete than mental knowing that informs cognition.

therapy and theory, and Gendlin's (1982) focusing-oriented therapy and theory.[3] I begin

by using gestalt therapy and theory to define and describe wholeness as a gestalt. I

explore how gestalt may be understood as a form of spiritual wholeness, using research

on religious and spiritual struggles by Pargament and his colleagues (2006, 2016). In the

second part of this chapter, I use Gendlin's therapy and theory as well as interoception

research to propose that embodiment is a process that occurs in four stages. In the final

part of this chapter, I outline a history of (dis)/embodiment and highlight some of its

salient debates and discrepancies in terminology.

**Part 1: Wholeness as a Gestalt**

It was early in my training as a psychotherapist that gestalt therapy was

introduced to me. I remember the classic gestalt[4] edict, "the whole is greater than the sum

of its parts," as a meaningful psychological concept pointing to a something *more* to be

found in the interconnected, interdependent totality of who a person is physically,

emotionally, mentally, relationally, ecologically, and spiritually in each incarnate

moment. This was the beginning of a therapeutic understanding of dynamic and ever-

present wholeness congruent with my Vedanta temple experience. *Wholeness*, as

described by gestalt therapy, is an immediate and dynamic integration of experience that

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[3] These two existential–phenomenological therapies anchor the clinical view of self, change, growth, and *felt* wholeness in this dissertation. These two therapies and theories have had a large impact on many forms of current somatic- and family-systems-oriented clinical methods.

[4] *Gestalt* is a German word often translated as a patterned whole or a complete configuration. Experientially, a gestalt is a moving, interactive, dynamic whole experience, greater than the sum of its parts. Gestalt psychology is a German research school based on experiments involving perception. Gestalt therapy is an existential and experiential psychotherapy, based loosely on gestalt psychology principles, founded in the 1950s in New York City by psychoanalysts Fritz Perls, Laura Perls, Ralph Hefferline, Paul Goodman, and others (Yontef, 1993).

requires somatically, psychologically, emotionally, and relationally congruent awareness

sometimes (overly) simply called *presence*. To be fully present in this distinct way is to

be aware of sensation, emotion, thinking (inner and middle zones of awareness), and

context or environment (outer zone of awareness) as a dynamic interplay or integrated

experience (Perls et al., 1951; Yontef, 1979, 1993). Gestalt therapy works with what

clients experience in the clinical session, beginning with their experience of *awareness,*[5]

which initially comes as a present-centered "ah ha" in the therapeutic moment.

Awareness in gestalt therapy is nearly everything: praxis and aim. A gestalt, therefore, is

a moment of wholeness as dynamic integration of senses, emotion, and cognition in

context (re-membered/re-evoked as in therapy) or in relationship with one's current

environments (here-and-now). Through this integration, something new can be revealed

that is greater than the sum of its parts (see Perls et al., 1951; Yontef, 1979, 1993).

### Spiritual Wholeness and Gestalt Wholeness

In my spiritually integrated clinical practice and teaching, mystery or the Sacred

is often experienced through the *more* that is evoked by the whole being greater than the

sum of its parts. I describe the implicit spirituality of gestalt wholeness with a definition

of spiritual wholeness developed by Pargament and colleagues (2016). They have

described wholeness as an ongoing and aware process of optimal functioning, a dynamic

"interplay of all the bits and pieces that make up a life," as "a multi-faceted numinous

construct" (p. 381) that inextricably includes aspects of the Sacred. This understanding of

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[5] A pragmatic phenomenological method coupled with the lens of field theory facilitates this gestalt awareness. Both phenomenology and field theory are enduring theoretical and methodological pillars in gestalt therapy theory (Brownell, 2013; Yontef, 1993).

wholeness connotes a quality of spiritual integration both in the moment of awareness and across time. Pargament et al. (2016) have operationalized this process of wholeness through the concept of an evolving "orienting system" (p. 383)[6] that, at best, is purposive, broad and deep, flexible, balanced, and benevolent. They have indicated that these descriptors of a well-integrated orienting system come together over life-long development and point to an evolving sense of and capacity for spiritual wholeness.

The central difference between a gestalt definition of wholeness and Pargament's understanding of spiritual wholeness is that gestalt wholeness is an immediate felt experience of an integrated or complete moment reliant on sensing-feeling-thinking-context integration. This is sometimes called a fruitional view, in helpful contrast to a developmental view of human experience and clinical focus (Tift, 2015). In a gestalt view, the immediacy and accessibility of an experience of wholeness is available through awareness in any moment, despite on-going struggles.[7] In their body of work, Pargament and colleagues (2016) have articulated an ongoing process of development of an increasingly integrated orienting system across time that results in greater depth and breadth of spiritual wholeness. They have written, "Wholeness is a dynamic process of movement toward a higher-order organization that continuously evolves over the lifespan" (p. 3). As I attempt to demonstrate, both experiences of wholeness, fruitional

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[6] As a "general way of viewing and dealing with the world" (Pargament, 1997, p. 99), this "framework of values, beliefs, practices, emotions, and relationships that offer direction and stability in the search for significance" (Pargament et al., 2016, p. 25) ideally evolves, changes, and adapts across time and with new contexts and experiences, yet continues to provide a cohesive sense of the world.

[7] The classic gestalt *cycle of experience* is a clinical map and an outline for an organismic process of identifying the obstacles to, aiming for (intention/direction), arriving at, and experiencing wholeness. This process is seen as trustworthy, *felt,* embodied, immediate, and ongoing (Perls et al., 1951).

and developmental, can be experienced at once—the immediate felt sense of dynamic

wholeness and an emerging developmental coherence that includes purpose, meaning,

and a growing ability to acknowledge the paradox of brokenness. Gestalt therapy's and

Pargament's views on wholeness point to a process of both *being* whole in an integrated

moment of awareness and *working towards* spiritual wholeness as a development across

time. My claim, which I support with research, theory, and clinical observation, is that

both experiences of wholeness, fruitional and developmental, can be enhanced by

engaging a process of embodiment.

### *Wholeness and Brokenness*

To understand wholeness in the context of this study requires addressing

brokenness, and the ways that spiritual struggles can shake and sometimes break spiritual

orienting systems (Pargament & Exline, 2022). Wholeness is not an idealistic or blissful

state free of struggles in the forms of suffering, losses, confusion, and despair. This kind

of utopian wholeness could not address the complex conditions of being human.

Pargament et al. (2016) have not described wholeness as the opposite of brokenness nor

does wholeness exclude unresolved struggles or heal all brokenness. Instead, wholeness

is in a paradoxical relationship with struggles and brokenness, all of which, together,

generates a larger gestalt. Clinical psychologist Allison Hart and colleagues (2020)[8] have

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[8] Hart and colleagues (2020) have determined that growth occurs through spiritual struggles under certain conditions. They sought to test the relationship between spiritual growth from struggle and the "degree to which their orienting system is characterized by wholeness" (p. 14). They conducted a cross-sectional exploratory study of four dimensions of wholeness (purposiveness, breadth and depth, life affirmation, and cohesiveness) using self-report surveys of 1162 undergraduate students who reported recent spiritual struggles drawn from three US colleges. The study demonstrated moderate positive correlation between spiritual growth and post-traumatic growth as mediated by degrees of spiritual wholeness. The *quest* aspect of wholeness was a surprising confounding aspect of the results as it led to

used quantitative psychological research on religious coping to demonstrate how spiritual wholeness is a dynamic interplay of biological, psychological, social, and spiritual aspects of a person, with brokenness as an intrinsic part of the mix. Pargament and psychologist Julie Exline (2022) have gathered years of research on spiritual struggles to demonstrate and illustrate how to help clients grow during their lived experiences of brokenness—its deep ruptures, struggles, laments, and tragedies of many kinds.

My assertion is that when brokenness arises from trauma and complex grief, clients can utilize the lived experience of *being* whole in a dynamic integrative moment to stir hope *toward* spiritual wholeness as a therapeutic goal. My clinical observations and the research presented in this dissertation suggest that intrinsically meaningful somatic spiritual practices help people trust in abiding sacred relationships that, in turn, can hold their struggles and brokenness, in ways that support and facilitate wholeness.

As a final note, the paradoxical relationship between wholeness and brokenness is conveyed well in the gestalt concept of *polarity*. From a gestalt theory perspective, polarity need not be dichotomous; instead, it is a dynamic tension between two poles that rely on and exist in relation to one another (Yontef, 1993). Think of the joy and pain of one's child going off to college, or the intensity of a fabulous and inevitably terminal summer romance. It has been my clinical observation across 20 years that clients can learn to trust the mystery of how wholeness and broken are intertwined, can explore this mystery within trustworthy, clinical relationships, and can learn to navigate this complexity through spiritual trust. The lived experience of polarity makes sense within

either growth or decline. The authors have acknowledged the limitations of self-report surveys and the limited dimensions of both wholeness and growth, inviting further research exploration.

organic rather than mechanistic processes of becoming, which can be elaborated using process philosophies and theologies. Thus, disembodiment, mistrust, and the profane can evoke or hint at their seeming opposites of embodiment, trust, and the Sacred. By their sheer extremity, they point to what is seemingly absent. From a gestalt existential point of view, without these interdependent polarities as both present possibilities and existential realities, experience itself is not whole. Hart, Pargament, and colleagues (2020), too, have seen a spiritual orientation to wholeness as involving "an ability to accept and live with life's paradoxes and struggles" (p. 6). As demonstrated in this dissertation, the paradox of polarities within a concept of wholeness can offer hope to clients suffering agonizing losses, when they feel broken, without a scrap of trust in life. To understand that polarity is part of the mystery of any moment is to find a glimmer of hope with a sufferer that agony can reveal new joy, that brokenness can be a part of wholeness, and that mistrust can lead to a deeper trust. Such complexity, such mystery fits well with the concept of spiritual wholeness.

Spiritually oriented gestalt therapy helps clients whose trust has been broken by trauma to experience moments of wholeness as dynamic integration of senses, emotion, and cognition in a renewed and safe context. I have proposed a spiritually integrated approach to gestalt as one present-centered therapy approach, using research on spiritual wholeness. I have highlighted the tensions between wholeness and brokenness, a tension especially meaningful for somatic spiritual care of trauma. In the second part of this chapter, I describe the central role of embodiment in these experiences of wholeness. I use Gendlin's focusing-oriented therapy and theory and research on interoception to propose that embodiment is a helpful process that occurs in four stages.

**Part 2. The Felt Sense of Embodiment**

Embodiment is a multifaceted concept, as I highlight in the third part of this chapter where I present an interdisciplinary review of the literature on embodiment. In order to build upon the description of wholeness as a gestalt, I draw upon Gendlin's (1982) book *Focusing* to define and describe his key concept of *felt sense* and highlight important neuroscience research on interoception. I incorporate Gendlin's description of *felt sense* and his technique of focusing in proposing a process of embodiment that develops interoceptive awareness and enhances integration and dynamic spiritual wholeness through somatic spiritual practices.

Gendlin has described felt sense as "a bodily sensation, not a merely physical sensation, like a tickle or a pain" that includes "a sense of a whole situation, or problem, or concern" (Karali & Zarogiannis, 2014, p. 37). This bodily sensation of felt sense is implicit for many people, who are often not explicitly attuned to bodily sensations. Gendlin's popular (1982) book *Focusing* describes how this implicit felt sense becomes explicit through practices that focus awareness.[9] The purpose of focusing is to develop an awareness of a felt sense through interoceptive awareness: an internal bodily sense that focuses and informs the felt sense.[10] Interoception has been defined by neuroscience researcher A. D. "Bud" Craig (2015) as the "sensory representation of the condition of

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[9] Gendlin has described this implicit or tacit knowledge accessed as the felt sense as the *more* that is available through a specific kind of interoceptive/somatic awareness. In fact, "one might assert that the major strength of this approach is the 'wholeness' that the clients may experience, as a result of their inner relationship" (Karali & Zarogiannis, 2014, p. 42).

[10] Interoception is currently studied extensively, along with proprioception and neuroception in neuroscience research (Craig, 2015). These terms are central in Porges's (2011, 2017) polyvagal theory discussed in Chapter Four.

the body" (p. 11) and interoceptive awareness as the ability to be aware of the condition of oneself as a whole in a given moment. Interoception and the felt sense are intertwined and mutually advance the aim of a holistic somatic sense of a given moment, situation, or experience. Simply put, interoception is a general somatic/sensate experience of oneself as a whole and the felt sense is focused on the whole sense of a specific experience (i.e., trust) utilizing the general capacity for interoceptive awareness.

The concept of the felt sense and the *focusing* technique meant to draw it (the felt sense) out was inspired by research into the outcomes of therapy. Studies by psychologists William Kirtner and Desmond Cartwright (1958) on success or failure in therapy suggested that much of therapy's success relied on "the manner in which clients approach and conceptualize their problems" (p. 333). Examining 42 clinical cases through factor analysis and length-by-outcome groupings, the researchers isolated a highly successful group of clients[11] as those having a strong and articulate sense of their in-the-moment feelings and reactions to problems coupled with a desire to explore resolution. According to psychotherapists Anna Karali and Pavlos Zarogiannis (2014), Gendlin built his five-step technique of *focusing* to address this finding that a person's relationship to their problem can be developed and explored through a phenomenological process of focusing on the felt sense.

Craig's (2010, 2015) research on how interoceptive awareness fosters flexible problem solving that reduces stress can be used to understand why Gendlin's focusing has an immediate clinical appeal to so many people. In Craig's (2015) research on

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[11] Success has been defined by the measured ability to utilized therapy well for the purposes the patients sought to attain (Kirtner & Cartwright, 1958).

primates (and later in humans), he has found that the higher the capacity to access

sensations, for instance, the ability to sense one's own heartbeat, the higher the ability to

regulate emotional states. He has written,

> Better heartbeat perceivers function better not only on an emotional level but also
> cognitively. They make better decisions based on subtle environmental cues, they
> perform better in tasks of selective and divided attention, and they respond more
> quickly to intuitive choices. (p. 22)

On the flip side, Craig (2015) has found the lack of interoceptive awareness to

correlate with an increase in chronic distress and less ability to articulate or navigate

problems. Craig has written, "There is indeed evidence that an individual's capacity for

interoceptive awareness can improve with training" (p. 7). His research supports clinical

descriptions of how clients who develop higher levels of interoceptive awareness have a

more nuanced capacity to be aware of feelings, emotions, and reactions that positively

impacts self-regulation. This interoceptive awareness helps them articulate and relate

flexibly with their experience in ways that lead to resolution of problems.

Cynthia Price and Carole Hooven (2018) have developed Mindful Awareness in

Body-Oriented Therapy (MABT), a therapeutic approach that built upon research on

interoception and mindfulness. They have described how interoception enhances

emotional regulation:

> Effective emotion regulation involves the ability to accurately detect and evaluate
> cues related to physiological reactions to stressful events, accompanied by
> appropriate regulation strategies that temper and influence the emotional
> response. There is compelling evidence demonstrating links between poor or
> disrupted awareness of sensory information, or interoceptive awareness, and
> difficulties with emotion regulation. (p. 1)

Such research (e.g., Price et al., 2019) supports therapies using interoception to regulate

emotions. One such therapeutic approach, Price and Hooven's (2018) MABT, uses

mindfulness practices to demonstrate that interoceptive awareness can be developed

through mindful awareness and that such practices make a meaningful impact on

wellbeing and psychological flexibility. They have drawn on research demonstrating that

"interoception and heart rate variability have been found to predict outcomes of mental

health and well-being" (Pinna & Edwards, 2020, p. 1) with heart rate variability being

positively and consciously impacted by self and co-regulation skills. More recently, Price

and Helen Weng (2021) have demonstrated that a mindfulness practice approach to

interoception facilitates a process of reappraisal and adjustment. Mindfulness practices

develop interoceptive awareness, which, when coupled with the compassionate stance of

mindfulness awareness, allows for *somatic reappraisal*[12] that can, in turn, directly impact

heart rate towards ease. This is a process of conscious emotional reappraisal and

regulation.

Empirical support for using interception to enhance emotional regulation and

well-being is found in a 2020 review of research by Thomas Pinna and Darren Edwards,

researchers in public health policy and social sciences. They have conducted a systematic

review (following PRISMA standards for reporting) of 237 studies in the current

literature on interoception and heart rate variability (HRV) concluded that, indeed,

"awareness of one's own bodily feelings and vagal activation seem to be of central

importance for the effective regulation of emotional responses" (p. 1). They have further

concluded that high interoception had a particularly strong impact on the downregulation

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[12] Price and Weng (2021) define somatic reappraisal as "creating new adaptive interpretations arising from and informed by bodily sensory information" (p. 2). Further, "when mindful attention is brought to interoceptive experience, somatic reappraisal may be engaged by learning to re-interpret internal bodily sensations with less judgement and more acceptance and by experiencing shifts in interoceptive experience" (p. 2).

of negative emotions and social uncertainties, which impacted overall well-being (well-being seen as positive emotional outcomes). They have stated,

> Some evidence suggests that the ability to emotionally regulate successfully may be strongly dependent on the moment-to-moment awareness of bodily parameters relayed via interoceptive pathways which are measured through the use of an electrocardiogram (ECG) in the form of interoceptive awareness (IA) (Thayer & Lane, 2000; Craig, 2008). (p. 2)

Gendlin's (1982) initial body-centered work, developed in collaboration with humanistic psychologist Carl Rogers, has evolved into an experiential psychotherapy (focusing-oriented therapy or FOT) that has influenced multiple somatic psychology[13] methods. As I have noted, FOT and other somatic psychotherapies are supported by neuroscientific research studies on how somatic awareness can be used to enhance emotional regulation, which has many positive outcomes (see Craig, 2015; Price & Hooven, 2018). Such research demonstrates the benefits of developing interoceptive awareness for self-regulation and emotional and cognitive flexibility (Craig, 2015).[14]

In an interdisciplinary review of embodiment theorizing, Craig (2015) has argued that scholars and researchers in evolutionary biology, psychology (particularly emotion theories), and now neurobiology are, implicitly or explicitly, describing the role of emotions and cognitions in interoceptive awareness either in dualistic or nondual fashion. Craig has reviewed the scholarship of what he calls mind-body nondualists—from

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[13] *Somatic psychology*, as discussed in Chapter Three, is an umbrella term for body-centered or physiologically sensitive research and praxis in psychology and psychotherapy. Somatic psychology and psychotherapy are proving particularly useful in addressing trauma-related symptoms, anxiety, stress conditions, and chronic health issues linked to psychological stress. Emerging evidence of efficacy and a host of simple techniques support somatic approaches (see Chapter Three).

[14] *Emotional-regulation* and *self-regulation* are terms that are often used interchangeably. They also have nuance that is better defined in the proceeding chapters.

Charles Darwin to William James to Antonio Damasio, and himself. This nondualist lineage of research and theory claims that emotion and cognition rise out of embodiment rather than exist in a separate and ephemeral *mind* that has dominion over but little influence from bodily life (Craig, 2015). Craig, Damasio (2012), and other embodied-cognition neuroscientists have described the body as the substrate for thinking, feeling, meaning making, and knowing. Neuroscientific research demonstrates that, on average, humans take in over 11 million bits of sensory information per second perceptually while only consciously encoding 6-50 bits of sensory data (Badenoch, 2018). This research can be used to describe how people consciously filter (with bias) this implicit embodied or tacit sensory information. In the next part of this chapter, I use this current concept of interoceptive awareness, Gendlin's process of focusing, and somatic psychotherapy strategies informed by mindfulness traditions to propose a four-stage process of embodiment.

### *A Proposed Four-Stage Process of Embodiment*

As the proceeding summary of the supporting theories for my model suggests, embodiment is a process that actively integrates, via interoception, a felt experience into one's awareness. I describe embodiment as a process that occurs and deepens in four stages: *somatic awareness, somatic trust, somatic reflexivity,* and *somatic wisdom*.

**Stage 1: Somatic Awareness.** Developing somatic awareness is the first stage in this proposed process of embodiment because all other stages rely on this foundational awareness. Somatic awareness is an intentional focus on the sensate landscape of experiences. It is an inward gaze that includes awareness of external temperature, bodily location (proprioception), and environmental context as sensed internally. Thus, one

could say that somatic awareness *is* a quality of interoceptive awareness that includes the internalized sense of the external environment. Facilitators of interoceptive practices use *body scan* techniques and somatically oriented mindfulness practices with clients, and then invite them to "come on back to the room and notice the environment around" them. Such practices help clients develop internal somatic awareness and then link such awareness to the external environment as coterminous.

A practice of interoceptive or somatic awareness is demonstrated in Gendlin's (1982) focusing technique, where a particular felt sense of a problem, issue, or insight is evoked as a clinical pursuit. Where the felt sense is a kind of sensory gestalt or complete phenomenological experience *of* something, somatic awareness is more diffused or open-ended than this while still maintaining a sense of wholeness. Somatic awareness then is turned toward sensations as a whole (as in interoceptive awareness), with one's inner and outer environment sensed from within, prior to a kind of seeking, aiming for, or evoking a central focus (i.e., an issue or dilemma)**.** Gendlin's handy term, the *felt sense*, is important to the central praxis presented in this dissertation because somatic awareness is developed and directed towards a felt sense of trust.

An important distinction to make is that the aim of somatic awareness is not primarily emotions. I like to think of emotions as the weather patterns that often predictably and sometimes unpredictably pass over, shape and are shaped by the land (soma). Somatic awareness seeks out the sensate landscape beneath emotions. In therapy, emotions often wait eagerly at the doorway of one's attention and can obscure sensate data (Gendlin, 1982). According to Craig (2015), emotional states emerge as a habitual or intentional way of relating with interoceptive data. He has explained that getting in touch

directly with one's somatic awareness of a moment has an impact on emotion, cognition, and even body functioning. Gendlin (1982), too, was clear that the felt sense is not an emotion and that emotion is often the place where one becomes stuck and therefore, can be aided by additional felt data. Many therapies aim for and end at the identification and aeration of emotion with often helpful and arguably limited effect. It has been my clinical experience that somatic awareness invites a fuller picture that allows for greater depth of enquiry, insight, and options for integration. Whereas Gendlin's focusing technique aims at the felt sense of a difficulty, the praxis I propose utilizes somatic awareness more broadly to develop a felt sense of trust, which I call *somatic trust*.

  **Stage 2: Somatic Trust.** Second in my proposed four-fold embodiment process is the experience of *somatic trust*, born initially out of relationality and experiences of felt goodness. Somatic trust is rooted in experiences of the trustworthiness of one's own sensations developed in caring relationships. Somatic trust is a felt sense of trust rather than an idea, wish, or even emotionally charged sentiment alone.

  Although there is no research on correlates of somatic trust, research on interoception and somatic awareness has been shown to be a significant biomarker of health and wellbeing (Craig, 2008, 2015; Park & Thayer, 2014). This research suggests that interoceptive or somatic awareness does provide a foundation for experiencing somatic trust. Physiotherapist and yoga therapist Marlysa Sullivan and colleagues' (Sullivan, Erb, et al., 2018; Sullivan, Moonaz, et al., 2018) research into yoga practices is just one of many examples of the emerging link between interoceptive awareness, integration of body-mind-environment (BME), self-regulation, and eudaimonic well-being. The movement from well-being to somatic trust is two-fold: first, outcomes of an

increase in self-regulatory capacity through somatic awareness have been demonstrated to impact a sense of trust in one's own ability to manage strong emotions (see Craig, 2008, 2015); and second, growing familiarity with one's sensate landscape in general can serve to increase trust in the tacit knowledge (Damasio, 2012) or wisdom of sensation itself, enhancing well-being. Gendlin (1982) has observed that over time, his clinical strategies for helping clients to develop a felt sense practice (described below) have resulted in patients' developing their abilities to discern a trustworthy gut knowing that enhanced agency and understanding.

Gendlin's (1982) focusing technique starts with explicit instructions to engage a nonjudgmental observational stance in relation to all sensations and emotions. In phenomenological terms this is called *horizontalization* where everything that is experienced is given equal weight and welcome. In the first step of his five-step focusing process, Gendlin invites the participant to say a *yes* to whatever is sensed, while allowing space to stand in observational relation to the sensations, emotions, and emergent thoughts. Part of the movement from somatic awareness to somatic trust that I demonstrate is exactly this: a curiosity and nonjudgment *yes* to what arises in awareness.[15]

Early nurturing relationships set the stage for somatic trust through the responsive care provider's *yes* to the needs of the child (Erikson, 1963). Attachment research is a

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[15] As I describe more fully in later chapters, I visualize somatic trust as a primordial *yes* to a responsive and receptive embodied life that fuels the first smiles and reaching impulses and may eventually contribute to a growing sense of autonomy and creativity.

category of empirical research into human development through an examination of the earliest stages of human relationships. Such research asserts the foundational role of trustworthy relationships in building the essential ingredient of trust in oneself, others, and life. This trust is said to be achieved through secure attachment (Karen, 1998). More recent research on *earned secure attachment* (Saunders et al., 2011) has elaborated on how this early trust (or mistrust) in the goodness of life can be advanced at a later stage of development via positive adult attachments and relational experiences across one's life span. For example, empirical research on attachment to God (Kirkpatrick, 1992, 1999) suggests a positive correlation between relationship with a benevolent God and earned secure attachment positively impacting other relationships. The *spiritual* aspect of the praxis of intrinsically meaningful somatic spiritual practice in care aims to advance earned secure attachment through felt relationship with the Sacred as a contributor to a sense of trust.

Trust is both relational and internal to one's sense of self. The felt sense of *somatic* trust described here is two-fold: it is a trust *in* one's sensations and *of* one's capacity to discern and regulate them. Attuned friendships, romantic relationships, and relationship with the Sacred (a spiritual or Divine relationship) can serve to enhance or reestablish a felt sense of somatic trust. It is my clinical observation that once somatic trust is established, the stage is well set for the ability to discern, decode, and reflect on more jarring or difficult sensations and emotions, leading to more differentiated integration. Not all sensations are of equal weight, validity, intensity, or congruence nor are they an equally accurate response to a present situation. Somatic awareness and somatic trust lend support for somatic reflexivity.

**Stage 3: Somatic Reflexivity.** Out of a growing somatic awareness, and somatic

trust in oneself, comes the ability to engage in what I call *somatic reflexivity,* which more

generally has its roots in self-reflexivity. Self-reflexivity, a cornerstone of intercultural

spiritual care,[16] is the act of critical and engaged awareness of one's own perspectival

biases, limitations, preferences, knee-jerk impulses, and perceived power differences as

they influence relationships. Self-reflexivity is "an ongoing conversation with your whole

self about what you are experiencing as you are experiencing it" (Nagata, 2004, p. 139) in

relation to others. The ability to be self-reflexive enhances self-responsibility and the

depth of respectful connection to others (Doehring, 2015ab; Doehring & Kestenbaum,

2022b).

Somatic self-reflexivity is my term for the use of immediate sensorimotor or

interoceptive data to better understand oneself and the habits and biases with which one

filters out context-relevant perceptions in relation to others. Somatic reflexivity takes the

implicit processes discerned through somatic awareness and makes them explicit by

listening for, disentangling, and decoding somatic signals in the context of a caring

relationship. Somatic self-reflexivity harnesses the *somatic reappraisal* process identified

by Price and Weng (2021) to "bridge implicit bodily sensations and explicit narratives"

(p. 1) towards greater present congruence and choice. Somatic reflexivity is the ability to

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[16] Doehring (2015b, 2018) has highlighted *theological reflexivity* as a key ingredient in intercultural spiritual care, which is discussed in later chapters. In brief, theological reflexivity is a process of reflection on one's own spiritual orientation and embedded/deliberative theology as evoked by or relevant in the immediate spiritual care encounter. In an interreligious approach that includes spiritual traditions that are nontheistic, Doehring and Kestenbaum (2022b) have used the term *spiritual self-reflexivity* and have described this as a process beyond theological reflection requiring a care provider or chaplain to identify how their religious and spiritual orienting influences the care exploration.

discern somatic data from a phenomenological or observational point of view for the sake of social empathy and self-responsibility.

Somatic reflexivity attempts to add discernment to somatic awareness. When one feels physiological agitation in an otherwise nonthreatening social encounter, one may begin to doubt oneself or wonder what might be going on with the other person, for instance, "I must be getting anxious because he/she is mad at me." This cognitive interpretation can be inaccurate and bound up in history or habit that interrupts the ongoing flow of relationship. This is easily addressed by strengthening somatic reflexivity. Using somatic awareness and trust to focus on the felt sense of the arising agitation, one may discern a historical source of the agitation only tangentially related to the current context. Through this discernment process of somatic reflexivity, one can better trust underlying sensations (by knowing their present or historical source) and make a more accurate and accountable assessment in the present moment. The element of decoding a reaction at its source in sensations, contributes to self and social responsibility and authentic relationship.

Implicit reactions and biases, including prejudices of many kinds, can be encoded in physiology and arise first as somatic discomfort. I propose somatic reflexivity can be engaged to examine such discomfort, agitation, anger, fear, or anxiety before it motivates negative social engagement or withdrawal. Social worker and activist Resmaa Menakem (2017) for example, has coined the umbrella term *cultural somatics* to examine racialized trauma across generations and to develop somatic modes of cultural healing. He has described how internalized racism in the form of unconscious negative bias towards the racial other may be experienced somatically and transformed through self-reflective

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trauma-informed care practices. Although he did not use the term *somatic reflexivity*, he has offered body-centered practices that people can use to become more aware of how the effects of stress or perceived threat can take shape in their bodies. He has asserted that by staying present to the felt somatic experience of discomfort, threat, vulnerability, or superiority, one builds the capacity to be mindful and proactive, more tolerant, and less reactive. He has claimed that somatic practices can lead to more general and abiding changes in somatic reactivity and open one up to curiosity, friendliness, and connection. Menakem's model is designed to move people through embodied prejudice that fuels unconscious racism towards healing and connection. Although somatic reflexivity can serve to identify implicit negative bias, knee-jerk fears, misguided gut feelings, and misplaced vulnerabilities, it can also uncover unanticipated tenderness, hopeful desires, cocreative impulses, and hidden wisdom.

    **Stage 4: Somatic Wisdom.** The development of somatic awareness and a felt sense of trust through a somatic spiritual practice, coupled with the cultivation of somatic reflexivity in cocreative relationships can position one for the fourth phase of the embodiment process, *somatic wisdom.* Akin to emotional intelligence, somatic wisdom may arise as one gains awareness, trust in that awareness, and the capacity to reflexively stand back from and make new meaning out of the novel bits of additional sensory data. Somatic psychologists have different names for somatic wisdom: *natural intelligence* (Aposhan, 1999)*, somatic intelligence* (Schwartz & Maiberger, 2018)*, somatic knowledge* (Gendlin, 1982, 1998), and *bodyfulness* (Caldwell, 2018)*.

    From the earliest roots of somatic psychology in the psychoanalytic work of Wilhelm Reich in the 1930s to its current renaissance, somatic wisdom has been seen

primarily as a wisdom of the *soma*—the wisdom in one's senses—somewhat separated

from cognitive meaning making, yet cognitive functions can be said to be bodily and

informed implicitly by one's sensations (Damasio, 2012). The term *somatic wisdom* as

used here is an expression of mind–body integration and not limited to sensorimotor data

alone; rather, somatic wisdom is in constant dialogue with the full gestalt of information-

processing faculties. Somatic wisdom is a kind of integrated and integrating intelligence

that can be actively cultivated through direct engagement with the embodiment process.

As a clinician, I use somatic wisdom as a helpful, attuned, and often surprising intuition

and contribution to the therapy work I engage in.

There is a kind of spiritual wisdom beyond somatic wisdom as well that somatic

spiritual practices can prime one for: *embodied revelation.* This term, developed in a

series of discussions with Pastoral Care Theologian and Psychologist Carrie Doehring

(personal communication, 2019), points to exquisite moments where Divine, God, the

Creativity of life, nondual experience, or a sacred encounter gifts one with an immediate

glimpse into the larger gestalt in which one's life is enfolded.[17] Such experiences happen

holistically and seemingly suddenly, illuminating one's feeling, thinking, orienting,

knowing, and meanings in one fell swoop. This is a felt revelation which, because it does

not require any explicit cognitive functioning, can feel like Grace, gift, or a sudden

spiritual "ah-ha." Embodied revelation includes the immediate and felt ways the Sacred

reveals itself through people's embodied lives. Since that fateful day in the Vedanta

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[17] Pargament et al. (2014) may have been referring to such embodied revelation in their research
and clinical examples of sacred moments in psychotherapy.

Temple, I have been pursuing a 25-year felt sense or sacred somatic gestalt[18] that was not

orchestrated, aimed at, or anticipated. I experienced it as an embodied revelation that

formed a meaningful pursuit. That embodied revelation has shaped the ways I orient to

life, love, work, and prayer, to this day.

**On Shame and Embodiment**

Shame and mistrust of embodiment are important considerations when seeking to

enhance an experience of embodiment. Historically in Western cultures and in some

Christian doctrines and theologies, shame about one's body and, indeed, about many

aspects of sexuality as part of bodily life has been reinforced. Historical and

contemporary doctrines of sin are often associated implicitly or explicitly with sexuality

and the body in ways that justify religiously based sexism, heterosexism, and racism.

This has led to mistrust in embodiment: for example, when one transgresses beliefs and

values about heteronormative sexual intimacy, which is only 'sanctified' in marriage

between a man and a woman. When such transgressions are seen as sinful, this results in

relational brokenness and avoidance of somatic experiences, impulses, and passions.

There are ways to address and eventually resolve feelings of shame and mistrust about

embodied life through a process of embodiment itself, particularly if acknowledged and

addressed as a felt sense.

Though one is never truly outside of one's own skin while alive, one can certainly

be unaware of or at a perspectival distance from "the power and intelligence inherent in

physical form, instead opting for the supremacy of an immaterial self" (Caldwell, 2018,

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[18] *Sacred somatic gestalt* is my term, used here to suggest an expanding of Gendlin's (1982) term *felt sense* into more holy domain open to embodied revelation.

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p. xxviii). When disconnection from sensate experience for whatever reasons (e.g., shame, trauma, or mere cultural habit) is addressed through practices that gradually enhance the goodness of somatic or interoceptive awareness, the essential trustworthiness and intelligence of the body can be revealed (Caldwell, 2018).

The model of embodiment proposed here is an active four-phase process of shifting one's perspective towards the richness of subjective sensate experience, bypassing emotion, and bracketing conventional thinking *about* what one is experiencing to perceive something more, and more directly. In the process of making more sensate experience known in awareness, new choices and insights, somatic wisdom, and embodied revelation can emerge. It has been my consistent clinical experience that the "whole that is greater than the sum of its parts" can be encountered by the cultivation of somatic awareness, somatic trust, and somatic reflexivity. That "more" hidden within our very bodies can become a somatic wisdom through awareness. This also sets the stage for experiences of a sacred somatic gestalt or embodied revelation.

**A Historical Perspective on Embodiment**

> The exclusion of the human senses as a subject of being, knowing, and connecting is rooted in and furthers the mind/body dualism that rends spirit from flesh, human from nature, female from male, and sensuality from holiness. (Baldwin, 2016, p. xii)

Any historic perspective on embodiment is slippery and prone to faulty generalizations and errors about when, how, and why this split between mind and body has been generated across time. In Western histories since Greek and Roman times, the *mind–body split* is the eventual product of a way of understanding the body as lesser, separable from, inferior to, or "primitive" in relation to mind (thinking, reasoning,

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cognition, consciousness) and spirit. This split or separation of thinking from sensing is a hierarchical one that places sensing and feeling—indeed, all seemingly separable bodily activities—in an inferior relation to reasoning, construction and acquisition of knowledge, and rationality. Current clinical interest in embodiment, reflected in the growing fields of embodied cognition, cognitive neuroscience, integrative/holistic medicine, somatic psychologies, and deep ecology, has emerged out of a Western intellectual history that has promoted active and passive disconnection from feelings and emotions. People in Western cultures have been subject to a denigration of body and emotions that has impacted many aspects of life, whether by accident, byproduct, or design.

Although the enshrining of a mind–body split in the West is often attributed to French philosopher René Descartes, according to theologian Ola Sigurdson (2008), it has deeper roots in Greek philosophy, supported by historical trends in Christian religion since the early Roman empire. In his extensive literature review, Sigurdson has noted that some scholars argue that the dualism propounded by Descartes could not have taken hold in philosophy and science had it not been a powerful zeitgeist out of European religious life in the 1700s as inspired by earlier Greek and Roman philosophers. Platonism, for instance, philosophically elevated abstract perfect forms in ways easy to (mis)interpret as independent from and superior to the material world. This had a strong and often misunderstood impact on both early Christianit(ies) and 17th-century Christian reforms (Sigurdson, 2008, 2016). Sigurdson (2008) has traced the most destructive turn away from embodiment in Western cultures to a three-fold perfect storm in early 17th-century life: the power of protestant puritanism and its demonizing of sensuous bodily life,

followed closely by Cartesian dualism (Descartes, 1641/1960), which philosophically personified a mind–body split either present or misunderstood in Platonism, and the early scientific medical popularity of dissection of the lifeless corpse which then became the "paradigmatic body" (p. 27).

### *Christianit(ies)*

Though it has become commonplace to associate the demotion and denigration of body and embodiment displayed in some forms of this mind–body split to Christianity, according to Sigurdson (2016), this is shortsighted and a misreading of Christian history from a modern desire to place blame outside of the Enlightenment, whereas at least some responsibility resides squarely within it. He has asserted that not only did the Enlightenment era center Cartesian dualism and further separate and elevate reason and rationality from sensing (and other, more intuitive, ways of knowing), but the rendering of Christianity as against sensuality may in part be seen as an Enlightenment reading of history in an attempt to justify (or find blame for) Westerners' current enlightenment-driven scientific, reductionistic, and medicalized relation to embodiment. Rather, the devaluation of the body as seen within Christian theology was often at odds with the deep reverence in the early Church for the mysteries of the incarnation as embodiment of God. The primary debate at the counsel of Nicaea and Chalcedon was about the embodiment of God in Jesus and his resurrection *in flesh* and not just in spirit, with enormous implications for God's relationship with humanity through incarnation.

For some of the early Church fathers, for instance, God incarnated in the flesh of Jesus, rather than the crucifixion or resurrection, was the critical moment of human salvation and sanctification (Sigurdson, 2016). Evolving theologies of incarnation

throughout history demonstrate how Christian traditions and communities have made this foundational doctrine of embodiment relevant and meaningful in their varying contexts (Sigurdson, 2016). According to Sigurdson, the struggles at the Council of Nicaea can be understood as a doctrinal conflict over whether God did or did not fully inhabit a human body. This doctrinal grappling with the meaning of incarnation and resurrection centered on the *embodiment* of God in Jesus and can be seen as reflective of an age-old human yearning to understand humanity's connection to God through embodiment. Sigurdson's (2016) systematic assessment of Christian literature from the time of the Nicaean Council describes how Christian traditions and communities have grappled with humanity's relationship to God in and through embodiment across time.

In further contrast to the body-negating narrative ascribed to Christianity, there were many trends within the early tradition in which one's body was the means by which God was experienced through communal spiritual practice and healing (K. Turpin, personal communication, 2020). For instance, Hildegard von Bingen's medical practice in Germany in the mid-12th century was a key element of her spiritual practice, writing, and leadership. Benedictine monasteries often included the first hospitals or infirmaries where practical premodern medicine was advanced in the care of monks and villagers alike (Sweet, 1999). The ongoing link between spiritual and somatic healing was not just a spiritualization of illness in the early Christian Church. It was also an engagement with and development of medical practice in support of preserving life and advancing medicine (Sweet, 1999). Care of suffering bodies fulfilled gospel mandates to feed the hungry, give shelter to strangers, look after those who are sick and visit those in prison (*King James Bible*, 1769/2017, Matthew 25: 35-36).

Care as respect for bodies and embodiment is implicit or explicit in multiple examples of early Christian values, practices, and belief; therefore, Sigurdson (2016) has warned against a simplistic or misrepresentative reading of early Christian history's devaluing of the body using modern notions of theological anthropology. Stressing today's difficulty of writing on embodiment without reifying or abstracting and therefore enacting violence upon it, Sigurdson has pointed out that the difficulty of speaking on embodiment that scholars and theorist grant themselves now should be granted to the voices of history as well; furthermore, "historical embodiment and contemporary embodiment may each constitute their own horizon" (p. 2). As practical theologian Katherine Turpin has pointed out,

> the story [of embodiment] is always mixed throughout in terms of actual religious practice, although, perhaps not surprisingly, the written theological record is more focused on rationality. This matters because sometimes the assumption is that one would have to leave Christianity to discover sources that take embodiment seriously, when in fact they are present in various forms throughout the history of the tradition. (personal communication, 2020)

Having the "theological record more focused on rationality," Sigurdson's (2016) most recent work, *Heavenly Bodies: Incarnation, the Gaze, and Embodiment in Christian Theology*, is his attempt to tell the story "on the margins of theology, … expressed in various Christian practices," where "'doctrine' and 'life' are intimately intertwined, … not least when it comes to the body" (p. 4). This intimate intertwining for which Sigurdson has argued is one of human relationship to God through embodiment as found

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in incarnation,[19] the gaze (or gaze of faith)[20] and doctrinally endorsed communal

practices. These three religious domains—incarnate relationship with the Sacred, the

gaze, and communal practices—can only be performed with the whole of one's embodied

self. Sigurdson has emphasized that embodiment *is* relationship to life, other, God, and

the mystery beyond one's senses. Embodied, sensate life reaches for, responds to, and

engages the approach of God in relationship with humanity. With the concept of *the gaze,*

Sigurdson has proposed that sensate life is the relational connection with God.

Embodiment as relationship is personified in rituals like the Holy Eucharist. God's

relationship to humans' embodied existence through the *body* of Christ is enacted in

communal ritual. "The temporal structure of communion," said Sigurdson, "is also that of

the body. … I have therefore accounted for the body as a medium for pain (past), the

presence of God (present), and hope (future)" (p. 576).

Pastoral theologian Ruben Arjona (2017) has described a theology of trauma

using the act of Holy Communion as a three-part "embodiment of care" oriented towards

"life in its fullness, here and now" (p. 182). This explicit reference to embodiment and his

recognition of physical participation in Eucharistic ritual as the site of healing

demonstrates a distinct way that Christian rituals affirm the value of the body as the site

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[19] Sigurdson (2016) was making the argument that the incarnation invites felt or direct relationship with God. Incarnation "thematiz[es] the body as a 'means of grace' and the active presence of God among humans in Jesus Christ" (p. 18).

[20] Sigurdson (2016) has argued that the "gaze of faith" (p. 244) is inextricably linked to embodied ways of being-in-the-world through perception (sight) and evoked in iconic images, sacred spaces, and the depicted reciprocal gaze in the eyes of Jesus. He has stated,

> That which characterizes the Christ image according to the theology of the image is that it wants to make the human, inclusive of her embodiment, participatory in the divine life by inserting her world into another context—another relationality—than her mundane context. (p. 231)

of healing and location for relation with God. Arjona has stated, "In Communion, a person who has experienced a traumatic event is offered (1) a trustworthy and nourishing relational home, (2) a therapeutic space for truth-telling, and (3) a life-sustaining absolutism" (p. 183). He has asserted that through embodied participation in the communal ritual of the Lord's Supper, the actual movement of material bodies within sensate ritual practices is at least as important as belief, meaning, and theological understanding of the gestures committed to in this process of wholeness (and holiness).

Rather than seeing the disembodiment of Christian faith as residing in an impenetrable past, Sigurdson (2008) has argued that secular privatizing of faith today is a consequence of Christianity's recent severing of an alive bodily connection to a faith community. He has called the privatizing of faith a devastating loss of the "intercorporeal" social body that once gathered in faith, and through that gathering, evoked, and shared in the felt relational presence of God (p. 27). Faith becomes a personal mental state or disembodied system of beliefs rather than what it once was: a living set of shared and trusted practices embodying communion in a trustworthy relational web that includes God. Sigurdson has proposed a "theological somatology" read through the lens of phenomenology (p. 25). I propose that a theological somatology can begin with (re)engagement and (re)centering of somatic awareness, somatic trust, somatic reflexivity, and somatic wisdom, discussed as a four-fold process of embodiment, mediated through spiritual practices.

### Feminist Theology

Feminist theologian Elaine Graham (1999) has argued that the female body, being associated with birth, sensuality, emotion, and "earthiness," was placed below male-

bodied persons as a powerful tool for patriarchy. According to Graham, patriarchy has asserted and maintained the false associations of men with reasoning (mind) and woman with emotional whimsy rooted in sensuality (body). In psychology, theology, and philosophy, women striving to achieve respect and social standing within patriarchal academic circles, turned away from sensuous ways of knowing, rejecting embodiment as a hindrance, and instead highlighted their capacity for rationality (at some cost). Graham has written, "'Liberal' feminists prefer to reclaim women's rationality and intellectual equality with men, regarding embodiment as a barrier to emancipation" (p. 112).

To some feminist theologians, Christian traditions in the West have informed and advanced patriarchy or vice versa with their subjugation of feminine, fleshly, and fearfully sensuous life, denigrating embodiment along the way. Practical theologian Bonnie Miller-McLemore (2014) has described how the body and emotions (as associated with the feminine) continues to be the null curriculum of religious studies scholarship striving for a place at the rationality-driven academic table. She has noted, "Not surprisingly, then, religion scholars have strived, perhaps more than others, to establish their subject as scientific by accentuating its theoretical capacities and downplaying its association with emotion, passion, and feeling" (p. 691). E. Graham and Miller-McLemore, like Sigurdson, have argued for a more embodied telling of Christian theology, where lived religious and spiritual practices within communities of faith can be made central and, indeed, revelatory. Telling the untold story of lived religious life across time provides evidence of the reverence for incarnation and embodiment throughout many of Christianity's various shapes and forms.

*Lived Religion*

Bodies are inherently involved in all material practice, feeling, thinking, and theologizing. Ethnographic studies of *lived religion* have demonstrated repeatedly how complex ways of embodying religious and spiritual values, beliefs, and practices can be life-sustaining, often upheld within a rich social fabric of formal ritual and ordinary daily faith gestures (Sremac & Ganzevoort, 2019). Embodying religious and spiritual values, beliefs, and practices can also be life-limiting and destructive depending on multiple complex social factors and the values, beliefs, and practices involved (Doehring, 2015b). It bears noting that lived religious life is not a universal, harmonious, benevolent, or unquestionable good. The field of lived religion examines the multiple ways that religious life is practiced and, as E. Graham (1999) has pointed out, sometimes radically at odds with espoused beliefs, for better and for worse with regard to embodiment. *Lived religion* engages the study of the material actions and experiences, both sacred and profane, of a religious person or community, which "takes place in concrete material, spatial, political, cultural, and social environments, through embodied subjects who act, think, feel, see, hear, smell, touch, and experience" (Sremac & Ganzevoort, 2019, p. 3).

The subject and study of lived religion focuses attention on the actual participants in religious life. The embodied nature of religious life as it is lived out in communities of faith across time is not articulated well in analytic, philosophical, theological, or historical texts (and that is generally not the purpose of such texts), yet it is important to note that embodiment and the body are never absent from religious life. It should not be assumed that embodiment is implicitly disparaged through this omission, even if not highlighted. Communities of the faithful, Christian and otherwise, have been and

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continue to be organized around embodied practices celebrated through sensuous

offerings and feasts. When life-giving, such practices are committed tirelessly to acts of

corporeal health and healing and share in the harboring or protecting of marginalized life

at great cost. Such lifegiving practices and more are the multiple sacred, religious

affirmations of the centrality of incarnate life deserving of protection, care, and

celebration.

### *Psychology*

The culmination of the primacy of reasoning and cognition over the more

"primitive" emotions and feeling states can be seen in the "cognitive revolution" in

Western psychology that initially positioned the human mind as a computational machine

and the body as mere hardware, "decontextualized and disembodied" (O'Connor, 2017,

p. 3). Reflective of the dualistic hierarchy in Descartes's (1641/1960) *Meditations*,

cognitive science split the physical brain from the body all together, with the brain

assuming a central place in psychology. The "decade of the brain" in the 1990s, when

brain research funding and public interest merged (thanks to the Bush administration's

well-intentioned campaign), produced a huge surge in brain research that favored the

only nominally embodied brain as part of the mind side of the mind–body split. To this

day, language in the West is burdened with the illusion that brain is not body. Speaking in

terms of the brain-body connection or the cognition-emotion, reasoning-passion, head-

heart/gut connection reenforces this Cartesian dualism (Tirado et al., 2018). Embodied

cognition researchers have stated plainly that "body and brain are a series of subsystems

that interact" (Boulpaep et al., 2009, p. 79) or have noted that such dichotomizing "is not

only a return to a Cartesian ontology, but also a contradiction of elemental human

anatomy and physiology" (Boulpaep et al., 2009, p. 79). The brain is an organ of the overall organism with dense connective fibers throughout the body. Cognition itself is one activity of the body as a whole, yet language continues to betray an older story even in fields as evolving as evidence-based cognitive neuroscience. Somatic psychology, informed by such evidence-based research and discovery in neuroscience, psychophysiology, and the like, seeks to rectify this split through theory and clinical practices that bridge the artificial divide.

Human bodies are teaming with important sensory data, empathic information, gut feelings, intuitions, and physiological memory sometimes collectively termed "tacit knowledge" first coined by chemist philosopher Michael Polyani (in Miller-McLemore, 2014, p. 697). Such tacit knowledge, when respected, is a part of the trustworthy felt sense of an experience, situation, relationship, problem, or solution (Gendlin, 1982). Gut feelings, intuitions, and unconscious biases can be assessed in the light of somatic self-reflexivity. Cognition, discernment, reasoning, social and emotional intelligence, and empathy are all rooted in humans' sensing bodies and enhanced by practices and processes of conscious embodiment (O'Connor, 2017). It is therefore important to challenge the historically driven and language-reinforced dichotomy of a mind–body split and (re)establish a two-fold trust *in* an interoceptive felt sense as well as a felt sense *of* trust in the goodness within life, starting with their own embodied aliveness.

**The Intersection of "Having" and "Being" a Body**

We humans are embodied being—we live in and with and from our bodies.

(Lipari, 2014, p. 30)

In this dissertation, the aim is not to elevate sensate experience above cognitive or mental activity and further a notion of a split or hierarchy, but rather to argue for bringing somatic awareness into dynamic balance with mental faculties for the sake of wholeness, and this is where language is important. Under the banner of *integrative medicine,* research and health practices are being designed to support a view of the whole person as organismically and ecologically integrated at all times. Within these efforts, bodies are seen as dynamic systems. Beyond the boundaries of skin, the whole person is seen to be ecologically embedded in a life world that is continually shaping and shaped by environmental factors. The fields of somatic psychology, traumatology, cognitive neuroscience, process and liberative theology and religious studies, and phenomenological methods point to the importance of human physiology and interpersonal relationship. In certain schools of psychotherapy, therapists and clients are regularly trained in somatic or meditative practices held within a sensed relational web (including mindfulness–awareness meditations, yoga, breath work, and martial exercises often first articulated in religious traditions), yet they are challenged by how to talk about bodies, relationship to one another, and the process of embodiment in ways that do not reinforce old unhealthy and unnatural dichotomies. Such discussions run the risk of either objectifying *the* body further as a concrete thing or narrowing the conversation to subjective phenomenological sensory data that, if universalized or generalized, risks the loss of wonder and alterity.

When body and embodiment are seen through an individualistic lens alone, risking a kind of biological reductionism and stoicism/individualism, one loses track of the fragile, provisional nature of sovereignty within any ecology. The flip side of this

polarity, that of a cultural construction lens, abstracts all agency and sovereignty out of human embodiment. Through humans' very embodiment, they are social, cultural, historical forces with both agency and vulnerability. The image of an interconnected "web of life"[21] is sometimes utilized to capture how people are shaped by the multiple forces unfolding around them at all times, and people are shapers through agency, influence, vulnerability, and creativity. They are both entirely relational and richly unique in their interdependent, interinfluencing identities as sovereign and embodied, ecologically embedded beings. The mystery and wonder, terror, and power, of this delicate dance cannot be understated.

To address the challenge of *how* to speak of this inescapable predicament of embodiment, I have spent the past few years asking those who engage in somatic psychotherapy, community faith leadership, and spiritual practice instruction how they choose to speak of *the* body. My central question has been whether they have a sense of *having* a body or *being* a body. Although the resounding majority thoughtfully answered, "both," one person, a dancer, answered, "neither." He instead responded,

> When I am moving from deep within myself, I do not have a sense of *being* a
>
> solid body, I have a sense of existing dynamically and of allowing awareness,

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[21] Miller-McLemore (2020) has proposed "the living human web" as a metaphor for communal contextual pastoral theology that has been widely used in ensuing years. In her "Epilogue" to editors Lartey and Moon's (2020) anthology, *Postcolonial Images of Spiritual Care: Challenges of Care in a Neoliberal Age*, she has noted

> Even though the metaphor arose to 'confront systems of domination'—the personal as political, illness as located within wider systems, and repression of minoritized voice in the discipline—the living web inherits the pathologies of its context and has inevitably covered over patterns of colonial erasure. (p. 192)

She has also cited chapters within this volume that explore how this living web is entangled with capitalism and neoliberalism.

movement, sensation, and insight to arise out of that ground—not out of a body

per se, but out of the present culmination of my experience felt through my

senses. (S. Love, personal communication, 2020)

I assert that this "both" or "neither" answer rests at a powerful intersection between

*having* and *being* a body, and the language used to favor one side of the coin over

another.

Philosopher Maurice Merleau-Ponty (1945/1962) has famously articulated this

seeming dichotomy by making a distinction between *the* (possessive/objective) body and

the subjective sense of oneself through embodiment, the distinction between having a

body (*korper*) and being a body (*lieb*). Humans *have* a physiological form about which

they can make objective decisions, chose to subject to medical intervention, and locate as

solidly taking up space. This body carries the weight of history, biology, and social

influence across time. People are aware of their *being* in this life through a phenomenal

experience that is neither solid, wholly "internal," nor even temporal (direct experience

does not always reference past or future). Feminist philosopher Maren Wehrle (2019) has

called this the "[differentiation] between the intentional temporality of being a body and

the temporal experience of having a body" (p. 499). To make matters more complicated,

this bodily life, embedded as it is in multiple intersecting contexts, is perceptively and

unwittingly shaped for better and for worse by social-relational influences.

This *being* a body or, better said, experiencing oneself phenomenologically as a

body (Wehrle, 2019), is often an aim of somatic practices. The capacity to be aware of

one's body objectively at the intersection of direct phenomenological/subjective

experience or somatic awareness, allows one a much fuller view of life, responsible

somatic reflexivity, and access to the integrative power of somatic wisdom. Therefore, the seeming dichotomy of *having* and *being* a body can create a meaningful intersection from which to observe, experience, relate, narrate, and practice wholeness. These objective (*having* a body) and subjective (*being* a body) modes of experience of corporeal existence refer to a dual awareness capacity that can be cultivated intentionally through somatic awareness practices. Research into interoceptive awareness is suggesting that such practices can lead to a more flexible, creative, integrated, and satisfying way of being in the world (Craig, 2003). Craig (2015) has claimed that interoceptive awareness itself is the direct experience of aliveness that, coupled with intentional awareness, is an expression of this *having* and *being* intersection.

An important contribution to this intersection of *having* and *being* a body is that people are embedded at all times in an interinfluencing relational, ecological web or *life world.* Humans are profoundly social beings moving within communities that react to, lavish attention upon, caress, define, control, subjugate, liberate, and organize each person by virtue of bodily differences and similarities. This is not a neutral process, but rather one that is interwoven with power, history, and mystery. E. Graham has stated it well when proclaiming that bodies are where "nature and culture, construction and agency meet" (1999, p. 115). As people envision this intersection of *having* and *being* a body, they can empower this vision by seeing themselves as an organizing center for a continuous flow of relational contexts, constraints, and creations.

The thrust of Western medicine, psychology, theology, and practical language continues to weigh heavily, even pathologically, on the objective *having*-a-body side of this intersection. *Having* a body still generally assumes it is a possession, vehicle,

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instrument, shell, machinery, or hindrance of a more elusive self. *Being* a body, on the other hand, is indeed hard to language, as it is more about identity as it arises out of experience. In *being* a body, less importance is given to historical, environmental, and social forces and factors that only the ability to reflect on embodiment can contribute. Both perspectives *having* and *being* a body are helpful at different times and are most effective when united; when divided, both perspectives may have limitations that can have devastating effects on health, environment, relationships, and spiritual growth. This intersection brings to mind the fruitional and developmental views of wholeness discussed at the beginning of this chapter. The unifying intersection in awareness of *having* and *being* a body is therefore essential in this process of embodiment, contributing to the aim of wholeness.

This dual vantage point of *having* and *being* a body living within intersecting relational contexts, when understood all together, can greatly enhance empathy, self-reflexivity, and spiritual care in the aftermath of trauma. At this ecological intersection, new insights, meanings, agency, and creative understanding can arise in the form of somatic wisdom and occasional gracious revelation.

**Conclusion**

I assert that the process of embodiment, supported by relational accompaniment, is trustworthy, even when painful, and can lead to a greater sense of spiritual wholeness. One may not yet understand the story unfolding in the process of embodiment, or one may not feel one can bear what is sensed, yet, as I attempt to clarify in this dissertation, the soma holds a key to wholeness. There are sensate stories to be welcomed, witnessed, lamented, integrated, and transformed through interoceptive awareness, leading to

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renewed trust in oneself and in life. Somatic spiritual practices provide a route to the development of somatic awareness and somatic trust, somatic reflexivity, somatic wisdom, and an opening to embodied revelation. Interoceptive awareness that can emerge from within intrinsically meaningful spiritual practices with a specific *focus* may provide both novel information and a ground for novel integration of one's senses, emotions, cognitions, and meaning making into a trustworthy whole (or gestalt). In this study, I attempt to demonstrate that certain kinds of somatically focused co-creative spiritual practices serve to develop interoceptive awareness of a felt sense of trust.

When one experiences a sense of trust in oneself, especially in the aftermath of traumatic rupture, not only is empowerment a potential outcome, but hope is as well. This embodiment process, facilitated by intrinsically meaningful somatic spiritual practice, can be a helpful, hopeful, and holy ground through which trauma survivors dare to lament and (re)build trust in felt goodness. This is one of many paths to spiritual wholeness uniquely helpful for trauma survivors. "The body keeps the score" of trauma, as van der Kolk (2014) has argued in his eponymously titled book. In this dissertation, I argue that the body also offers a felt landscape of renewed goodness, trust, wisdom, revelation, and a hopeful path to spiritual wholeness. As editor of the compilation *Sensing Sacred,* Baldwin (2016) has declared that sensate embodiment is the "means in which human beings know themselves, others, and the divine in this world" (p. vii).

In his call for a critical somatology, Sigurdson (2016) has asserted, "For us human beings the body is not necessarily the fixed point we often imagine, but rather a dimension of ourselves whose mystery continually turns towards the invisible" (p. 599). In his book on phenomenology and deep ecology, philosopher David Abram (1996) has

stated, "To acknowledge that 'I am this body' is not to reduce the mystery of my yearnings or fluid thoughts to a set of mechanisms, … rather, it is to affirm the uncanniness of this physical form" (p. 46). Incarnate human life is complex, adaptive, temporal, embedded, relational, and deeply mysterious. It is also trustworthy because it must be so for life to go on, and on. Quite possibly, there cannot be a human self without a body just as there is no weather pattern without land, or gravity without planets, and possibly no spirit without form to pass over, tether to, and transform—and so, we become embodied beings. We are tied to life through this uncanny, mysterious, marvelous physical body. The occasional felt meta revelation of the uncanny yet deeply familiar mystery of embodied existence is a sacred somatic gestalt not unlike the memory opening this chapter. Such moments can be the culmination of a process of embodiment or a sudden somatic revelation of an ongoing spiritual wholeness. Holding to this vision, I turn now to those significant disruptions in a sense of wholeness: trauma and moral injury.

## Chapter Three: The Landscape of Trauma and Moral Injury

**Introduction: Josie**

"It felt as though she was ripped from me the day my mother died and a part of me was ripped away too. A part of me died when she died. As a medical student at the top of my class, utter shame washed over me that I could not save my own mother. I should have saved her. I blamed myself for her death and felt I did not deserve to live on. Everything essential seemed to end there at her deathbed; my ability to deeply love, my feeling that I deserved to be loved, my trust in myself as a physician, mother, and wife." (Josie,[22] personal communication, January, 2021)

In this chapter, I describe how the ever-present possibility of wholeness discussed in Chapter Two may be experienced in a process that includes lamenting brokenness through somatic awareness practices in the aftermath of trauma. This brief clinical verbatim comes from my psychotherapy practice with my client Josie (a pseudonym). Josie's case exemplifies how wholeness is lost and how brokenness (a sense that part of her was "ripped away"), in the form of complex traumatic grief, includes and is interrupted by unyielding moral distress and shame. The sudden loss of her mother was traumatic for Josie, in part, because so much of her emotional, psychological, spiritual,

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[22] Josie is a Caucasian physician, wife, and mother of Ashkenazi Jewish descent in her 30s. Raised in the Unitarian Church, she identifies as spiritual and is part of a strong spiritually based recovery community. I worked with this client from the sudden death of her mother in August 2017 to the present. She has reviewed and given me permission to share this case study. Her case exemplifies the theme of traumatic grief and moral injury.

and physical life was entwined with and dependent on her mother, evoking perceived life threat at her death. The experience of a dramatic health crisis for her otherwise youthful and vibrant mother also contributed to a sense of shock, disbelief, rage, and despair that, at times, overwhelmed her capacity to cope. Josie struggled to understand and articulate to those around her the magnitude of loss involved in her mother's death. Initially, Josie did not find the relational support needed to integrate the depth and breadth of her loss. The experience of sudden loss combined with isolation led to a protracted or traumatic grief that disrupted her daily life.

For Josie, traumatic grief was compounded by shame. As a newly minted medical doctor, she felt ashamed that she was not able to persuade her mother to choose treatments that might have saved her life. Josie knew clinically that physicians cannot make patients choose treatments or healthful options against their will. Yet, Josie's core family value of responsibility for her mother's well-being sent her down a dangerous path of self-reproach, self-sabotage, loss of trust in her capacity as a doctor, and an unyielding belief that she, herself, no longer deserved to live. "I cannot live because I may suddenly die and leave my children," was the traumatic response to the sudden loss of her mother and, "I do not deserve to live because I did not save her," was the moral condemnation holding the trauma in place. Grief was woven painfully together with thick strands of guilt and shame, numbness, self-doubt, and despair. For 4 years after her mother's death, Josie struggled with a pervasive sense of self-exile and emptiness[23] that often served as a

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[23] Emptiness, numbness, feeling paralyzed are words often used by care seekers. Levine (2010), Porges (2011), and other trauma theorists have noted this as part of a physiological *freeze* response to significant emotional overwhelm. In trauma literature, *functional freeze* (Levine, 2010) is outlined as a generalized or prolonged state of low-level, functional numbness in the aftermath of a traumatic event. Different somatic interventions for the subtle differences in state between, let us say, numb and frozen, may

self-protective mechanism to dampen the magnitude of turmoil within. Her deepest loss was, as she claimed, of her "imagination, joy, confidence, and spiritual life." Arriving at the heart of her despair through spiritually integrated care, Josie had the courage to acknowledge aloud, "I honestly don't want to live this life without her. I don't want to live anymore." This was not a suicidal moment per se but rather a moment of sharing her deepest lament and utter "brokenness" (Josie). This was the beginning of a new engagement with her life as it is now: more empty, yet eventually, perceptively more "spacious" (Josie).

Josie's case illustrates traumatic grief involving the "death of a loved one due to traumatic events" evoking posttraumatic stress responses of "anger, emotional numbing and detachment, feelings of a bleak/foreshortened future, and agitation that could manifest as anxiety or startle" (Drescher & Foy, 2010, pp. 152-153). In Josie's traumatic grief, the sense of life threat inherent in traumatic stressors came from the suddenness of her mother's death as well as from her psychological sense of dependence on and responsibility for her mother. The sudden loss of her mother, the abrupt ending of their intertwined lives, and the feeling that she was responsible for her mother's death[24] caused an overwhelming upheaval in her sense of what is trustworthy in herself and in her life. Moral injury, explained at length further on, held her grief in place as if she deserved to

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be warranted by degree yet the root of each is emotional overwhelm in the form of terror, despair, rage, and/or defeat (a perceived unsuccessful fight/flight that results in a freeze response).

[24] An important detail: Josie supported and encouraged a strongly recommended surgery for her mother, which resulted in a surgical injury, immediate medical release to hospice, and three days later, her mother's death by sepsis. Josie's role in encouraging the surgery contributed to a moral sense of responsibility and the suddenness of her mother's death made this death traumatic for her—hence, a moral injury.

be isolated from compassionate support and frozen (dead) in time because she experienced herself as an agent who could have prevented her mother's death.

Josie felt with utter conviction that she "should have saved her mother" and failed to do so. She felt that she did not deserve to be happy or alive and was therefore even unable to consistently or deeply delight in her newborn children. For a protracted time, she felt intense anxiety and mistrust of herself as a medical doctor. This self-questioning led to disruptive self-sabotage behaviors in her career and homelife. Further, Josie was experiencing a pervasive sense of being punished by or deserving punishment for her mother's death. Clinical Psychologist Katy Barrs and Carrie Doehring (2022) have noted,

> Perpetration-based [moral injury] is associated with (a) guilt, shame, and sadness; (b) re-experiencing symptoms and numbness (Stein et al., 2012); (c) beliefs about being unlovable, unforgivable, or incapable of moral decision-making; and (d) self-sabotaging and acting out behavior. (p. 299)

Jonathan Shay (2014), one of the first experts on military moral injury, has emphasized that "first, last, and always, the question of trust is on the table, regardless of what forms of moral injury are in play" (p. 188). When trauma and agential moral injury co-occur, trust in oneself and others is radically challenged. Josie frequently expressed her dismay at a pervasive sense of emptiness and despair about why she has "not felt like herself for 4 years now." Shay has asked and answered, "How does moral injury change someone? It deteriorates their character; their ideals, ambitions, and attachments begin to change and shrink. … Moral injury impair[s] and sometimes destroy[s] the capacity for trust" (p. 186).

Josie's case is revisited in Chapter Five to demonstrate a model of spiritual care that utilizes the process of embodiment to restore trust, share authentic lament, and foster

dynamic wholeness or, in her words, advance "joy and growth beyond that moment when my mom died." Josie is spiritually committed to her own integration process. It has been my clinical experience that therapeutic integration beyond initial support seeking generally requires personal effort, self-responsibility, and collaboration. This chapter serves to define trauma, moral injury, and integration, demonstrating how trauma and moral injury undermine a foundation of trust in ourselves, others, and life itself. I illustrate how spiritually integrated and somatically based trauma care helps by highlighting three evidence-based best practices in trauma care that preference or include processes of embodiment suitable to the inclusion of cocreative spiritual practice.

**Moral Injury**

In the field of psychological studies, there is renewed consideration of the meaning and nature of morality and how it plays out in relationships, politics, and cultures. The current lack of focus or training in this area in counseling psychology can negatively affect the ways one understands trauma, shame, and despair as well as essential aspects of the process of integration.[25] In the history of psychological studies, one can observe a movement away from an emphasis on or research into the moral aspects of human experience (Shay, 2014). The cognitive revolution that placed the brain and reasoning at the center of all psychological life did not consider moral struggles as a distinct and significant category of stress. The work of psychiatric researcher Jonathan

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[25] *Integration* is defined more fully below as the process of making whole. The term *integration* is preferred over *healing*, *recovery*, or *resolution* because it points to the clinical and spiritual view held in this dissertation that one does not get rid of bad experiences or return to some mythical or ideal state of health but rather grows in integrity, courage, and moral complexity by expanding to include painful experiences.

Shay and others has recentered this important domain in the 1990s by identifying moral

injury in both its betrayal (Shay, 2014) and perpetrator or agential forms (Litz et al.,

2009). Shay (2014) has pointed to the discrepancy in the psychological trauma literature

regarding moral stress or injury, here, in terms of traumatized veterans:

> The DSM diagnosis, Posttraumatic Stress Disorder (PTSD), does not capture
> either form of moral injury. PTSD nicely describes the persistence into life after
> mortal danger of the valid adaptations to the real situation of other people trying
> to kill you. However, pure PTSD, as officially defined, with no complications,
> such as substance abuse or danger seeking, is rarely what wrecks veterans' lives,
> crushes them to suicide, or promotes domestic and/or criminal violence. Moral
> injury—both flavors—does. (p. 184)

Morality has been hypothesized as either a rational, developmental acquisition

(nurture) or an inbuilt "set of evolved intuitions" (nature) alone (Haidt, 2012, p. 31).

Moral psychologist Jonathan Haidt (2012) has developed the *social intuitionist model* to

argue for a dynamic, cross-culturally observed, interaction of both nature and nurture that

forms a person's *moral matrix*. Based on the work of Richard Shweder, Lawrence

Kohlberg, Elliot Turiel, and others in the field of developmental and social psychology,

Haidt's collaborative research on morality has suggested "some combination of

innateness and social learning" (p. 31) at play. Haidt has considered innate moral

intuitions, of which a finite number exist,[26] to be shaped by emotional valence, reasoning,

important relationships, and cultural context. In simple terms, then, *morality* can be

defined as one's emotionally energized intuitions (nature) about deeply held values

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[26] Haidt has conducted cross-cultural research building on the work of Shweder to identify six
moral *taste buds* that are then advanced to varying degrees in differing cultures, socio-economic groups,
and through political or religious ideologies. He has called these the *six moral foundations*. Moral
foundations theory has a growing body of collaborative research, publications, and methods of application
towards personal and social problems. Oversimplification, universalizing, and reductionism are a few of the
criticisms of this theory.

(nurture) regarding right and wrong, particularly regarding how people should treat one another to live well together. There is ample, growing evidence for an inbuilt human moral template at birth—an organismic *sense* of right and wrong (Bloom, 2013)—that grows in strength and nuance as one develops within cultures that place emphasis on certain values over others (Haidt, 2002).[27] Morality is an innate and intersubjective human characteristic formed through nature and nurture working together, whereas ongoing moral development can be relationally advanced.

A healthy, congruent, and flexible *moral orientation*[28] is key to a personal sense of goodness and serves as a trustworthy inner compass for social life. Moon has defined moral orientation or *moral identity* as "a dynamic web of beliefs, values, and behaviors connected by sinews of meaningful relationships" (personal communication, 2020). People move about in an extraordinarily complex world somewhere on a spectrum between moral flexibility or rigidity. This attitude inevitably generates degrees of moral stress arising from core values in conflict within oneself or within meaningful relationships. People who tend to feel responsible for suffering, for example, experience moral stress from conflicted values most of the time. Those who externalize stress, on the other hand, are more likely to blame others. A simple example of moral stress may be feeling conflicted about purchasing an expensive latte after telling a homeless woman

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[27] Haidt's work suggests a moral pluralism rather than moral relativism.

[28] Whereas Haidt (2012) has referred to an individual and cultural *moral matrix* in reference to developed moral intuitions, Pargament and colleagues (2006) have referred to religious, spiritual, or moral *orienting systems*.

that you cannot offer her anything.[29] In this example, moral stress could arise from

conflicts in values of care and fairness. Another example of moral stress generated

between friends who gather in a park during the coronavirus pandemic is symbolically

demonstrated—one in a mask and one not in a mask—because their safety behaviors are

shaped by conflicting values, differing information sources, and shared empathy.

Behavior scientist Eugene Chan (2021), after studying three behaviors meant to help

"flatten the curve" of covid—staying-at-home, wearing face masks, and social distancing

(p. 2), has found that

> caring and fairness concerns predict complying with all behaviors, while sanctity
> concerns only predict compliance with wearing face masks and social distancing.
> A deeper investigation revealed age differences in loyalty and sanctity concerns
> for staying-at-home and social distancing, and in sanctity concerns only for
> wearing face masks. The findings document the innate intuitions that guide one's
> decision to comply with such behaviors. (p. 2)

Moral stress involving conflicts in core values may deeply impact trust in oneself

over time, leading to moral struggle. *Moral stress* arises from life experiences where core

moral values come into conflict within oneself or in relationships of importance (family,

religious, social life, work, etc.) potentially resulting in ongoing personal *moral struggles*

of an ultimately spiritual nature (Doehring, 2015c). Doehring (2015c) has specified that

"moral stress, conflict, and injury are inherently religious and spiritual in that they

involve one's ultimate values and beliefs and ways of coping with existential suffering

and finitude" (p. 190). Some moral struggles cause deep fissures in one's personal sense

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[29] Depending on one's hierarchy of values, this example need not be one's personal moral
struggle. Haidt (2007, 2012) and Atari et al. (2021) have described six moral foundations and their nuanced
expression, differing valiance, and hierarchical organization. Humans negotiate communal life in a
complex world, where moral compromise is not just necessary but may demonstrate healthy flexibility,
humility, complexity, and empathy.

of goodness, place in the world, and connection to others and God, bordering on spiritual struggles.[30] As interdependent persons, such a rupture in oneself and in connection to others can be experienced as akin to life threat and result in trauma symptoms such that moral stress becomes moral injury. As pastoral theologian and moral injury scholar Zachary Moon has stated,

> "faced with challenges, one's moral identity will accommodate or assimilate new experiences, or it will experience rupture or trauma, an overwhelming of the baseline functioning of our sense of self, leading to disconnection, disorientation, or loss of previous beliefs, values, and behaviors. This also causes a strain or alienation from constitutive meaningful relationships." (personal communication, 2020)

The magnitude of moral stress and struggle can feel like a threat to life itself, taking the diagnostic and symptomatic form of psychological trauma.

> Shay (2014) has explained,
>
> Moral injury is present when there has been (a) a betrayal of 'what's right'; (b) either by a person in legitimate authority (my definition), or by one's self … ; (c) in a high stakes situation. Both forms of moral injury impair the capacity for trust and elevate despair, suicidality, and interpersonal violence. (p. 182)

Moral injury may result from trauma that includes a sense of guilt from harm caused or a sense of betrayal that those responsible for protecting life did not fulfill their responsibilities. The moral dimension of this form of traumatic rupture was first

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[30] Pargament and Exline (2022) defined spiritual struggles as "experiences of tension, conflict, and strain that center on whatever people view as sacred" (p. 6). Spiritual struggles with self, others, and God or the Sacred can be an expression of "the desire to find, hold on to, and, at times, transform the things that are most significant to us" (p. 25).

described by those treating combat-related trauma. Military moral injury has been defined

diagnostically as "the emotional, spiritual, and psychological wounds that stem from the

ethical and moral challenges that warriors face in combat, especially nontraditional forms

of combat, such as guerilla war in urban environments" (Drescher et al., 2011, p. 8).

Moral stress and moral injury may be understood as being on a continuum

(Doehring, 2015c). Both moral stress and injury result "because we acted against our

moral center and feel regret for what happened" (L. Graham, 2017, p. 82). Moral injury

results when moral dissonance includes the life threat of traumatic stressors, where

people may feel responsible for or hold others responsible for traumatic harm. "The

parallel," said Moon, "is post-traumatic stress. Moral injury is the most radical or severe

expression of moral stress and symptomatically would resemble PTSD" (personal

communication, 2020). Much research in military moral injury has been dedicated to

better understanding the wounds of war and the *soul repair* or moral integration that can

assist in resolving posttraumatic stress symptoms linked to moral stress (Shay, 2010; L.

Graham, 2017). Pastoral theologian Larry Graham (2017) has written,

> Trauma becomes moral injury when the actors and recipients find their moral
> centers to be disrupted by what others did to them or by what they did to others in
> the traumatic events in which they were victims, witnesses, or perpetrators. (p. 82)

In his book on moral injury, L. Graham (2017) has more fully differentiated moral

injury and trauma, locating moral injury in the realm of pastoral and spiritual care by

calling it a "soul wound" (pp. 77–93). He has cautioned against medicalizing moral

injury (p. 15–16) and promoted spiritually informed trauma care to "understand, engage,

and advance moral options in concrete or everyday circumstances" (p. 6). L. Graham has

discussed embodiment in such spiritual care in contextual, ecologically inclusive terms:

"Bodies and souls are coterminous, co-generative, and perpetually interconnected" (p. 97). Holding that "moral injury has ongoing consequences for bodies and souls" (p. 92), he promoted spiritual practices towards restoration of wholeness (p. 98) as an addition to his hallmark *collaborative conversation* informed by his psychosystems approach (1992).

In the aftermath of trauma, the moral stress or moral injury of the care seeker may well be the main source of most grievous suffering, as I demonstrated in Josie's case. Trauma therapy will need to explore the role of moral injury as part of posttraumatic stress, both of which will need to be integrated. With Josie, the clinical path to the integration of traumatic loss was through the landscape of moral injury. Shay (2014) has pointed out that the symptom set of moral injury can be nearly identical to that of PTSD, including physiological symptoms because "the body codes it [moral injury] as physical attack, mobilizes for danger and counterattack, and lastingly imprints the physiology" (p. 185). Moral injury will not always overlap with trauma, and trauma need not always have a core of moral stress, yet the important thing to note is that trauma often has some moral dimensions by virtue of the relational nature of morality and trauma. Further, some trauma symptoms may be almost entirely moral at root and will benefit from spiritual care that focuses on the moral and spiritual life of the person. Given the tremendous connective fibers of individual and social moral orienting[31] within one's physical,

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[31] An orienting system "consists of habits, values, relationships, belief and personality … [and] contains both helpful and unhelpful attributes, resources, and burdens. … Spirituality is one aspect of the general orienting system [that] contributes to the individual's framework for understanding and dealing with the world" (Pargament et al., 2006, p. 130).

psychological, spiritual, and social lives, moral struggles and moral injury should not be neglected in a discussion of trauma integration in spiritual care.

**Defining Trauma**

*Trauma* is an overutilized and underdefined term in current Western cultures.[32] Through clinical observation and teaching, I have come to firmly believe that clear and concise definition allows for more precise and helpful solutions. I therefore outline here a brief history of the development of a comprehensive understanding of psychological trauma that culminates in this working definition: *Trauma is the result of unintegrated overwhelming stress or distress due to inadequate intersubjective or relational support that helps survivors integrate a perceived threat to (a) life, (b) psychological integrity, and/or (c) moral or spiritual identity.* Each historical turn in the theorizing of psychological trauma provides a piece of the puzzle that leads to more robust and nuanced clinical solutions. The working definition I have come to is expressive of an emerging fourth epoch of understanding in which psychophysiology is (re)centered and, I believe, the opportunity for spiritual or religious and moral aspects of struggle and solutions are ripe for integration.

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[32] Social psychologist Nick Haslam (2016) has used the term *concept creep* to explain this trend. He has researched the creeping expansion of useful psychological concepts such as trauma, safety, prejudice, addiction, and bullying through an examination of public discourse, media, and trends in social and behavioral science since the 1990s and has concluded:

> Many of psychology's concepts have undergone semantic shifts in recent years. These conceptual changes follow a consistent trend. Concepts that refer to the negative aspects of human experience and behavior have expanded their meanings so that they now encompass a much broader range of phenomena than before. This expansion takes "horizontal" and "vertical" forms: concepts extend outward to capture qualitatively new phenomena and downward to capture quantitatively less extreme phenomena. … In each case, the concept's boundary has stretched and its meaning has dilated. (p. 1)

*An Epochal History of Trauma Theory*

**Epochs One to Three.** Herman's (1992) now-classic definition states, "Traumatic events … overwhelm the ordinary human adaptations to life" (p. 33) and are characterized by a feeling of terror and helplessness. This state of terror and helplessness obliterates a person's sense of "control, connection and meaning" (p. 33). The trauma symptom categories she outlined continue to be relevant in current diagnoses of posttraumatic stress: hyperarousal (high levels of activation and emotion), intrusion (invasive thoughts and memories), and constriction (emotional numbing and avoidance) that endure beyond the time for adjustment to acute stress. Herman has noted that the core experience in the aftermath of trauma is that of *disempowerment* and *disconnection.* The route to recovery must therefore rest upon empowerment and reconnection. The following summary of Herman's historical overview of the evolution of thought on trauma indicates how she arrived at her definition.

Herman (1992) has attributed a history of "episodic amnesia" (p. 7) in the field of psychological trauma theorizing to political climate and social readiness. Her claim in the 1990s was that an understanding of psychological trauma has evolved in three different waves since the early 20$^{th}$ century, each with its own political context. The first wave occurred in the early 1900s with Sigmund Freud, Josef Breuer, and Jean-Martin Charcot's conceptualizations of hysteria (p. 10). *Hysteria* was one of the earliest psychological terms used clinically to connote the symptom set and origins of trauma. It bears noting that hysteria was aptly seen to be rooted in the soma as a psychophysiological condition.

The second wave of trauma studies Herman (1992) has identified as occurring at the end of World War II, as researchers and clinicians such as psychiatrist and psychoanalytic therapist Abram Kardiner have written about combat neurosis or *shell shock*, a term used to describe the set of traumatic symptoms resulting from wartime combat. Shell shock assessment focused less on physiology and more on neurosis arising from conflicts within the mind of the soldier, sometimes with demoralizing results.

The third major contributor to the current understanding of trauma was recognition of a stress-response disorder seen more generally in society at large and highlighted in domestic violence situation (Herman, 1992). The formulation of the diagnostic category of PTSD in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-V*; American Psychiatric Association, 2013) reflects this third epoch and has as its first criteria exposure to actual or threatened death.

**Fourth Epoch: (Re)turn to Physiology.** Herman's (1992) definition of trauma was a culmination of the first three epochs. Van der Kolk (1994) has added to Herman's definition by stating that trauma stems from "a failure of the natural physiological activation and hormonal secretions to organize an effective response to threat" (p. 282). Like Pierre Janet, who proposed in 1899 that psychological trauma is a "failure of integrative capacity" (Ogden et al., 2006, p. 183), van der Kolk (1994, 2014) has seen trauma as a failure within the person's psychophysiology to respond to and integrate an experience rather than trauma resulting from the event or life threat itself. Being overwhelmed is a key dynamic in both Herman's and van der Kolk's understanding of traumatic stress. A fourth epoch of psychological trauma research proposed by van der

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Kolk (2014) is arguably a biological one, turning or returning to the soma. Though this biological epoch, exemplified in neurobiological research, is a helpful return to psychophysiology, there is a risk of biological reductionism that ignores the role of moral emotions like shame, guilt, anger, and disgust, as researchers of military moral injury such as Shay (2014) have noted.

Van der Kolk and Herman have worked rigorously within the field of psychology to include a more nuanced and *complex*[33] understanding of what constitutes trauma that reconciles the greatly differing approaches to treatment and attempts to catch some omissions. Herman's (2011) recent addition to this nuance of traumatic experience across time includes the role of shame in leading to and/or sustaining PTSD, which she has said is "intrinsic to the experience of social subordination" (p. 262) inherent in many trauma experiences. Though she has not focused on moral or spiritual life directly, her understanding of aspects of trauma as a "shame disorder" (p. 262) inches ever closer to the deep moral despair and self-recrimination that can be at the heart of trauma for some survivors. For her part, Herman (1992) has predicted the field's increasing focus on biology. In her "Afterword" to *Trauma and Recovery*, she has written,

> Some of the most exciting recent advances in the field derive from highly technical laboratory studies of the biologic aspects of PTSD. It has become clear that traumatic exposure can produce lasting alterations in the endocrine, autonomic, and central nervous system. (p. 238)

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[33] Herman and van der Kolk have defined a category of trauma as *complex trauma* (sometimes abbreviated as C-PTSD) that describes the long-term developmental changes that result from prolonged trauma or ongoing relational and cultural dynamics that compound trauma. Examples are toxic home environments; neglect in childhood; pervasive verbal abuse; and intergenerational, racial, and cultural traumas. Baldwin (2020) has asserted, "Threats that are ongoing (e.g., domestic violence, systemic oppression, pandemics) have the potential to gradually erode our felt sense of trust in others and our self as well as any hope in resiliency and a return to safety" (p. 32).

This most recent *turn towards the body* (van der Kolk, 2014) in the study of

psychological trauma is part of a larger neuroscience revolution that studies the impact of

extremely stressful events on physiology, memory, and emotion, providing an

understanding of psychological wellbeing as rooted in dynamic brain–body structures

(van der Kolk, 2014). Van der Kolk, who is at the forefront of psychological and

psychophysiological research into the mechanisms of trauma and healing, has outlined a

four-step method for treatment that incorporates physiology in the form of self-regulation

through interoceptive awareness. His research points towards the importance of self-

regulation as well as co-regulation[34] of the nervous system inducing calm states for

integration to occur. He has suggested, "To come to terms with the past it may be

essential to learn to regulate one's physiological arousal" (p. 285).

As part of this biological epoch where self and co-regulation is highlighted, the

autonomic nervous system (ANS) is taking center stage. The ANS houses the body's

sympathetic and parasympathetic (with polyvagal branches) systems for regulating

arousal, defense, digestion, immune health, memory consolidation, creativity, and social

engagement (Porges, 2011; Levine, 2010). Once thought to be primarily outside of

human control, the ANS is currently hypothesized to be highly malleable, flexible, and,

observably, open to degrees of conscious regulation. A host of new methods for working

with trauma symptoms by directly engaging somatic awareness and nervous system

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[34]*Co-regulation*, as supported by interpersonal neurobiology and attachment research, is a term for the ways humans can have a positive impact on each other's physiology in an ongoing fashion via a calm and caring presence, compassionate facial expressions, soothing or attuned voice tone, and body language (Schwartz & Maiberger, 2018).

arousal are proving of significant value (e.g., Fisher, 2021; Levine, 2015; Ogden, 2021; Schwartz & Maiberger, 2018; van der Kolk, 2014).

According to Porges's (2011) polyvagal theory, the ANS has evolved a phylogenetic hierarchy of responses to traumatic threat that move survivors towards restored social engagement. He has proposed that when a person's survival response is overwhelmed, they may greatly reduce social engagement and revert to more primitive defense strategies like fight or flight, which then require more time and assistance to resolve. In other words, symptoms of trauma are the lingering effects of a person's best efforts to survive overwhelming stress in the relative absence of supportive social connection. The evolutionary development and power of social engagement and a nuanced understanding of the physiological impact of a perceived sense of safety are key elements of Porges' contribution to a current understanding of traumatic stress and its resolution, where relationships and working with bodily states to *sense safety* are key.

This proliferation of psychophysiological and neurocognitive research data risks producing a biological reductionism that Herman also warned about in 1997:

> The very strength of the recent biological findings in PTSD may foster a narrowed, predominantly biological focus of research. … A new generation of researchers will need to discover the essential interconnection of biological, psychological, social, and political dimensions of trauma. (p. 240)

Even in the field of moral psychology, a "biologicized" turn toward ethics being studied as "the interpretation of the activity of the 'emotive centers' of the brain" (Haidt, 2012, p. 78) advances the importance of moral intuitions and related emotions yet also risks reduction of morality to mere brain activity. Yet clinically, it is apparent that, for example, the reliance on medication that alters only physiology has not been adequate in

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treating complex PTSD and its correlates in moral injury. This situation alone points to the need for an interdisciplinary approach to wholeness and wellbeing that takes into account the cultural and personal development of a sense of morality and ethical identity over a lifetime, beyond physiological structures.

In her formulation of *trauma sensitive theology,* Baldwin (2020) has described "episodes of threat [as] not inherently traumatizing," but specified that "they can induce trauma responses when the intensity, frequency, or duration of the threat exceeds our capacity of response or resources for resiliency" (p 32). Having grappled with her own definition of trauma, she has reported,

> Over the past couple of decades, there has been a clear shift among trauma and dissociation professionals to move away from events as trauma generating to an understanding of trauma as a set of responses to circumstances that overwhelm the individual's capacity to respond and achieve a restoration of safety. In other words, trauma happens when the threat is too much, when it overwhelms our resources, when it threatens our life in visceral ways. (p. 4)

Baldwin has captured the nature of this fourth epoch well. The fourth epoch of trauma theorizing has added the dimension of *perceived* threat across some time (or complex trauma, C-PTSD) that rises to a magnitude that significantly disrupts a sense of safety and leads to psychophysiological overwhelm. Trauma is not a significant loss or even a life threat, it is a cumulative and complex interplay of body-mind and context in or lacking in relationship.

**The Addition of an Interpersonal or Relational Dimension.** Existential philosopher and psychoanalytic theorist Robert Stolorow (2007) has contributed the dimension of relationship to this emerging definition of trauma. He has agreed that trauma is a result of overwhelm as "an experience of unbearable affect" (p. 9) yet has

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argued that trauma emerges as an enduring set of disruptive symptoms in an intersubjective absence. Stolorow has asserted that in the absence of a "relational home" or relational network in which to integrate the overwhelming distress, psychological trauma can occur (p. 10). He has proposed that the lack of intersubjective, co-regulatory support contributes to a sense of overwhelm that is physiological and emotional: "Painful emotional experiences become enduringly traumatic in the absence of an intersubjective context within which they can be held and integrated" (p. 47).

In a complementary tone, trauma therapy theorist Bonnie Badenoch (2018) has defined trauma as "any experience of fear and/or pain that doesn't have the support it needs to be digested and integrated into the flow of our developing brains" (p. 23). Badenoch has tended to categorize many ordinary fearful events as inherently traumatic, requiring relational sensitivity, focus, and energy to overcome. In one example, she has described as traumatic the common childhood experience of sitting alone and witnessing other children fighting while having no support for properly integrating the jarring experience. In contrast, Stolorow (2007) has argued that "pain is not pathology" (p. 10), stating that although the possibility of trauma is built into the very nature of human existence, every upsetting event does not rise to the pitch of trauma or result in enduring symptoms. He has asserted that, to a great extent, people are well designed to weather difficulties through internalized relational support without the experience becoming an enduring legacy to be overcome. Time is also an important criterion for assessing whether a person has a relational support system and inner resources for recovering from acute stressors. Trauma treatment innovator Peter Levine's (2005) resources on trauma first aid offer tangible ways to understand the role of immediate social support in

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alleviating long-term development of trauma symptoms. Relationship has therefore come to be considered both a source of and buffer against enduring psychological trauma, with time revealing inner resources and emerging relational supports.

The word *trauma* is used in cultural and in psychological literature in multiple ways to denote common stressors on one end of the spectrum and to capture the notion of extreme harm on the other. Understanding how complex it is to define trauma currently, I utilize an apt metaphor from Shambhala Buddhist meditation training on how to approach mindfulness practice via the idea of a hand holding a delicate (sometimes living) object: "not too tight, not too loose." This image of and aim for the *middle way* in meditation is helpful for proposing a clear provisional and pragmatic definition of trauma as well. In North American psychiatry and psychology today, trauma is viewed either as the aftermath of a distinct life threat with specific categories of symptoms as outlined in the *DSM-V* (American Psychiatric Association, 2013) (possibly too tight a definition) or as a plethora of subjective difficulties and even ordinary challenges across time (possibly too loose a definition). Badenoch's (2018) example of a child witnessing other kids fighting over a toy as potentially a distress akin to trauma for the witnessing child may be too loose as a definition of trauma. She has argued,

> This perspective is in no way intended to diminish the experience of those of us who have suffered the most egregious harm, but instead to diminish the distance between those who are seen as wounded and those who are not. (p. 23)

But why diminish a distance that serves as an important spectrum in kind and quality of experience? A definition that is inclusive enough (not too tight) and distinct enough (not too loose) creates a meaningful container for defining a discreet set of experiences in need of distinctive sensitivity and nuanced methods of care.

Traumatic events have long been distinguished from other forms of distress by the ways that people experience overwhelming physiological arousal (hyper- or hypo-arousal) that cannot be processed within the time frame of adjustment to acute stress, contributing to extreme emotional or moral distress and social isolation. Trauma as an unintegrated stress response remains active in one's physiology, impacting one's psychological, moral, social, existential, and spiritual landscape. I offer this working definition, not too tight and not too loose: *Trauma is the result of unintegrated overwhelming stress or distress due to inadequate intersubjective or relational support that helps survivors integrate a perceived threat to (a) life, (b) psychological integrity, and/or (c) moral/spiritual identity.*[35] This definition indicates the distinct need for body-based stress reduction tools, relational support, and moral and spiritual sensitivity in the aftermath of trauma.

**Integration of Experience**

Traumatic experiences can fragment or rupture a sense of self. Integration is an on-going process of making whole or bringing back together. Integration is not achieved by fixing, getting rid of, healing from, coping with, or returning to a previous state of relative safety (though these are worthwhile points along the way). Integration

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[35] Some significant emerging research on various kinds of trauma is not discussed here. Collective trauma, intergenerational trauma, racial trauma, vicarious trauma, and reenactment trauma are exceptionally relevant research and treatment subfields. In each of these types of trauma, one can easily find the erosion of integrative capacity, the perceived threat to life or psychological integrity, and the lack of sympathetic relational support capable of holding the magnitude and/or duration of the experiences. Menakem (2017), for example, has researched intergenerational racial trauma and has argued for somatic awareness and embodied practices for confronting and transforming the impacts of racism and unconscious biases held in place by fear.

incorporates whatever has happened into a new sense of *empowered* and *connected* (Herman, 1992) wholeness.

As a key way of encountering and assimilating experiences, integration is central to human learning and development. The word *integrate*, in its simplest form, means "to form, coordinate, or blend into a functioning or unified whole : UNITE" (Merriam-Webster, n.d.a, def. 1). It is an action and growth-oriented concept that points to a process of including, incorporating, and making room for new experiences, new understanding, and new ways of being. As psychology of religion researchers Jonathan Morgan and Steven Sandage (2016) have pointed out, integration relies on flexibility, whereby "one's experience of self is expanded" p. 136). Their findings have shown that "healthy integration requires wise coping strategies, effective self-regulation, and a mature differentiation typically combined with finding communities of support" (p. 136). Jankowski & Sandage (2012) have viewed integration as a life-long process by which humans learn, grow, and develop towards "differentiation of self" (DoS) or mature differentiation (p. 417).[36]

As I have stated previously, Josie is spiritually committed to her own integration process, engaging personal effort, self-responsibility, and collaboration. Developing her capacity to more flexibly cope and self-regulate through (a) somatic awareness practices and (b) communities of support, Josie is underway in an integration process that is leading her towards mature differentiation. As she integrates the reality of her mother's

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[36] Jankowski &Sandage (2012) have defined differentiation of self (DoS) as a process by which one uses emotional and spiritual self-regulation and self-awareness to become more distinctly oneself while also more fully connected to others.

death into her life with relational and spiritual support, she is developing emotional stability, optimism, and renewed trust or confidence in herself. Josie is an example of maturing differentiation from her mother, and in her life as a whole.

When one can integrate seemingly dissonant and disturbing experiences into new ways of living and meaning making, one is well equipped to grow in courage, complexity, and integrity as indicated by differentiation of self (DoS) research (Morgan & Sandage, 2016) and others (see Pargament et al., 2006 and Pargament & Exline, 2022, on flexible orienting systems and integration of spiritual struggles). I see integrity as an aspiration to live life in accordance with one's deepest values while flexibly allowing for the experiences of life to change, disturb, expand, and ultimately realign one with new moral depths and spiritual heights. Integrity is not a given, it is an intention that enhances a sense of direction and purpose, and requires active engagement, trust, and ideally, processes that incorporate or integrates as much of one's embodied self into the experience for full inclusion, congruence, and wholeness.

**Evidence-Based Somatic Trauma Therapies**

Integration is a central process of care for both trauma and moral injury. We are changed by trauma and moral injury in ways that can lead to pervasive brokenness or a more mature, differentiated, flexible, complex, and whole sense of self. S*oma* can be a central landscape for experiencing wholeness in integration. Somatic awareness can advance integration, and various interoceptive practices have been designed to facilitate such somatic awareness and integration. Furthermore, as Price and Hooven (2018) have pointed out,

individual ability to detect interoceptive signals may be influenced by stress and adverse life experiences that negatively affect willingness, tolerance, interest, and practice with attending to the language of the body. People who have experienced undue stress, chronic pain, or trauma may have ceased to trust or listen to their bodily cues, making it difficult for them to predict their emotional responses and to regulate them. Furthermore, such stress histories appear to affect the magnitude of the interoceptive response, complicating how this important internal information is accessed, processed, and interpreted. (p. 10)

With these complications in mind, integration often requires delicate and attuned navigation of distress while approaching embodiment. Levine's (1997) 30 years of research and practice have led him to the often-quoted *urban legend* assertion that "trauma happens in the body, not in the story". Integration of traumatic experiences into restored or expanded wholeness cannot fully occur without the body, regardless of the event; the meanings made; or the stories told about it in talk therapies. This focus on accessing soma and the awareness of the delicate dance that this may take has long been supported by innovators in the sub-field of *somatic psychology*.

Somatic psychology researcher and clinician Arielle Schwartz and Barb Maiberger (2018), EMDR trainers specializing in somatic therapies, have defined somatic psychology as "the study of the interactions among brain, mind, body, and behavior and how these relationships directly impact psychological and physical health" (p. 11). Grounded in a biopsychosocial model of therapeutic care, the authors have stressed always understanding the whole person as intercorporeal and intersubjective. This emphasis points to the soma as a nexus for a self that is a "dynamic intertwining between the individual, other people, and the environment" (p. 22) where "all behaviors and interactions must be interpreted contextually" (p. 22). An intercorporeal and

intersubjective view of the whole person is both innate and contextually formed, helping

to provide an understanding of the complex ways moral intuitions are shaped as well.

One could speculate that a moral imperative of somatic psychologies is to *give the body*

*its due* (van der Kolk, 2014), and in so doing, expose the wise, fundamentally good, and

trustworthy nature embedded within and expressive of corporeality, relationality, and

incarnation.

Somatic therapies center on body-based practices that assist people in the

development of interoceptive awareness, self-regulation, and specific somatic

awareness's akin to the felt sense Gendlin (1982) has described. Such processes can

relieve trauma symptoms, helping people shift from trauma-based emotions to self-

compassion and trust and fostering insight, new meanings, and unexpected growth.

Outlining the history of somatic psychology, Levine (2008) has reported, "These

various approaches have arrived on the scene in this approximate chronological order:

mesmerism, hypnosis, analysis, exposure, Somatic Experiencing (SE), eye movement

desensitization reprocessing (EMDR) and various 'energy psychologies'" (p. xxi). The

(sub)field of somatic psychology emerged in the early 1930s, first, as simply a set of

distinct body-centered treatment methods developed by Wilhelm Reich out of

psychoanalytic drive theory (Schwartz, 2020). Gestalt therapy theory, the main influence

and orientation of my clinical work, was also directly influenced by Reich and is

considered in some circles to be a somatic therapy.[37] As somatic theories and practices

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[37] Gestalt therapy theory is often described as a somatic therapy, especially its strategies on
integration through experiments that center the soma. Reich was Fritz Perls's analyst. Progenitors of
Gestalt therapy, Fritz and Laura Perls, utilized movement in the form of dance and psychodrama beginning

developed, they were enriched by a growing body of scientific data on physiology, neurology, endocrinology, and holistic or integrative medicine.

A proliferation of body-centered, physiologically sensitive, or holistic mind-body approaches in psychotherapy, fueled by exciting psychophysiological research data, are all under the umbrella of somatic psychologies (Schwartz & Maiberger, 2018). Residing at the intersection of having and being a body, somatic therapies attempt to bridge the perceived (and manufactured) gap between body and mind (emotions and spirituality). Such treatment methods are particularly useful for trauma-related symptoms, anxiety disorders, stress conditions, and chronic health issues linked to psychological stress, because body-centered approaches work directly with the central nervous system and psychophysiology, often at the heart of stress disorders and trauma symptoms (van der Kolk, 2014). Research on the efficacy of somatic treatment (Levine, 2010; Porges, 2011; Schwartz & Maiberger, 2018; van der Kolk, 2014) supports this dissertation's thesis that specifically crafted and intrinsically meaningful somatic spiritual practice can greatly assist in trauma integration. Next, I discuss three popular evidence-based somatic psychology approaches that I utilize that lend strong support to this claim.

### *Somatic Experiencing*

Levine (2010) has argued that implicit, body-based, or procedural memory is what holds trauma in place and is not easily accessed by verbal, cognitively oriented talk therapies. His internationally acclaimed approach to trauma treatment, Somatic Experiencing (SE)*,* works slowly and directly with nervous system activation, somatic

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in the 1940s, taking psychoanalysis off the sofa (literally) and allowing movement to mobilize awareness, insight, and a sense of wholeness.

memory, and trust in what Levine has called *organismic wisdom* in a process of *sequencing* or releasing truncated, overwhelmed fight/flight/freeze responses *trapped* or held within the body. Levine's approach affirms the trustworthiness of trauma treatment focused on embodiment, in which therapists offer co-regulation and guided interoceptive awareness for the sake of tracking and coaxing remnant fight or flight impulses in restrained fashion in the aftermath of trauma. He has demonstrated the effectiveness of somatic experiencing—a paced process of *titration* and *pendulation* that reliably reveals the incomplete survival response manifested in what are entrenched trauma symptoms. For many, his method has provided an enduring end to the pernicious symptoms once thought to be a permanent fixture of life after trauma.

      *Titration* (Levine, 2010) is the very slow release of powerful physiological arousal or survival energy so that care seekers can (re)develop trust in their bodies, their capacity to bear distress, and their ability to allow a physical and emotional release of the past while staying rooted in present relational support. Titration is essential so that a paced integration can occur, rather than re-traumatization through overwhelming somatically held memories. Levine teaches that titration, along with being supported by the co-regulatory therapeutic guidance itself, is supported by practices that enhance somatic awareness and conscious self-regulation, and that *pendulation* supports titration. In SE therapy, it is a deliberate practice of pendular movement between a state of distress and a state of ease, requiring some amount of interoceptive awareness. This oscillation enriches titration by providing a counterpoint to distress prior to being overwhelmed, so that one can access the cyclical rhythmic or flow of life force from survival to restoration. Pendulation also develops somatic trust in oneself as a sense of personal control over

arousal states gets (re)established. A person is encouraged to develop a felt experience of ease, courage, or goodness as a place of departure and return for the integration of small (titrated) amounts of traumatic distress.

Although Levine's (2010) SE method does not highlight spirituality or spiritual practices per se, titration and pendulation benefit from somatic practices that increase awareness and trust in oneself in direct, compassionate, felt ways. "Struck by the wedded relationship between trauma and spirituality" (p. 347), Levine dedicated a chapter of his book, *In an Unspoken Voice*, to this relationship while noting that spirituality deserves much more attention. He has spoken of emergent "spiritual encounters" as a "side effect" (p. 346) of trauma resolution and has stated that he remains in "wonder and curiosity" (p. 348) about how the movement out of dissociation and into embodied trust leads to such profound and permanent changes in self as could only be spiritual in nature. Cautious about the tendency to reduce spiritual experiences to their psychophysiological underpinnings, Levine has encountered the numinous with his clients when powerful, previously dissociated, survival energies are released. He has explained, "In healing the divided self from its habitual mode of dissociation, [people] move from fragmentation to wholeness" (p. 356).

Within his chapter on spirituality, one can discern Levine's (2010) nod to a kind of spiritual wholeness that is revealed immanently through somatic integration and may also be experienced in *transcendental* ways, as suggested by his frequent use of the word *numinous*. Supported by brain-scan research indicating that the same regions of the brain that light up in profound spiritual experiences are also highly active during somatically oriented trauma resolution, Levine has asserted that the powerful survival energies

housed within trauma can "catalyze authentic spiritual transformation" (p. 350); yet, before dreaming of transcendent spiritual transformation, one can aim, via the *elan vital* or simple aliveness available through ordinary yet novel somatic awareness, for the slowly opening doorway of trauma integration via somatic spiritual practices. Spiritual wholeness is too often only noted when numinous or transcendent states (ecstasy, bliss, timelessness, eternal now, and oceanic feelings, as Levine has noted) are palpably present or emergent, but ordinary experiences of felt relationship with the sacred encountered in somatic spiritual practices may be a more frequent aid to integration, which is explored in a later chapter.

As a therapist trained in the SE method, I often help clients find personally meaningful practices that help them trust the process. With Josie, I explore how she might find a felt remembrance of a sacred place in nature as her soothing pendulation point, or I might explore with her a remembrance of a helpful quality of strength, ease, or spiritual connection that she could evoke as a resource to return to when overwhelmed by grief or despair. When Josie begins to feel overwhelmed by trauma memories, she becomes quickly sleepy, dissociated (foggy or numb), or distracted, indicating the need for greater titration (smaller doses of the distress). Pendulation is paced to help her stay present with a small amount of traumatic distress while supporting her capacity to self-regulate via a soothing, sacred experience, which, for Josie, often takes the form of nature, family, or sunlight.

### Sensorimotor Psychotherapy

Out of her extensive work in psychiatric treatment and her co-development of a somatic modality called Haikomi therapy (Schwartz & Maiberger, 2018), somatic

psychotherapist Pat Ogden (Ogden et al., 2006; Odgen & Fisher, 2015) has developed

sensorimotor psychotherapy (SP) as an interpersonal, neurobiology-informed therapy that

continues to be on the leading edge of trauma treatment approaches. In her attempt to

devise a holistic treatment modality, Ogden utilizes a *top-down, bottom-up* approach that

emphasizes the need for physiological, emotional, and cognitive (holistic) integration. SP

begins with building somatic resources[38] and tracking sensations (bottom-up), only

reintroducing emotion and cognition once the body has had its expression, often in the

form of reengaging *truncated* defense strategies (Ogden et al., 2006). Preferencing

bottom-up processing of a traumatic experience encourages sensation, emotion, and

cognition to be integrated in often deeply meaningful, surprising, and sometimes quite

satisfying ways.

SP utilizes the *window of tolerance*[39] as a dynamic image of the "window" of

optimum ANS activation or arousal where social engagement, tracking sensations

(interoceptive awareness), self-regulation, and a more holistic integration can occur

(Ogden et al., 2006). I utilize this window of tolerance image as a teaching and diagnostic

tool as well as a somatically astute trauma treatment map. Top-down and bottom-up

integration of cognition, emotion, and sensation is a useful map for both locating and

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[38] Somatic resources are body-based ways of soothing the ANS and supporting self-regulation (Ogden et al., 2006). An example of a somatic resource may be feeling a particular soothing sensation more fully through increased focus or awareness—smell of lavender, touch of back supported by chair, deep breath, sound of birds chirping, water running over hands, and even re-member-ing a moment in time then focusing on the sensory aspects of the memory.

[39] This term was originally coined by psychiatrist and researcher Daniel Siegel (1999). Through his decade long research in areas of mindfulness awareness, interpersonal neurobiology, psychiatry, and attachment/attunement research, he has developed the window of tolerance as a visual guide for working with distress within an optimum level of arousal—not too little, not too much.

intentionally utilizing the intersection of having (top-down) and being (bottom-up) a body, as discussed in the previous chapter. SP encourages the bottom-up/top-down movement of trauma healing as a helpful holistic intersection of thinking, feeling, and sensing suggested for full integration. The window of tolerance is a helpful tool for tracking when and how a process of embodiment and somatic spiritual practice is helpful or hindering integration.

As a relationally attuned method of top-down/bottom-up orchestration, coupled with the somatic map of the window of tolerance, SP aims for a kind of integration that supports restored wholeness (Ogden et al., 2006). SP also assists in the development of a clear understanding of what is somatic, what constitutes a somatic wisdom, and what integration looks and feels like from a biopsychosocial vantage point. SP does not offer a spiritual orientation or lens yet highlights mindfulness and flexible humanistic ethics in a meaningful way. Focusing on building somatic resources and healing attachment wounds, SP would likely see spiritual practice and a sense of sacred relationship as enriching of the overall approach yet does not invite spirituality specifically into its attempt to "weave a wide vision of our subjective experience" toward an understanding of "being human" (Siegel, 2006, p. xiii).

In the case of Josie, I regularly utilize the window of tolerance as a method of tracking the need for pendulation and titration as noted above. I am aware that Josie is moving outside her window of tolerance when sleepiness, slumping in her chair, or reports of fogginess or numbness emerge. Along with working directly with Josie on changing her posture, reorienting to something soothing in the present environment, or sipping her tea (all somatic resources), a somatic *spiritual* resource serves as a

meaningful place of departure and return for her as we traverse the bottom-up and top-down process of trauma integration and moral injury resolution, session to session. Spiritual care and spiritual practice contribute to this ever-expanding weaving of what it means to be a differentiated and integrated human being.

*Eye Movement Desensitization and Reprocessing*

Psychologist and researcher Francine Shapiro (2001) developed eye movement desensitization and reprocessing (EMDR) during her doctoral research in psychology. Originally seen as a form of exposure therapy, the eight-phase protocol built around the central psychophysiological practice of desensitization and reprocessing has long been seen as a holistic approach and a somatic therapy (Schwartz & Maiberger, 2018; van der Kolk, 2014). Schwartz and Maiberger (2018) have identified four essential features that EMDR shares with somatic psychologies: a phased or paced (primarily somatic) orientation, mindfulness, a noninterpretive stance, and a focus on the body.

Phase two and phase five of this highly systematized method (EMDR) are particularly relevant for the process of embodiment via somatic spiritual practice. The main aim in phase two of EMDR is what is called *resource development and installation* (RDI) (Schwartz & Maiberger, 2018; Shapiro, 2001). Here, the care seeker is taught to develop a somatic resource for returning to a state of ease. RDI is meant to develop somatic self-regulation through the felt sense of a personal visualization of a *safe place*[40] or another positive sensory experience like calm, ease, self-compassion, or peace. RDI is

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[40] In EMDR sessions, I use the term *soothing place* or invite a memory of *ease and peace.* This is to avoid some of the baggage of the word safety to be discussed in a later chapter. Furthermore, *safe* is a concept with a variant mental understanding, whereas soothing, ease, peaceful are closer to direct sensory experience.

not simply one step towards the processing phases of EMDR (phases three to six); it is an important therapeutic practice in itself, a diagnostic tool of sorts (noting dissociative tendencies, capacity to hold a positive thought and experience, ability to focus internally, etc.), and an anchoring self-regulation practice that culminates each EMDR therapy session. RDI is also often prescribed as a self-regulation practice outside of the therapy office (Shapiro, 2001). Practicing self-regulation through a soothing visualization during the week can become a trustworthy somatic resource in times of stress; for example, prior to engaging a potentially stressful situation, breathing deeply for 5–10 breaths while visualizing sitting in a beloved and soothing nature spot can place a person in a more relaxed state of mind, centered more dynamically within the window of tolerance.

In addition to staying in touch with somatic awareness throughout the entire eight-phase process, phase five asks the care seeker to heighten sensing and feeling of a *positive cognition* (PC) (Schwartz & Maiberger, 2018; Shapiro, 2001). Deepening this felt sense of the PC and assessing the potential validity of the PC on a 1–7 felt scale is at the zenith of the therapy. The assessment question utilized is often "On a scale of 1–7 (where 1 is not true and seven is totally true) how true does the statement X *feel?"* This concept of PC felt validation highlights Shapiro's (2001) trust in the fundamental intelligence of somatic or felt experience for integration of the EMDR process. After the processing of difficult or traumatic material, a PC may be something like "I am worthy of love" or "I am able to secure my own safety" or "I can trust myself again." This is meant to be a deeply felt sensate experience, not merely a cognitive affirmation, and thus it is reinforced with directives to notice emotion and sensation during PC integration. What separates the PC integration phase of EMDR from, for example, such practices as daily

affirmations or vision boards[41] is precisely that the PC is presently true and an accurate, albeit previously underemphasized, positive assessment of current reality.

RD and PC installation reflect the importance of consciously investing in true and accurate, positive sensations and emotional states in support of trauma integration. RDI and PC are also helpful, embodied, meaning-making steps. RDI and PC can enrich care for those seeking spiritual integration when the care provider points towards the spiritual landscape of the care seeker for both a resource and a positive cognition. For example, while exploring Josie's personal spiritual landscape and learning her own language for the sacred, I encourage her to add this to her soothing resource (RDI) each week with unwavering positive results. Often, a Higher Power, as felt through sunlight that is holding and warming her, is an in-office somatic resource that she can later encounter daily outside as spiritual accompaniment. Additionally, her weekly PC is initially quite pragmatic (i.e., I deserve to be here) and often shifts spontaneously by the end of the session towards existential and spiritual meaning making (i.e., My life is a gift, held in Divine hands). A recent deeply felt PC statement made by Josie was "My mother was ultimately responsible for her own living and dying. I did the best I could to help her." Intrinsically meaningful spiritual resources and positive cognitions contribute to somatic self-regulation during times of lament and contribute to spiritual meaning-making out of distress.

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[41] These are two of a plethora of therapeutic activities sometimes assigned to the pop-psychology or self-help movement. I have personally and clinically found both affirmations and vision boards to be quite helpful therapeutically yet, unlike EMDR, the effectiveness of these method is not yet supported by clinical research and hence are not evidence-based. Further, affirmation and vision boards are future focused whereas a PC integration process is meant to highlight a neglected and helpful, albeit subjective, aspect of current reality.

**Conclusion**

In this chapter, I have defined trauma not as an event but rather *as the result of unintegrated overwhelming stress or distress due to inadequate intersubjective or relational support that helps survivors integrate a perceived threat to (a) life, (b) psychological integrity, and/or (c) moral or spiritual identity.* This overwhelming stress is due to the lack of "a relational home" (Stolorow, 2007, p. 10), in which the more painful experiences of life can be integrated. The lack of integration of experience can feel like brokenness, disempowerment, and disconnection. I see trauma, at heart, as a rupture in the fabric of relationship to life, to others, and/or to one's sense of the sacred.

"Loss can be an emotional trauma for which it is especially difficult to find a relational home," said Stolorow (2007, p. 50). This particular dilemma is highlighted in Josie's case, where the loss of her mother is the sudden loss of a central and significant relational home itself. Emerging from the traumatic loss of her mother and the moral injury she experienced, Josie reports a significant increase in sense of connection with her spiritual life and with her deceased mother. She has stated,

> "I see my mother every day in my daughter now. I delight in the way she dances around, her inexplicable New York accent, her flair, everything about her is my mom and I embrace it now. My aliveness and joy have never stopped. It simply expressed itself through my effervescent daughter."

Cocreating an intrinsically meaningful somatic spiritual practice that centers on God's[42] immanent love and presence as felt through sunlight and her children has become a

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[42] *God* or *Higher Power* or *Spirit* are Josie's words of choice for the personal relationship she feels with the sacred in nature, sunlight, family, springtime.

central relational home that supports Josie in her lament. Josie is beginning to

(re)encounter her own aliveness as she integrates the loss of her mother into herself and

her family life; thus, brokenness is held with wholeness.

This chapter prepares the reader to appreciate the positive contribution of somatic

spiritual practices in intercultural, spiritually integrated trauma care by defining trauma,

moral injury, and integration and showing how processes of embodiment are utilized in

evidence-based therapies. In the previous chapter, I approached embodiment as a process

in relationship, including a personal relationship with the sacred dimensions of life as

expressed through experiences of wholeness and somatic revelation. Because trauma can

be a rupture in the relational fabric of life, the process of embodiment is a means of

restoring relationship from the bottom-up toward relationship to self (through somatic

awareness and trust), to others (through attunement and somatic reflexivity), and to a

sense of spiritual wholeness (through somatic wisdom and revelation). Trauma-sensitive

therapies that acknowledge processes of embodiment as a source of critical intelligence

and pathway to wholeness contribute to the evidence for and praxis basis of an

investment in somatic spiritual practices as part and parcel of a spiritually integrated

trauma-care approach. When such practices are intrinsically meaningful to the care

seeker, spiritual integration is enhanced. Relational trust that allows for cocreativity in the

aftermath of trauma is addressed in the next chapter.

## Chapter Four: Relational Trust and Cocreativity

When one of my 5-year-old twins asks me why a wasp stings him, a snake bites,

bears growl and attack, or nowadays, a virus hurts people, I tell him a fundamental

observation about life: "Most everything wants to live and much of life is organized

toward protecting, defending, adapting, and evolving to survive." I also assure my sons

that the universe is, in my view, and for a great part, *friendly*. Though I do not wish to

and do not tend to shy away from discussions of unfriendliness, I do believe that this

evolving world of which they are a part is often on their side by way of, at the very least,

being on the side of creativity and adaptive survival. "We are all in this wild and

awesome universe together," I tell my sons. "We are all trying to live here as best we can,

and we need each other to do it."

### Friendliness

Years ago, I learned that theoretical physicist Albert Einstein felt that the

fundamental question each person must ask in their innermost depths is whether they

believe the universe is ultimately a friendly place.[43] He felt that when one could trust in

the fundamental friendliness of the universe and one's place in it through science and

reason, then a more reverent way of living this life would be required. One might say that

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[43] In some Judeo-Christian contexts, the statement that God looked upon creation and saw that it was good supports the assertion that creation was made for good, has a good purpose, is well intended, and is redeemed in God. These assertions can be seen as theologically affirmative of the friendly universe perspective.

Einstein's life's work was to affirm his personal theology[44] of trust that God, "the 'Old One,' … is not playing at dice" with the universe (Einstein & Born, 1971, p. 95), but rather acts benevolently through ordered "laws which he has himself prescribed"[45] (Einstein, as cited in Lipton & Regan, 2021, p. 10). Einstein invited each person to answer the question of a friendly universe for themselves. He hoped that his life's work would contribute to an affirmative answer.

There are a few trustworthy aspects of human existence one can, for the most part, readily observe: Human beings evolve in ways that help them survive, they have made many evolutionary adaptations to facilitate survival, they are creative participants in these adaptations, and they are fundamentally resilient in interdependent ways (Ungar, 2012). Humans are relational to the core. Though unpredictability, suffering, aggression, and extraordinary losses are also observably woven into the fabric of life, so, too, are inexplicable benevolence, goodness, and grace. Einstein postulated that the perspective one takes on the benevolence, cruelty, or randomness of life in the universe has a direct impact on how one chooses to live (Natarajan, 2008). I would add that such a perspective also has implications for how one chooses to view and integrate traumatic struggles. Although one can observe many things about this uncanny life, the choice to look judiciously toward what is friendly or trustworthy helps to promote the fruitful

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[44] Einstein's faith in a friendly universe was exemplified by his awe for the utter beauty and mathematical perfection of theories he developed about the universe. It is debatable whether Einstein would have considered himself to be an atheist or simply a man without a religious affiliation. Though he used the word *God* at times, for the atheist assertion see Natarajan, 2008.

[45] In a 1945 letter, Einstein further clarified this statement while explaining his appreciation of and objection to aspects of quantum mechanics, particularly in relation to randomness (Lipton & Regan, 2021).

perspective that life can make sense again and be lived meaningfully despite, or with, suffering, loss, and significant existential uncertainties. As care providers hold hope and invest in trust, they become "felt representatives of that friendly universe for the other" (A. Bryce, personal communication, Integration Lab, 2021).

Traumatic experiences and moral injury prompt survivors to question their beliefs in a friendly universe. In the aftermath of overwhelming suffering, terror, or grievous losses, these beliefs can be greatly challenged. Reestablishing beliefs in the friendliness of some small corner of the universe becomes the central objective during the first phase of the trauma integration process. Herman's (1992) imperative of reestablishing a sense of safety as the first task of trauma care is part of this process of sensing friendliness through caring relationships. Experiencing safety is currently the foundational process of trauma care (Badenoch, 2018; Porges, 2011). Pargament and Exline (2022) have discussed how a kind of optimistic and benevolent *life affirmation* supported by compassionate relationships of trust contributes to shaping the outcome of spiritual struggles towards growth and wholeness. What is the distinction between safety and trust, and what role does each play in spiritually integrated trauma care? I describe safety as a provisional place along the path and abiding trust as the destination for good reason. Life may well be a delicate and relentless balance between suffering and joy, cruelty and benevolence, and danger and safety that can be anchored through ongoing experiences of a kind of radical yet optimistic trust in oneself, a friendly universe, and a personal sense of the sacred.

In Chapter One, I introduced the process of embodiment and described it as central to the cultivation of somatic awareness, trust, reflexivity, and wisdom. I also

defined the domain of trauma, moral injury, and described the place of embodiment in the

process of integration at the core of trauma care oriented toward wholeness. I concluded

Chapter Three with the statement that at its heart, trauma is a rupture in the relational

fabric of life (relationship to self, other, a friendly universe, and the sacred) and moral

injury isolates and implicates oneself in the rupture. In this chapter, I address the role of

relationships in the process of such integration by describing a provisional belief in

participation in a *friendly* universe expressed through relational *trust* and *cocreativity*. I

start by drawing out the important distinction between safety and trust, which establishes

the provision for a sense of a friendly universe despite dangers and points to the loss of

such a provision in an overemphasis on safety. This chapter supports my claim that a

process of integration of trauma is greatly advanced through experiencing relational trust

and cocreativity. For trauma survivors, trust and cocreativity have been challenged and

yet are essential dynamics of integrative care within life-giving relational webs.

Establishing—or reestablishing—trust in oneself, in others, and in the goodness in the

world via a sense of friendliness and empowered cocreativity is central in this praxis to

an emergent wholeness.

**Safety**

From a biopsychosocial perspective, seeking safety is an age-old survival drive

and a helpful ingredient in many forms of creative social engagement (Porges, 2011). A

sense of safety may have its earlier roots in infancy experiences of care, consistency, and

comfort (Tronick & Beeghly, 2011). In simple terms, *safety* is the physical "freedom

from danger or harm" (Merriam-Webster, n.d.b). This basic sense of physical safety

obviously cannot be guaranteed but is a worthy need harbored deep within humans' most

primitive physiology and evolved social ethic (Porges, 2011). *Psychological safety*[46] adds

the dimension of harm or danger to one's sense of self or psychological/emotional

integrity. Psychological safety is what is often meant when people describe the need to

"feel safe." This more subjective form of safety places a complex demand upon social

conditions and contracts and is sometimes at odds with the actual, present situation. A

sense of psychological safety is shaped by personal history, past learning, epigenetic

inheritance, aspects of one's social identity that contextually give one privileges or

disadvantages, and unconscious biases stored in implicit memory. Research and literature

on somatic awareness practices in clinical care, discussed in Chapter Three, has described

how reestablishing a sense of relative psychological (or physical) safety is a process that

supports the initial development of somatic awareness and somatic trust as well as

somatic reflexivity meant to inform and empower care seekers with an increasingly

accurate assessment of themselves in relationship.

 The on-going assessment of relative physical and psychological safety is a key

ingredient in therapeutic trauma integration. Because safety is somewhat or entirely

absent from traumatic experiences as a core aspect of trauma, ascertaining an accurate

perception of present safety is a key task often initially requiring trustworthy others. As

Herman (1992) has explained, the first step in establishing a sense of psychological safety

in an otherwise safe environment is through emotional regulation and co-regulation,

which is sometimes first practiced in trauma care. Emotional regulation is a key

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[46] Also sometimes called *emotional safety,* a clinical term, it does some important work in the corrosive areas of verbal abuse, microaggressions, emotionally toxic familial and cultural environments, and relational/cultural power imbalances such as sexism, racism, and the like (to name a few).

component in and often used interchangeably with self-regulation, though self-regulation

engages more of the body directly and generally utilizes interoception practices more

fully. Self-regulation is the ability to utilize internal and external resources to experience

flexibility and moderate control over levels of stress arousal and activation, which, in

turn, shapes one's emotions and capacity for social engagement (Porges, 2017a). Because

of the relational nature of trauma integration, one could say that self-regulation is always,

at some level, co-regulation (Schwartz & Maiberger, 2018). According to Schwartz

(2021),

> co-regulation, also called mutual regulation or social affect regulation, refers to the ways in which our connections with others help us learn to hold ourselves in a more loving manner … providing opportunities for our clients and ourselves to have new, socially learned experiences of connection, attunement, acceptance, and compassion. (p. 55)

This definition refers to one person's ability to be in their social engagement system[47]

while offering that regulating state of ease to another, advancing a shared experience of

safety.

Herman and van der Kolk's Victims of Violence treatment program (Cambridge

Health Alliance, 2022) has helped survivors find age-old practices (e.g., yoga,

meditation, or breath control) that help care seekers self-regulate when they experience

stress arousal. Using these practices over time helps care seekers develop their capacities

for self-regulation in stressful situations, reinforcing trust in oneself and personal

empowerment. More recently, van der Kolk and others have been conducting research on

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[47] Porges (2011) has used the term *social engagement system* to connote a highly evolved human capacity to over-ride threat and survival instincts in favor of creative social interplay of a very complex nature.

yoga in the treatment of post-traumatic stress, finding that these body-centered practices can help to regulate arousal states (see Emerson, 2015; Sullivan, Erb, et al., 2018). Emerging research on the neuroscience of traumatic stress further emphasizes the need for restored self-regulatory capacity for trauma survivors with the aim of enhancing a present sense of *psychological safety* (Geller & Porges, 2014; Porges, 2011, 2017a, 2017b). Research on mindfulness practices and yoga demonstrates that such practices can facilitate emotional and physiological regulation with the outcome of an increase in perceived safety and social engagement (Emerson, 2015; van der Kolk, 2014; West et al., 2017). Novel and deeply impactful spiritual experiences that enhance a sense of wellbeing are also common occurrences due to such practices (Levine, 2010; van der Kolk, 2014); for example, qualitative and quantitative research studies on the benefits of trauma sensitive yoga (TSY) conducted at the Center for Trauma and Embodiment at the Justice Resource Institute Brookline have demonstrated the strong prevalence of not just self-regulation but outcomes of personal growth with, for example, an emphasis on compassion and experiences of grace (West et al., 2017).

At a physiological level, safety is an on-going assessment of the absence of danger or threat often below awareness. Porges (2017a) has called this ongoing assessment process *neuroception* and has defined it thus:

> Neuroception is the process through which the nervous system evaluates risk without requiring awareness. The automatic process involves brain areas that evaluate cues of safety, danger, and life threat. Once these are detected via neuroception, physiological state automatically shifts to optimize survival. … Alternately, this system also triggers physiological states that support trust, social engagement behaviors, and the building of strong relationships. Neuroception is not always accurate. Faulty neuroception might detect risk when there is no risk or identify cues of safety when there is risk. (p. 19)

Feelings of safety come from internal (proprioception and interoceptive) and sensed environmental cues (exteroception) together making up what Porges calls neuroception. One could say that neuroception is the *felt sense* of safety or danger. Porges (2011) has argued that a sense of safety is not objective or dependent on the environment being free from threat or danger, but instead is subjective, being based on one's sensory perception, history (learning, biases), and the degree of perceived *trust* or mistrust in one's capacity to engage with the threat successfully.

Porges (2011) has explained that when a person can use neuroception in a danger-free environment to realistically assess absence of danger, on average, a person feels safe and responds with relaxed prosocial behavior while having access to the full range of their thinking and feeling capacities. Meanwhile, when one's process of neuroception detects threat, either external or internal, one's sense of safety may be lost and a series of defensive or protective strategies are engaged. Responding to danger to protect oneself may, in turn, limit creative access to thinking and feeling as well as social engagement. Neuroception of safety or danger evokes survival-relevant cognitive-emotional state shifts toward social engagement or away from social engagement and toward defensive actions such as fight, flight, or feigning death (Badenoch, 2018; Porges, 2017a, 2017b; Schwartz & Maiberger, 2018). The subjective assessment of safety is partly determined by *trust* in one's capacity to assess accurately and engage creatively and to seek out or rely on trustworthy relationships. Experiences of self- and co-regulation toward a sense of safety facilitates a deepening sense of somatic trust (self-trust) that can, in turn, assist in moments where one feels threatened psychologically or physically.

Self or emotional regulation is often referred to as an internal *sense of safety* but it may have more to do with trust. The ability to self-regulate is expressive of relative trust in oneself, other, or sacred connection (discussed in the next chapter) despite manageable threats. At a basic physiological level, the trust it takes to self-regulate toward subjective safety and physiological ease, either inculcated through trusting relationship (co-regulation) or as an upwelling from within, can also be developed through interoceptive practice. As one practices self-regulation through various means, a trust in one's increasing ability to accurately assess threat and (re)establish a sense of safety is developed. When an accurate assessment of danger is present, this practiced self-regulatory trust can be harnessed to either mount a creative defense or a swift exit. I propose that the trust in oneself, reliant on the capacity to self-regulate, is foundational for a dynamic and on-going sense of psychological safety. This trust in oneself sometimes initially comes from experiencing one's care provider first as safe and then trustworthy, especially during initial phases of introducing and practicing self-regulation.

Neuroception of safety or danger sets up a rudimentary binary choice in each instance that, according to Porges (2011), results in two poles: easeful social engagement or disengaged survival defense, with an adaptive five-modal spectrum of creative response in-between.[48] Yet human responses to life are far more nuanced, multiple, creative, and diverse than this simple binary of safe–unsafe would initially indicate. Current topics of research are the complex interplay of biological, social, and agency differences between the sexes, marginalized groups of people, and the impacts of

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[48] Porges (2011) has distinguished five response options to experiences based in a combination of dorsal vagal, ventral vagal, and sympathetic activation of the polyvagal nervous system.

intergenerational trauma on creative responses to threat. For example, concerning the much higher rate of PTSD occurrence in females, neurobiology researchers Teniel Ramikie and Kerry Ressler (2017) have examined the few, yet significant biological studies available on sex differences in the fear response that undergirds the commonly accepted fight-or-flight response to threat. Research psychologist Shelly Taylor and colleagues (2000) have challenged this overarching fight-or-flight theory by proposing that this is a biologically male response and that the slim data on biological females indicates the need for further research into a *tend-and-befriend* response to threat. This response is built on attachment processes that carry different biomarkers likely impacting action or behavior, memory, emotions, and later residual effects.

Polyvagal theory (Porges, 2011) adds a helpful dimension to the former bimodal fight-or-flight model by proposing the evolutionarily new social engagement system as an advance from more primitive defense strategies. This theory supports a tend-and-befriend response to threat as wise and adaptive, potentially evolved to protect offspring. In the growing data on developmental or complex posttraumatic stress, the *fawn* (Walker, 2003) and *submit* (Fisher, 2021) responses to threat are being examined as the possible downside of a tend-and-befriend defensive strategy that could lead to distinct PTSD symptoms in females connected to the evolutionarily most primitive *freeze* response to threat. This possibility raises these questions: Could females be more biologically adapted and/or conditioned to utilize this social engagement response to threat that would generate different creative options and problems out of a neuroception of danger and safety? How might multiple generations of racially based trauma and disempowerment cue adaptive epigenetic responses to perceived safety and threat?

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From an existential perspective, seeking safety is one important consideration among many within social life and occasionally an obstacle to authentic encounters (B. Cannon,[49] personal communication, 2021). An undeniable existential reality is that life comes with risk, challenge, and losses of all kinds built into the dynamics of change, growth, evolution, and spiritual development. One is often not entirely safe, and emotional or psychological challenge abounds. Though one should not use this fact to minimize or justify harm, it can be empowering to acknowledge this aspect of reality and to notice the evolved ability to tolerate unavoidable and sometimes fruitful risk. Journalist, statistician, and philosopher Nassim Nicholas Taleb's (2012) discussion of *antifragility* has highlighted research that demonstrates human strength, adaptability, and growth in the face of challenge. Psychologists Richard Tedeschi and Lawrence Calhoun's (1995, 1996, 2004) and, later, psychologist and clinical researcher Steven Joseph's (2011) groundbreaking research on posttraumatic growth has extended and supported Taleb's argument by demonstrating when and how even the most egregious suffering can lead to extraordinary growth that would be unattainable without such distress. Again, this is not a justification for trauma, harm, or tolerating unsafe environments but rather a demonstration of trustworthy human adaptive strength or antifragility when coupled with the needed internal and external resources (i.e., relational supports). If people place safety[50] above growth, above judicious social risks, above human empathic instincts

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[49] Author of *Sartre and Psychoanalysis: An Existentialist Challenge to Clinical Metatheory*, 1991.

[50] Attorney Greg Lukianoff and Haidt (2018) have discussed this cultural moment as a time when fragility is being emphasized over adaptability, vulnerability is over-shadowing strength, and safety is dangerously becoming a "sacred value" (p. 30). *Safetyism* is "an obsession with eliminating threats (both

toward each other, they may lose what is, arguably, most fundamental about being human; an adaptive, empathic, and daring relational creativity. I propose that, along with assuring relative safety in care, an investment in a sense of trust can open a door to the fruitful uncertainty and cocreativity that is our most empowered and connected (to harken back to Herman, 1992) place within an uncanny yet friendly universe.

**Relational Trust**

*Trust* is initially a somatic experience of *inner goodness* built primarily upon "adventures of the senses" (Erikson, 1950, p. 247) and the relational foundation of care, consistency, comfort, *rupture*, and *repair* (Tronick & Beeghly, 2011). The rupture and repair dance at the heart of building a dynamic foundation of trust supports the impulse toward novelty that is central to learning by demonstrating that risks that lead to rupture also can present with repair as a correlate for learning. Early experiences of somatic trust (from which a sense of goodness emerges) are relationally reinforced or deteriorated across the life span in increasingly complex ways, dependent on this rupture and repair dynamic (Tronick & Beeghly, 2011). Tronick's (2007; Tronick & Beeghly, 2011) *mutual regulation model* confronts the notion of safety as the cure and safety *as* the treatment (Badenoch, 2018) with the theory, instead, that risk, rupture, and repair are the essential counterweights to safety that lead to trust. This necessary polarity (rupture and repair) is what promotes growth and a trustworthy feeling of agency or confidence despite risk. As essential ingredients in survival and growth, care, consistency, and comfort are the earliest ways one perceives safety; however, where attachment and developmental

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real and imagined) to the point at which people become unwilling to make reasonable trade-offs demanded by other practical and moral concerns" (p. 32).

theories once emphasized the dire importance of meeting an infant's needs with maximum attuned attentiveness and safety (care, consistency, and comfort) at all times, Tronick (2007; Tronick & Beeghly, 2011) has observed that healthy human attachment is messy more times than not and repair seems to be the key action, not perfect attunement. Repair, according to Tronick, is a cocreative or mutual action set that generates trust within oneself (infant) and in the other (care provider).

Trust is established somatically through relationships and points to the relationality or mutuality of human learning, growth, and confidence (Tronick & Beeghly, 2011). The felt sense of trust can become a dynamic bodily experience of the capacity to assess the relative safety, danger, and positive risk within life, moment by moment and creatively adjust. In Porges's (2003) review of attachment literature, he has concluded that safety and a social bond are precursors to the *initiation* of healthy attachment, yet trust (in oneself, in the goodness in life, in the other) is paramount and likely the abiding outcome of healthy attachment (relationship). To say this another way, trust is at the core of heathy attachment rather than safety per se. Attachment is a biobehavioral system rooted in evolution that is designed for the sake of survival to adapt to messiness with maximum growth when trustworthy, cocreative repair is available (Tronick & Beeghly, 2011). In such a relational dance, trust is built through the oscillation between feelings of minor danger (risk), safety, rupture, and repair, with "felt security … [as] the critical emotion underlying attachment and well-being" (p. 115). This "felt security" points to a trust in the whole rupture-and-repair dance, not just in terms of a sense of safety alone.

This dance of rupture and repair does not end in infancy. Referring to his mutual regulation model and human development, Tronick and developmental scientist Marjorie Beeghly (2011) have stated,

> An important advantage of this perspective is the recognition that the process of making sense out of the world is a lifelong transactional process, not a developmental perspective in which early experience or genetics alone rigidly determine later outcomes (Kagan, 1998). Rather, although the past does constrain the future, over the life span there is always the possibility of creating new meanings of self and the world that are age possible and polymorphic in character. Both in the moment and over time, these meanings become increasingly coherent and complex and, at the same time, constrained by the past. Even more vital is the need to recognize that no connection between individuals is perfect; yet out of all this imperfection, dyadic reparatory processes generate unique meanings, and new connections emerge. Such is the wonder of the human condition: the emergence of new ways of being together and new meanings in relation to the world and to one's self. (p. 116)

Humans are deeply relational and inextricably shaping and shaped by their embedded contexts across their entire lifespan (Stolorow, 1992, 2004). Captured in the African *ubuntu* phrase "I am because we are" (L. Graham, 2017, p. 20), psychological understanding of human development has taken an enormous relational turn. Research on attachment theory as well as research on neuroplasticity and interpersonal neurobiology (see Cozolino, 2014; Siegel, 2015) offer a perspective that at any stage of life, one can have opportunities to relationally (re)establish many fundamental developmental achievements such as a sense of basic trust.

Infants act on primordial impulses toward trust (Erikson, 1950), preverbally (or somatically) asking the existential question, "Is this world an OK place to be?" This is essentially a question about whether the world is friendly and trustworthy. One continues to ask and provisionally answer this question with each challenging, pivotal, developmental, jarring, and novel experience. Infants, children, and adults do not ask or

answer this on-going existential question in isolation. Tronick and Beeghly (2011) and

other key developmental theorists have examined extant interpersonal neurobiology

research to enrich historic attachment theory by highlighting the mostly "messy" ways

that trust is internalized relationally through a cocreative repair process (p. 112). Whereas

it once was proposed that good attachment was an attuned dance not unlike Fred Astaire

and Ginger Rogers's, Tronick and Beeghly have seen it more like two brand new tango

dancers, stepping on toes, getting it wrong more than right, and continuing to stick with it

(p. 112). In this view, safety is one dynamic ingredient in a complex dance that builds

trust in personal agency and relational cocreativity.

Adding to this conversation, several current trauma theories and psychological

methods center on the concept of resilience (Schwartz & Maiberger, 2018; Siegel &

Bryson, 2019; Tronick, 2007) for good reason: it is part and parcel of an innate and

developing sense of trust. Resilience is an evolutionarily adaptive capacity to meet the

challenges of life, based in the complex interplay of nature and nurture. It is a part of that

friendly universe within one that can weather challenges and creatively participate in the

integration of difficulty toward growth. Innate, primed, and learned resilience helps one

make it through difficult and traumatic experiences in unique ways.[51] Adverse

experiences and even traumatic ones can serve to strengthen resilience as indicated in

post-traumatic growth (PTG) research.[52] In fact, research psychologists Eranda

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[51] Trauma symptoms themselves may be a part of a resilient response to trauma on the way to wholeness. According to Porges (2011), Levine (2010), and others, trauma symptoms are not categorically a failure of resilience but rather a possible positive sign of being under way and in need of additional supports.

[52] Joseph (2011) has presented extensive qualitative and quantitative research on the fact that many people emerge from trauma with greater strength, wisdom, hopefulness, and depth in their lives. He has written, *"People are capable of finding pathways to reverse the destructiveness of trauma and turn it to their advantage"* (p. xvi).

Jayawickreme and Laura Blackie (2014) have advised that there should be even more

consideration of resilience in PTG research. They have conducted a critical review of

existing empirical PTG research and have highlighted the lack of emphasis on prior

resilience and personality factors in the findings on growth that "occurs when an

individual's traumatic experience leads to an increase in these specific domains—self-

acceptance, purpose in life, environmental mastery, autonomy, and positive relations with

others (Ryff, 1989)" (p. 314). I see trust and resilience as a mutual feedback loop, where

trust in oneself is strengthened by experiencing resilience, and resilience is often an

expression of deepening trust in oneself, others, or the sacred. According to Schwartz and

Maiberger (2018), somatic awareness (and somatic trust) can facilitate or unblock an

innate somatic resilience and lead to growth. Baldwin (2020) has added,

> When we abandon our trust in our innate capacity for resiliency (even when it
> requires significant resources and support), we are at risk of falling into despair
> that then can take on its own threat characteristics. Advocating for trust in the
> robust resiliency of the human and planetary being prioritizes the role of informed
> hope and faith in the innate restorative capacities in all living beings. …
> Cultivating our awareness of this divine resource of connection requires a
> capacity to trust our felt sense. (p. 11)

Though trust is originally established relationally and points to the mutuality of

existence, the felt sense of trust becomes a dynamic bodily experience of confidence

(Erikson, 1950) in an assessment of self, life, and other—an assessment that

acknowledges the wisdom of mistrust within it. The ability to navigate mistrust through a

process of rupture and repair (Stolorow, 2007) may manifest later in life as self-

regulation, discernment, emotional intelligence, and resilience. As developmental

psychologist and psychoanalyst Erik Erikson (1950) has asserted, the capacity to trust as

well as navigate mistrust with a growing sense of internal coherence leads to both

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confidence and hope by virtue of a *favorable ratio*. Hope is a sense of trust in the positive

potential of the future and one's ability (confidence) to cocreate such potential

successfully within the given relationships and contexts of one's culture. Trust, as a felt

somatic relational foundation, and hope, as a future focused cocreative movement, are

dynamically interdependent. A step-by-step pragmatic spiritual practice approach of

sensing trust encourages hope for renewed spiritual wholeness in the aftermath of

traumatic devastation.

A care provider's trust in the resilience, creativity, and integrative capacity of the

care seeker provides an empowering co-regulatory strength to the therapeutic

relationship. When I harness trust in the innate capacities of those I am serving, not only

am I more curious, open, and respectful of the other, I am in a relaxed alert state of social

engagement ideal for co-regulation. Why? Because rather than feeling responsible and

anxious about what is possible for the person seeking help, I lean into trust that often

leads to cocreativity. Badenoch (2018) has made the claim that "it is more important for

me to trust my people than it is for them to trust me" (p. 38). Her sentiment points to the

value of care providers deeply trusting in the capacity of their "people" to use available

internal and relational resources toward an integration process unique for each person.

She has noted that when a care seeker is held in the light of trustworthiness, the care

provider contributes to a vision of the person as capable of navigating their own life.

When a care provider stands in as that friendly universe, beckoning the person beyond

the treacherous past experience, a sense of trust is lent and empowered in the care seeker

that can evoke mutuality and creativity. Somatic awareness and somatic practices serve to

deep this empowerment, resilience, and self-trust, advancing creative options toward integration.[53]

**Cocreativity**

I first learned of the concept of cocreativity in the context of care in 2011 through the work of Carrie Doehring. Cocreativity is a cornerstone in her intercultural spiritual care as a respectful means of engaging alterity. In this dissertation, I define cocreativity as involving a deep sense of interpersonal connection supported by alert ease, which promotes freedom to open, generate, or access new possibilities and shared meanings. To support my use of the term *cocreativity*, I locate its roots in psychology, field theory, interpersonal neurobiology, and existential philosophy, but for the sake of intercultural spiritual care, Doehring's (2015b) use of cocreativity remains the strongest influence. She has written, "Relational trust opens up a space for cocreating meanings that make emotional and spiritual sense" (p. xv).

To *create* is to "bring something into existence" (Oxford University Press, 2021b). Creativity is active participation in the emergence of something novel, an act of discovery through which a new possibility takes shape out of the givens in an environment or context. Like the whole being greater than the sum of its parts, the new creation moves beyond the givens in sometimes mysterious and unpredictable ways, involving risk and trust. *Cocreativity* is the novel emergence that can occur between two or more people, and it enhances and is enhanced by provisional safety, relational trust,

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[53] Respecting mistrust is as important as reestablishing trust and hope initially in the aftermath of trauma. The rupturing or devastating experience of trauma begs mistrust in the immediate circumstance and its aftermath as a wise protective measure. Without respect for the lingering somatic wisdom of mistrust, care seekers could be taught to disregard real dangers and override internal self-protective signals.

and hopeful intention. *Cocreativity*, as Tronick and Beeghly (2011) have used the term, is a dynamic mutual attunement process (with sensitivity to power) and a palpable enrichment of trust. Through their child development research, they have demonstrated that cocreativity begins in infancy in acts of mutual repair. They have claimed that infants are not passive but instead have agency and participate in acts of repair. These actions are cocreative with regard to the perceived givens among parent, child, and context. This cocreative process serves to generate growing trust in oneself and in the other. When successful, this cocreative repair process generates a sense of confidence in oneself. Cocreativity is a relational event that arises out of a "common interpersonal home" (Parlett, 1991) of shared "reciprocal mutual influence" (Stolorow & Atwood, 1996, p. 181) that has an output "greater than the sum of its parts." Together, bringing something new into existence.

### *Field Theory*

In gestalt therapy theory, reciprocal mutual influence and trust in cocreativity are engaged through its central praxis of experiential dialogic exchange with the intention or aim of experiences of wholeness (gestalt) for the care seeker. The cocreative, dialogic daring in gestalt therapy stands on the foundation of the I–Thou intersubjective philosophy of Austrian Jewish and Israeli philosopher Martin Buber (1923/1958), in terms of the therapeutic duo being inherently more whole and creative together, and pioneering social psychologist Kurt Lewin's (1952) field theory, which embeds the duo in a dynamic life-world. Graeme Summers and Keith Tudor (2000), co-developers of co-creative transactional analysis, have defined field theory as "a general theoretical outlook that emphasizes interrelationship" and have stated,

> Drawing on the metaphor of an electrical or magnetic field, this holistic approach questions linear causality and suggests that events occur "as a function of the overall properties of the field taken as an interactive dynamic whole" (Parlett, 1991, p. 70). (p. 23)

The implication of this approach is that

> when two people converse or engage with one another in some way, something comes into existence which is a product of neither of them exclusively. … There is a shared field, a common communicative home, which is mutually constructed. (p. 75)

This approach has been particularly developed in gestalt theory and therapy (p. 23).

Using field theory and social constructionism to develop the acclaimed *cocreative transactional analysis*, Summers and Tudor (2000) have outlined three principles for cocreativity in therapy that reflect the perspective underlying many cocreative praxes: (1) *we-ness* or the understanding that there is both a self and a shared field that we jointly are making; (2) shared responsibility through dialogue; and (3) present-centered development of the field for the sake of encountering novel experiences and crafting shared meanings.

In describing the care provider as a "participant-observer of cocreativity," Summers and Tudor (2000) have highlighted the importance of being self-reflexive as a good participant–observer with the intention of supporting the care seeker. Doehring (2015c) has discussed cocreativity as a means of supporting the development of intrinsically meaningful intentional theologies and practices of self-compassion as part of an intercultural method that respects and engages the religious or spiritual world of the other. In Doehring's praxis of cocreativity, self-reflexivity is a central ingredient for monitoring power, persuasion, and unconscious biases. Malcom Parlett (1991), an innovative thinker in the field of gestalt studies, has offered this guidance out of field theory in support of the imperative of self-reflexivity:

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Everything in our own phenomenal field becomes part of the matrix from which we co-create fields with others. And when there is clarity of our own present field, a minimum of distracting unfinished business, and good self-support, the greater the likelihood of our dancing creativity and centeredness being available in our interactions with others. (p. 17)

### *The Interpersonal Field*

The intersubjective cocreativity available in field theory is supported by data on heart rate variability (HRV) and social coherence research. *Coherence* is the "quality of forming a unified whole" (Oxford University Press, 2021a), and HRV research has demonstrated tangible coherence between two or more people via HRV synchronization. One piece of evidence of being in a coherent intersubjective field together is the synchronization of heart rate central to coregulation, where heart rate tends to synchronize towards the lower (more relaxed) frequency (McCraty, 2017). It may well be that the *field* of field theory is most cocreative when it is coherent and easeful between two people as reflected in attuned synchronization. As psychophysiologist Rollin McCraty (2017) has observed, "various studies examining synchronization between mothers and infants, pairs and groups, indicate that feelings of cooperation, trust, compassion and prosocial behaviors are facilitated by physiological synchronization between individuals" (p. 10). McCraty has found that social or interpersonal coherence that leads to an increase in prosocial behaviors correlates with and is influenced by heart rhythm synchronization. He has stated,

Our hypothesis is that biomagnetic fields produced by the heart may be a primary mechanism in mediating HRV synchronization among group members. This perspective is supported by the work of quantum physicists Larissa Brizhik and Emilio Del Giudice. They have suggested that magnetic fields are the most likely physical agent that can continuously provide an exchange of information between living systems within the larger ecosystem. (p. 6)

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In their review of the science of HRV and resilience, psychophysiologist Fred

Shaffer and colleagues (2014) have noted that self-regulation is a key mediating variable.

They have reported that on the communication pathways between heart and brain, 85% of

the communication fibers travel *from* the heart to the brain.[54] Thinking and feeling are

greatly impacted by the dynamic homeostatic state of the heart; therefore, a person's

ability to self-regulate arousal is key to thinking and feeling. HRV and social coherence

research suggests that heart rate and cardiac vagal tone[55] are directly influenced by social

engagement. This indicates that people have a direct impact on each other's hearts and

minds. According to Shaffer et al., HRV is primarily derived from the autonomic nervous

system and significantly impacted by the vagal nerve's ability to put the brakes on

sympathetic activity (vagal tone) toward a calm that influences heart rate and,

subsequently, thinking and feeling. Polyvagal theory is utilized in Shaffer et al.'s

integrative model to demonstrate that *vagal tone* in the form of the ability to suppress or

modify sympathetic nervous system activity via the social engagement system is at the

heart of both self-regulation and coregulation. They have written, "According to this

theory, quality communication and pro-social behaviors can only be effectively engaged

when [the] defensive circuits are inhibited" (p. 13) and defensive circuits become

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[54] Psychophysiologists Fred Shaffer et al. (2014) have written,
> Interestingly, the majority of fibers in the vagus nerve (approximately 85–90%) are afferents, and signals are sent to the brain via cardiovascular afferents to a greater extent than by any other major organ (Cameron, 2002). Mechanical and hormonal information is transduced into neurological impulses by sensory neurons in the heart before being processed in the intrinsic nervous system. These impulses then travel to the brain via afferent pathways in the spinal column and vagus nerve (McCraty, 2011). (p. 3)

[55] According to polyvagal therapy, the vagus nerve modulates arousal states and social engagement, and vagal tone or cardiac vagal tone play a key role in this and can be developed across time and with practice (Porges, 2011, 2017a).

inhibited by calm and connective social engagement as part of an evolutionary

adaptation.

McCraty and Doc Childre (2010), director of research and founder, respectively,

of the HeartMath Institute, have focused "on increasing individuals' self-regulatory

capacity by inducing a physiological shift that is reflected in the heart's rhythms. They

theorize that rhythmic activity in living systems reflects the regulation of interconnected

biological, social, and environmental networks" (Shaffer et al., 2014, p. 14). According to

polyvagal theory, "self-regulation through social engagement and bonding can reduce

SNS [sympathetic nervous system] activation while increasing HRV" (p. 15), which in

turn generates more cognitively and emotionally complex and creative thinking, feeling,

and integration of experience. McCraty has theorized that "emotional self-regulation can

increase resilience and accelerate recovery from stressors" (p. 15). In an extensive review

of studies on HRV and social coherence, McCraty (2017) has pointed to

> various types of synchronization in infants, pairs and groups, indicating that
> feelings of cooperation, trust, compassion and increased prosocial behaviors
> depends largely on the establishment of a spontaneous synchronization of various
> physiological rhythms between individuals. (p. 1)

Positive social engagement thus influences HRV, and HRV impacts prosocial behavior

through reciprocal mutual influence. This positive feedback loop influences thinking and

feeling, all the while building flexible internalized self-regulation and vagal tone that

contribute to a growth in resilience and self-trust (McCraty, 2017). From a field

perspective, "we happen to each other,"[56] and one result is the potential increase in

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[56] Teaching clinical skills at Naropa University in 2015, I would demonstrate field theory through
dyadic exercises that were meant to be stirring examples of what I called "how we happen to each other."

creative thinking and feeling together. This can be seen as a bidirectional, intersubjective, and intra-influential feedback loop that points to and enhances cocreativity.

The heart also has the capacity to directly initiate the production of hormones such as oxytocin for increased feelings of connections and care (Shaffer et al., 2014). As Porges has said, "We wear our hearts on our faces and in our voices" (audio recording, as cited in Badenoch, 2018, p. 10). People offer each other a sense of safety or danger moment by moment with their faces, voices, and bodily activity, each impacting the physiological state of the other. This back-and-forth, continual process of coregulation is what interpersonal neuroscience researchers call the *social synapse* (Cozolino, 2014), and within this synapse, people directly impact each other's biochemical, physiological, psychological, and, perhaps, spiritual state.

### Social Engagement and Alert Ease

An innately trustworthy part of human life is that people are wired for connection, co-regulate their internal world throughout their lives, and are highly adapted to self-regulating (down-regulating) defensiveness to seek out connection for survival and love (Porges, 2011). Porges (2011) has asserted, "The social engagement system not only provides direct social contact with others but also modulates psychological state to support positive social behavior by exerting an inhibitory effect on the sympathetic nervous system" (p. 512). In the social synapse, or the space between, people harness the power of the social engagement system to down-regulate defense and to advance thinking, feeling, and acting together, forming a more coherent and creative whole.

Porges (2011) has proposed that the evolutionarily advanced social engagement system moves humans beyond mere survival and into *creation*. He has coined the term

*alert safety* or *alert ease* as an engaged, open, energized, and connection-seeking outcome of the social engagement system. His polyvagal theory highlights the greater capacity for creative engagement with an increase in vagal tone (vagal flexibility) that regulates sympathetic arousal when in the presence of others. Alert safety can be a highly creative and engage state of awareness that involves HRV and relational synchronization (co-regulation). Porges (2011, 2017) has noticed that when their physiological focus is not toward defense or survival, humans turn readily to enjoyment, love, and complex social engagement that carries some risk and reward. Reflected in brain imaging, fMRI, and neurofeedback research on arousal states, it has been demonstrated that in a socially engaged state of alert ease, one has access to the largest amount of mental, emotional resources (CITE). One may be most creative and capable when in a socially engaged state of dynamic, alert ease. Creativity in this explicitly socially supported sense is more aptly called *cocreativity*.

Cocreativity is an element of therapeutic trust-building and a potential bridge to intrinsically meaningful somatic spiritual practices in spiritual care. Cocreativity in spiritual care may even venture into shared, novel experiences of the sacred. Buber (1923/1958) has proposed that all interpersonal relationships have the potential to highlight or bring forth the sacred. In his description of a quite ordinary yet underutilized human capacity for I–thou[57] relating, he not only highlighted his view of the intersubjective nature of the self (*as* relationship) but also the ways in which one can

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[57] Buber (1923/1958) has contrasted I-Thou relating with I-It procedural relating as the distinction between meeting someone as a subject of unpredictable aliveness rather than as an object or means to another ends. Radical presence, alterity, and openness is culled in I-Thou encountered.

experience the mystery of God through the incomprehensible yet familiar Other. He has

written, "When two people relate to each other authentically and humanly, God is the

electricity that surges between them" (p. 57). Buber has made the radical claim that the

sacred can be felt through human connection. In the experience of meeting as care seeker

and care provider, there exists a possibility of an I–Thou encounter and for sacred

connection to be felt, invigorating or sacralizing cocreativity in the process. As Doehring

(2015b) has written, "radical respect for alterity describes the quality of relationship that

awaits the emergence of mystery" (p. 3). Buber and Doehring have pointed out the

possibility of a sacred influence in interpersonal cocreativity that enhances spiritual care,

spiritual meaning-making, and spiritual integration.

**Conclusion**

Badenoch (2018) has asked an important question that begs a spiritual answer: "If

it is true that the experience of being alone with pain and fear is fundamental to the

development of trauma, how available is the necessary support of accompaniment in our

culture?" (p. 26). Whereas Badenoch has answered in the negative due to what she has

called a *left-centric* or left-brain society unavailable to emotional connection and support,

I would counter with the myriad age-old, cocreative, and adaptive sources of

accompaniment already available to people through lived religious and spiritual

communities. The psychologizing (and horizontalizing) of society in which Badenoch

and I are wary participants may well contribute to this left-centric dilemma that overlooks

spiritual and religious communities and resources. Perhaps we are meant to reach beyond

now-traditional forms of therapy, even the otherwise somatically elegant trauma

therapies, toward horizons more equipped to hold uncertainty and offer unpredictable

friendliness as is still found in some spiritual and lived religious communities and practices. Spiritual care, spiritual practice, and cocreative spiritual or sacred connections provide a rough road map for such accompaniment.

I argue that friendliness, trust beyond safety, creative social engagement, and a sense of the sacred are important anchors in spiritual care. In this chapter, I described how provision for the development of and regular engagement with cocreative somatic spiritual practices in spiritual care is fueled by the power of relational trust. In support of the importance of *a sense of trust*, the chapter focused on three areas:

- the dialogically derived cocreativity of field theory as adapted to care,

- polyvagal theory with regard to the alert ease available in social engagement, and

- the implications of social coherence and synchrony in HRV research.

Cocreating intrinsically meaningful and embodiment-oriented practices relies on knowledge of the intersubjective field, the socially engaged power of alert ease, and the phenomenal proof of this power of coregulation found in HRV research. Such practices support the integration of traumatic experience and moral injury accomplished through the enhancement of felt compassionate relationship with self, other, and the sacred, offering an experience beyond safety, toward trust in a much larger unfolding and enfolding of suffering and possibilities for radical hope.[58] The final chapter turns specifically to *spiritual care* in a multicultural, interreligious world in the aftermath of

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[58] Philosopher Jonathan Lear (2006) has defined *radical hope* as a present, rather than future, goodness that transcends all ability to understand it, a kind of *imaginative excellence* that seems to require a felt sense of trust outside of what is reasonable or expectable. Buddhist teacher Tara Brach (2012) has likened this to spiritual hope.

trauma; presenting a synthesis of best practices and a 3-step praxis of cocreating somatic

spiritual practices that relies on the integration of the process of embodiment, evidence-

based somatic theories on trauma integration, cocreativity, and a felt sense of trust.

## Chapter Five: Spiritual Care and Embodied Praxis

The spirituality of the care seeker is implicitly present in therapy (Pargament &

Exline, 2022), though it is often not explicitly addressed (Vieten & Lukoff, 2022).

Borrowing from multiple scholars, I define spirituality as *a relationship with the sacred*

(Shults & Sandage, 2006) that includes *seeking or searching for the sacred* (Pargament,

2007) and *an abiding or dwelling in the sacred* (Sandage & Harden, 2011). The sacred is

that which one has deemed significant and marked by reverence (Taves, 2009). In their

relational description of spirituality, psychologists of religion Peter Jankowski and

Sandage (2012) have described the sacred as "persons and objects of ultimate truth and

devotion, including Deity" (p. 418). These psychological descriptions of spirituality focus

on the ways that humans strive for and seek significance (Pargament, 2007, 2021), and

are "fundamentally concerned about aspects of life they hold sacred" (Pargament et al.,

2016, p. 381). When used in caregiving relationships, these definitions of spirituality help

people understand how aspects of religion and spiritual orienting (values, beliefs, and

practices) may help or harm their relational webs and their search for significance.

In this chapter, I draw upon decades of research on how spiritual struggles are

correlated with or predict psychological decline and/or growth. Much of this research has

focused on the role of meaning-making in religious and spiritual coping, highlighting

how often struggles arise when overwhelming life events challenge situational and global

beliefs (Park et al., 2017). As I highlighted in previous chapters, trauma research and

many trauma therapies begin with the somatic impact of trauma, exploring practices that reduce emotional numbing or the intense stress of traumatic re-experiencing. In this chapter, I bring somatically oriented trauma care into dialogue with spiritually oriented care of spiritual struggles that arise from trauma. I focus on how spiritually integrated care that begins with somatic spiritual practices helps trauma survivors lament loss and seek wholeness, which significantly impacts meaning-making.

It is my long-standing clinical consternation that many somatic trauma therapies rely upon once-spiritual technologies (i.e., meditation, yoga, breath practices, etc.) that are stripped of any religious and spiritual meanings and severed from religious or spiritual relationships and communities. Trauma survivors are left on their own to identify how past religious or spiritual practices, values, and beliefs might be re-experienced in somatic trauma symptoms in life-giving or life-limiting ways that exacerbate or integrate spiritual struggles. They are not prompted to explore any self-identified sacred dimensions of somatic practices that foster an incarnational and/or transcendent experience of goodness revealing and clarifying life-giving beliefs and values fostering lament and wholeness. The spiritual and religious[59] life of the care seeker has both relevant obstacles and potent integrative power (Doehring, 2019c), particularly in the aftermath of trauma and moral injury, as psychologists of religion have

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[59] In their curriculum equipping therapists to practice spiritually integrated care, Vieten and Lukoff (2022) have used this definition: "Religion most often refers to an organized belief system, guided by shared values, practices and understandings of the divine, and involvement in a religious community" (p. 2). Hedges (2010) has drawn upon comparative studies of religion to define religion as "a tool for naming categories of traditions, like dharma, … that have an emphasis on or tendency towards transcendence" (p. 77) and thus "are not bounded or monolithic but porous and intermingling across time … dealing with sacred matters" (p. 84). He has called religion "an area of cultural activity" (p. 244) and has stated, "Religious identities are always created and negotiated in context" (p. 84).

demonstrated through research (Pargament & Exline, 2022; Park et al., 2017) and

Doehring (2015a) has described in her approach to faith-based and interreligious spiritual

care by faith community leaders and chaplains. To miss the spiritual domain in the

aftermath of trauma and moral injury is to miss an important obstacle to and integrative

resource for wholeness, as research on spiritual struggles demonstrates (Pargament &

Exline, 2022).

I have focused on how trauma is, at heart, a rupture in the fabric of relationship to

life, self, other, or the sacred, often evoking spiritual, religious, moral, and existential

struggles. *Spiritual trust,* "a relational foundation unique to spiritual care" (Kestenbaum

& Doehring, 2022a, p. 135), "goes beyond the caregiving relationship to include spiritual

dimensions of relationality" (2022b, p. 129). Spiritual trust is a "felt sense of spiritual

connectedness beyond oneself" (2022b, p. 130). I claim that spiritual trust is a

foundational relational dynamic that can be developed through trauma-sensitive

intercultural and interreligious care, adding an explicit spiritual depth and dimension to *a*

*felt sense of trust*, contributing to the repair of relational (self, other, or Divine) rupture.

Kestenbaum and Doehring (2022b) have drawn upon research on how stress is

somatically experienced to describe spiritual trust as initially developed through breath-

and body-based spiritual practices that support spiritually based self-regulation and

spiritual self-reflexivity in both care providers and care seekers. They have argued that

spiritual care providers will not be able to fully trust the process of spiritual care unless

they have breath- and body-based practices that help them experience the goodness of

their bodies and their relational webs as well. Care providers' spiritual self-care enables

them to spiritually self-differentiate and respect the mystery of their care seekers.

Similarly, when care seekers find and use breath- and body-based spiritual practices to be aware of and reflexive about how they experience stress, they are more able to trust the process of spiritual care and self-regulate in ways that enhance their meaning making (for example, by differentiating from past trauma experiences and life-limiting trauma-shaped emotionally and physiologically charged orienting systems).

As I have argued in previous chapters, when care seekers experience their trauma care providers as trustworthy, they are more likely to be able to (a) creatively use somatic practices for self-regulation and (b) trust the process of trauma integration. In this chapter, I propose and illustrate how spirituality can be explicitly invited and spiritual trust advanced in trauma care, to foster spiritual cocreativity, somatic revelation, and integrative (even transformative) spiritual meaning making. Buber (1923/1958) has claimed, "When two people relate to each other authentically and humanly, God is the electricity that surges between them" (p. 57). Buber's well-known description of the I-Thou relationship resonates with my focus in this dissertation on a felt sense of somatic, relational, and spiritual trust and enlivened cocreative mystery. In this chapter, I demonstrate that spiritually integrated trauma care relationships must begin with somatic spiritual practices that (a) mend the relational ruptures of trauma and (b) restore a felt sense of trust in a friendly universe that positively anticipates or "awaits the emergence of mystery" (Doehring, 2015b, p. 3).

In this final chapter, I address the importance of spiritual care competencies in a multicultural, interreligious world in the aftermath of trauma. I start by reviewing current research on spiritual struggles, and the kinds of struggles that often arise in the aftermath of trauma. Then, I review current evidence-based competencies in spiritually oriented

therapy. Next, I propose a three-step praxis of cocreating intrinsically meaningful somatic

spiritual practices that are sensitive to spiritual struggles and aligned with spiritual care

competencies. My proposed care praxis utilizes the process of embodiment supported by

(a) evidence-based somatic theories on trauma and therapies utilizing interoception

reviewed in Chapter Three, (b) cocreativity and HRV research reviewed in Chapter Four,

and (c) this chapter's literature review of intercultural and interreligious spiritual care that

enhances spiritual trust. The thesis of this dissertation—that *reclaiming embodied trust*

*through intrinsically meaningful somatic spiritual practice helps trauma survivors lament*

*loss and seek wholeness*—is demonstrated in the culminating care praxis that I propose

here, as one of a number of useful tools for clinicians seeking to conduct competent,

spiritually integrated trauma care.

**Spiritual Struggles**

"I feel that I am cursed or being punished for something," Josie has recently

reflected as we navigate the PTS symptoms emerging in the aftermath of a local disaster.

Josie and her family have been suddenly displaced by a wildfire which ripped through her

neighborhood on 80-100-mile-an-hour winds. The words "cursed" and "punished" may

signal intrapersonal and supernatural spiritual struggles within Josie's spiritual

orientation to this natural disaster—struggles perhaps somatically experienced when Josie

links this current acute crisis to past trauma. By linking this current stressor with past

trauma stressors, Josie is burdened with additional anxiety (including death anxiety) and

a sense of guilt and isolation punctuated by "avoidant coping" (Trevino et al., 2019,

p. 221) and, at times, an "insecure relationship with God" (p. 215). Reviewing decades of

research on spiritual struggles, Pargament and Exline (2022) have stated,

> Spiritual struggles are among the deepest of all conflicts. They can shake us to the heart of our being. … We define spiritual struggles as experiences of tension, conflict, or strain that center on whatever people view as sacred (Exline, 2013; Pargament, Murray-Swank, Magyar, & Ano, 2005). (p. 6)

Their review of research demonstrates that "spiritual struggles can be found in surprising places, including conflicts and tensions around seemingly secular parts of life" (p. 7). The development of the Religious and Spiritual Struggles Scale (Exline et al., 2014) demonstrates that spiritual struggles fall into distinct categories, and that often one kind of struggle coexists with other kinds of struggles. Emerging research on the mediating roles of spiritual struggles, reviewed below, demonstrates how such struggles mediate the relationship between traumatic stressors and their positive or negative outcomes (Pomerleau et al., 2020). Pargament and Exline (2022) have described how spiritually oriented care can help people understand how spiritual struggles are like a fork in the road, leading either to (a) further brokenness or (b) ongoing integration and wholeness.

In Chapter Two, I referred to a definition of a general orienting system and add this: "an individual's general way of viewing and dealing with the world [that] includes resources and burdens for handling stressful events" (Trevino et al., 2019, p. 214). Doehring (2015b) has drawn upon psychological research on orienting systems to highlight spiritual orienting aspects of one's general orienting system. She has focused on the distinction between a person's deeply held, often unconscious or inherited religious or spiritual beliefs (here she has used the descriptor *embedded*[60]) and the learned, adopted,

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[60] Doehring has drawn upon practical theologians Stone and Duke's (2006) book, *How to Think Theologically*, and their definition of embedded theology as "the implicit theology that [people of faith] live out in their everyday lives," and they note that "some of us find it easy to articulate the embedded theology that we carry with us. But many do not" (pp. 13, 14). Doehring (2015b) has used research on stress in the body and moral intuitions (Moral Foundations Theory) to describe embedded values, beliefs, and coping practices as "often emotionally charged values, beliefs, and practices formed throughout one's

or adapted deliberative (or intentional) spiritual orientation[61] of adulthood. Doehring (2015b) has stated, "A spiritual orienting system is a psychological way of describing people's lived and intentional theologies [philosophies]—those emotionally related constellations of values, beliefs, and practices that arise from one situation to the next" (p. 191). Spiritual practices that connect one to an embodied sense of goodness help people reconcile their intentional and embedded theologies or philosophies, strengthening life-giving spiritual orienting systems. In contrast, spiritual practices that intensify spiritual struggles by invoking, for example, a distant, condemning 'god' can intensify anxiety and self-judgment, keeping people locked in a 'covenant' with the 'god' of trauma.[62] Assisted by somatic self-reflexivity, somatic spiritual practices that connect people to goodness contribute to physiological and emotional integration of embedded and deliberative theologies or philosophies.

Spiritual struggles become entwined in ordinary life as a result of magnitude, duration, and amount of cumulative stress upon the individual's spiritual orienting system. Not surprisingly, Trevino et al.'s (2019) research has indicated that

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childhood, some of which are left behind in adulthood" (p. 187). These embedded values, beliefs, and practices may be evoked under stress, and inscribed in habitual ways of coping shaped by anxiety and depression, continuing to exert a physiological and emotional influence over one's reactions to current life events.

[61] Doehring (2019b) has argued that intentional theologies/philosophies consist of the values and beliefs one clarifies through somatically oriented spiritual practices that connect one to goodness (for theistic practitioners, a good God), differentiate values and beliefs, are flexible, and integrative (four markers of spiritual wholeness described by Pargament [2007]). This ongoing process of spiritual integration may be likened to an ongoing process of spiritual homemaking. Here I am drawing upon Doehring's (2015b) description of intercultural spiritual care providers as trusted guests who are invited into another's spiritual orienting system as if invited into their home.

[62] Pargament and Exline (2022) have identified an aspect of divine struggle that focuses on *small gods,* which is a narrow concept of god that does not stand up well to the "full range of life experiences" (p. 172).

experiencing a larger number of stressful life events is associated with a higher level of R/S[63] struggle. Further, the experience of R/S struggle after stressful events is impacted by the burdens in the individual's general way of viewing the world. Individuals with higher emotional, social, spiritual, and behavioral burdens experience greater R/S struggle in the context of stressful life events. Identifying individuals who may experience R/S struggle and working to strengthen their orienting systems may reduce their experience of R/S disruption after stressful events and perhaps facilitate their long-term health and wellbeing. (p. 222)

Just as psychological struggles from traumatic or stressful events can increase spiritual struggles, Trevino et al. have noted that spiritual struggles also increase psychological distress through particular burdens in the individual spiritual orienting system. In other words, there often is a bidirectional relationship between psychological and spiritual struggles. This distress can be significantly disruptive to trauma integration and well-being if left unaddressed. For example, Josie's initially significant posttraumatic stress response to sudden disruptive life events is an example of the cumulative impact of multiple stressors[64] upon her orienting system, which became life limiting because of the burdens of a conflictual relationship with a *punishing* supernatural or a *cursing* force within life that went hand-in-hand with significant (inherited) self-doubt or self-criticism. The development of the Religious and Spiritual Struggles Scale has demonstrated

six domains of r/s struggle: *divine* (negative emotion centered on beliefs about God or a perceived relationship with God), *demonic* (concern that the devil or evil spirits are attacking an individual or causing negative events), *interpersonal* (concern about negative experiences with religious people or institutions; interpersonal conflict around religious issues), *moral* (wrestling with attempts to follow moral principles; worry or guilt about perceived offenses by the self),

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[63] The authors have utilized the abbreviation R/S as a common shorthand for religious and spiritual. Although religious or spiritual struggles are distinct, as indicated by the categories and types of spiritual struggles (delineated later in this chapter), there is considerable overlap among them and the nuances differentiating them can be drawn out through respectful interreligious and intercultural care.

[64] In her case, toxic work environment, sudden loss of mother and grandmother, difficult pregnancy/birth, pandemic isolation, loss of home and work, were some of the "larger number of stressful life events associated with a higher level of R/S struggle" (Trevino et al., 2019, p. 222).

> *doubt* (feeling troubled by doubts or questions about one's r/s beliefs), and *ultimate meaning* (concern about not perceiving deep meaning in one's life). (Exline et al., 2014, p. 208)

People often experience overlapping domains of struggles within trauma-related orienting systems that create what Pargament and Exline (2022) have described as burdens that hinder people's spiritual growth and integration. Trevino et al. (2019) have used this research to argue that targeted ways of strengthening the spiritual orienting system through, for instance, teaching emotional regulation skills that build confidence and encourage trustworthy social engagement can "reduce the impact of stressful life events on their R/S beliefs and worldview" (p. 222).

Although separating out the spiritual from the psychological struggles is, according to Pargament and Exline (2022), like separating the white from the black threads of a grey sweater, categories of spiritual struggle can assist in delivering competent care that addresses the spiritual aspects of struggle more explicitly. Based on extensive research and review, Pargament (2007) has delineated three distinct categories of spiritual struggles: intrapersonal, interpersonal, and Divine or supernatural. As notes above, Pargament and Exline (2022) have recently developed these categories further by identifying six types of spiritual struggles that expand upon, though not exhaustively, the kinds of spiritual struggles that can be encountered: Divine, demonic, interpersonal, doubt, moral, and ultimate meaning. Pargament and Exline have described these struggles

as pervasive,[65] painful,[66] and pivotal.[67] They are not mutually exclusive and combine in

unique ways, increasing the complexity of the clinical care picture. Surveys like the Brief

RCOPE (Pargament et al., 1998) and others such inventories assist spiritual care

providers in identifying spiritual struggles and coping resources.

Trauma, as previously defined, is a result of isolation during psychological and

physiological overwhelm in the presence of perceived threat to life, integrity, and

spiritual identity. Pargament and Exline (2022) have observed that "people are especially

vulnerable to spiritual struggles following an encounter with life events that (1) touch

matters of deepest significance, and (2) overwhelm the individual's orienting system"

(p. 53). Some form of spiritual struggles, however brief, in the aftermath of trauma seems

inevitable because trauma evokes core existential dilemmas and often overwhelms one's

coping strategies, generating disorientation within one's spiritual orienting system. As the

authors have put it, "spiritual struggles are a natural expression of those disturbing times

in life when we are shaken to the core" (pp. 53–54). Significant stressors overload the

orienting system, taxing resources and challenging core spiritual beliefs about life.

Pargament and Exline have found that some life events "directly threaten, damage, or

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[65] As an example, one national study of 1,000 people found that 75% of them had experienced most of the six categories of struggle over the course of their lives (Exline et al., 2014). Further, atheists have been found to have spiritual struggles that can be assessed in the categories that Pargament and Exline (2022) have laid out.

[66] Spiritual struggles cause extreme emotional pain and often accompany some of the most difficult and torturous psychological struggles. See McConnell et al. (2006) for a survey of the link between psychopathology and spiritual struggles.

[67] Spiritual struggles often are experienced as a time when "destiny is hanging in the balance" (Boisen, 1955, p. 116, as cited in Pargament & Exline, 2022, p. 18), and as a fork in the road that may lead to great opportunity or devastating brokenness.

violate the fundamental assumptions that underlie the orienting system" (p. 57) resulting in doubt or loss of faith. They specified that "stressful life experiences can overwhelm the orienting system by targeting particular areas of vulnerability, vulnerabilities that vary from person to person" (p. 57). Like a sweater with white and black interwoven threads that make the sweater grey, said the authors, the overwhelm of trauma and the overwhelm of the orienting system seem to weave together and craft unique intertwined struggles.

Regarding the impact of trauma on one's spiritual orienting system, Doehring (2015b) has written that trauma is "like an earthquake that exposes beliefs and values formed in childhood that may be buried but still exer[t] an influence in the form of emotionally charged automatic thoughts" (p. 15). She has also stated, "Theologians do not often consider how the physiological effects of emotions give rise to lived theologies" (2015c, p. 642). These statements underscore the need for an embodied spiritual orientation to trauma care. As Doehring has asserted, "spiritual care helps people cocreate intentional theologies that draw upon goodness, compassion, and love—moral emotions that connect them to the web of life" (p. 636).

This chapter focuses on how somatic spiritual practices help trauma survivors find a path to wholeness in spiritually integrated trauma care. Pargament et al. (2016) have described the challenges of determining what contributes to growth versus decline when spiritual struggles are present:

> Whether spiritual struggles lead to growth or decline depends on the individual's degree of wholeness and brokenness. In speaking about wholeness and brokenness, we turn away from the possibility of discovering a single key to well-being and, instead, wrestle with life in its entirety and complexity. (p. 35)

As discussed in Chapter Two, wholeness and brokenness are balanced together as dynamic polarity. Wholeness is a process that uses lament, as I describe below, as a way of sharing the anguish of what may be experienced as shards of brokenness through somatic practices that help survivors trust the process of lamenting (Doehring, 2019b; L. Graham, 2017). The development of a felt sense of spiritual trust through engagement with a cocreated, intrinsically meaningful somatic spiritual practice provides a simple yet self-regulatory and spiritually connected ground for complex integration that includes soma (body), emotions, and meaning making. Dynamic balance of (brokenness within wholeness) and complex, multifaceted spiritual integration through intentional practices contribute to wholeness out of brokenness by *degree*.

In the language they employed, Pargament and Exline (2022) have made a shift from referring to negative and positive spiritual coping to discussing *spiritual struggles* for two important reasons: "(1) the coping methods that were previously labeled negative do not always lead to negative outcomes; and (2) by using the language of spiritual struggle, we convey the possibility of growth as people work through these conflicts" (p. 9). Recall in my case study that Josie's initial aim in seeking spiritually integrated care in the aftermath of traumatic loss was a restoration of her capacity to experience "imagination, joy, confidence, and her spiritual life" again. She used the words "utterly broken" to describe how she felt. Eventually her sense of brokenness became an "odd sense of emptiness" that evolved into what she described as a sense of "spaciousness". This sense of spaciousness has served as a container for a new kind of mature wholeness and spiritual differentiation of self (DoS) to be discussed later. Her current spiritual struggles, which occasionally have taken the form of divine spiritual struggles with a

punishing or condemning supernatural, are almost entirely identified as intrapersonal

spiritual struggles (doubt and moral) with a highly critical internalized parental voice.

Josie has projected this critical parental voice onto a deity in times of extreme distress.[68]

Research on attachment to God has demonstrated *correlations* between a punitive or

cruel parent and a punishing God as well as a *compensatory* relationship with God as an

effort to regain or *earn*[69] secure attachment through sacred relationship. Divine or

supernatural struggles may arise from cruel, critical, and punitive parenting. Spiritual and

religious practices as well as lament may be used as a way to call upon Divine justice,

love, mercy, and protection. As Pargament and Exline (2022) have suggested, "spiritual

struggles are, we believe, a natural outgrowth of the desire to find, hold on to, and, at

times, transform the things that are most significant to us" (p. 25).

Contributing to Josie's spiritual struggles, moral stress has burdened Josie's

orienting system with physiological shame (*feeling punished*) and fear (*feeling cursed*) in

the aftermath of acute crisis. As Doehring (2015c) has stated, "moral stress is inherently

spiritual and religious, requiring both psychological and theological approaches to care"

(p. 636). The process of spiritual integration, as outlined by Doehring, is to (a) connect

with God/goodness through spiritual practices, (b) identify the personal struggles and

embedded theologies that cause moral stress, and (c) cocreate intentional theologies

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[68] Using attachment theory, psychologists Lee Kirkpatrick (1999) and Pehr Granqvist (1998) have broken ground at the intersection of religion and attachment with research on attachment to God. Their preliminary finding was that secure and insecure attachment to parental figures translated to either *correspondence* or *compensation* in relationship with God. A person can attribute both, as with Josie, where the Divine can be critical and punitive as well as loving, forgiving, and protective. Psychologist Angie McDonald has developed a measure called the Attachment to God Inventory (AGI; Beck & McDonald, 2004) that advanced this research.

[69] See *earned* secure attachment literature (Main, 1995; Siegel, 2007).

(values and beliefs) (p. 637), again supported by spiritual practices. In her spiritual community, Josie is actively engaging in a spiritual enquiry method designed to address these struggles through compassionate connection to a benevolent Divine, personal discernment practices, community commitment, and active investment in spiritual trust through the virtues of gratitude and surrender. In our spiritually integrated trauma work together, I am sensitive to moral and spiritual struggles as a sign of a particular kind of heightened distress in need of spiritual care that is competent and cocreative and that includes the spiritual community with which Josie is already deeply engaged.

Preliminary research conducted on the buffers to religious and spiritual struggles and their impact on wellbeing found that spiritual or religious commitment and support as well as *sanctification* of life events served as a buffer to decline during spiritual struggle (Abu-Raiya et al., 2016). The recent spiritual insights Josie brings to her spiritual struggles are, in her words, to "stay curious," looking for the opportunities and synchronicities the Divine is weaving into current challenges, and to follow the "Golden Path"[70] unfolding in these complex opportunities. Though "the cumulative stress of multiple negative events may increase the likelihood of R/S struggle" (Trevino et al., 2019, p. 220), I trust Josie's capacity to weather struggles toward growth and spiritual integration because of the particular way her spiritual orienting system currently operates in alignment with findings of the study cited above (Abu-Raiya et al., 2016) in terms of commitment to her path, seeking spiritual supports, and the sanctification of struggle

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[70] The words-turned-image of the "Golden Path" within the possible loss of her family's home came to Josie as she was fleeing from the encroaching fire. This sanctification of struggle was an immediate spiritual resource or buffer to the unfolding tragedy.

found in the language of the "Golden Path." This sanctification continues to hold power for her as she intentionally seeks out the opportunities in the increasing hardships. I continue to be alert to spiritual struggle and spiritual resources that respect Josie's alterity,[71] in accordance with spiritual care *best practices* emerging out of intercultural spiritual care praxis and spiritually integrated care competencies developed through empirical research in the field of the psychology of religion.

**Competencies in Spiritually Integrated Care**

Spiritual care is a unique support rooted or centered in a larger spiritual view of human agency, need, meaning, significance, and wholeness. Doehring and Kestenbaum (2022a) have defined spiritual care as ideally "an integrative process that begins with exploring calming spiritual practices that help people to experience spiritual trust" (p. 135).[72] Spiritually integrated care in clinical settings has primarily been advanced by theory development and research in the field of the psychology of religion (Pargament & Exline, 2022). As one would expect, spiritual care, particularly in secular settings, is most likely to lead to spiritual trust and cocreative integration when the care provider shows respect for the practices, beliefs, and values of the care seeker (Doehring & Kestenbaum, 2022b) with a strong emphasis on respect for *alterity* or fundamental difference. Leaders at the intersection of pastoral and clinical care, Doehring (2018), Pargament (2022),

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[71] Alterity is a philosophical concept that is relevant to pluralistic intercultural and interreligious spiritual care. A concept originally developed by philosopher Emmanuel Levinas, Morgan and Sandage (2016) have defined it for spiritual care purposes as respectful "ways of relating with otherness … that shape and mold encounters with religious difference" (p. 131). They have stated, "The religious other can be understood as any individual, practice, or belief perceived as representing a different way of relating to the sacred" (p. 142).

[72] The edited volume by Rambo and Cadge (2022), in which this chapter is published, provides an overview and detailed descriptions of how spiritual care in chaplaincy contexts is practiced today.

Vieten & Lukoff (2022), Morgan and Sandage (2016), and others have advocated for spiritual care to be *interculturally* or *interreligiously* sensitive and to follow evidence-based competencies.

### Spiritual/Religious Competencies

Drawing upon evidence-based intercultural spiritual care, interpersonal competencies as identified by Doehring and Kestenbaum (2022b) specifically highlight *spiritual self-differentiation*, *spiritual empathy*, and *spiritual reflexivity* as necessary skills to be developed though intensive training, self-awareness, and quality self-care. These three essential spiritual care qualities are illuminated in more detail through the metaphor of entering the *spiritual home of the other* (Doehring, 2015b) in the conclusion of this section. Doehring (2015c, 2019b, Doehring & Kestenbaum, 2022a) has argued that the essential spiritual care competencies must initially focus on the felt relational domain between care provider and care seeker. She has noted that an initial over-focus on meaning-making can obstruct the necessary cultivation of spiritual trust and the establishment of a felt sense of goodness needed to contemplate and clarify new meanings in spiritual care. Doehring (2019b) has asserted that "the first step is to explore body-aware, intrinsically meaningful, intentional practices that help people experience traumatic grief without feeling overwhelmed" (p. 256). Doehring and Kestenbaum's (2022b) case studies have illustrated that "developing interpersonal competencies in spiritual care is a deeply relational process grounded in a felt sense of spiritual trust experienced in one's body through calming spiritual practices" (p. 152) engaged by the care provider as a means of both spiritual reflexivity and somatic, spiritual self-care.

In the domain of clinical psychotherapeutic care,

Spiritual and religious competencies are defined as a set of attitudes, knowledge, and skills in the domains of spirituality and religion that every ... [care provider] should have to effectively and ethically practice [care], regardless of whether or not they conduct spiritually oriented psychotherapy or consider themselves spiritual or religious. (Vieten et al., 2013, p. 133)

Based on their research, psychologists Cassandra Vieten and David Lukoff (2022) have viewed the inclusion of religious and spiritual competency in clinical training as an important aspect of multicultural diversity training. Most training, however, focuses only on ethnic and racial diversity. Standard multicultural training competencies are the ability

(1) to engage in the process of becoming aware of one's own assumptions about human behavior, values, biases, preconceived notions, personal limitations, and so forth; (2) to attempt to understand the worldview of culturally different clients without judgment; (3) to implement relevant, and sensitive intervention strategies with culturally different clients (Arredondo et al., 1996; Sue, 1998). (Vieten et al., 2013, p. 131)

It is baffling to attempt to separate out religious or spiritual issues from the important area of cultural sensitivity because it is highly likely that cultural differences would involve religious or spiritual differences as well, or even primarily. Vieten and Lukoff (2022) have asserted, "Psychologists receive little or no training in R/S issues, in part because no agreed upon set of spiritual competencies or training guidelines exist" (p. 1). Not only should religious and spiritual competence be developed for the purposes of quality multicultural sensitivity, but according to Vieten et al. (2013), religious and spiritual issues need to be included in assessment and treatment planning as well.

Based on their extensive literature review, focus groups, and surveys, Vieten and Lukoff (2022) have suggested 16 spiritual and religious competencies that should be demonstrated by clinical care providers under three headings: (a) *attitudes* that

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demonstrate respect, appreciation, and implicit and explicit self-awareness including biases; (b) *knowledge* of spiritual and religious diversity/multiplicity, life-span issues, struggles, resources, and legal or ethical issues; and (c) *skills* in identifying and engaging spiritual or religious matters in therapy, making helpful referrals, staying abreast of research, and regularly seeking out competent supervision. An American Psychological Association task force has been formed to address this gap in ethical, competent, multicultural training and care. Researchers Michelle Pearce et al. (2019) have developed the Spiritual Competency Training in Mental Health (SCT-MH) program, a novel multidisciplinary, online training program that includes these 16 competencies. Copywritten by the American Psychological Association, the program will be empirically tested for feasibility, helpfulness, and impact on engagement with spirituality and religious life in care. Vieten and Lukoff (2022) have concluded that "in addition to addressing this important aspect of diversity, attention to the spiritual and religious domains of people's lives should result in greater client satisfaction, better outcomes, and a more complete approach to clinical care" (p. 10).

"A developmental model of interreligious competence" has been proposed by Morgan and Sandage (2016, p. 129) as a self-reflexive *framework* and a path to personal refinement of competence along a developmental continuum with regards to religious difference. Morgan and Sandage have identified the strengths and weaknesses in intercultural and interreligious competencies to propose their integrative model, which emphasizes training programs that promote growth and differentiation of self (DoS). They have justified their move from an intercultural to an interreligious framework by referencing studies that have demonstrated that although care providers are moderately

skilled at navigating multicultural and intercultural differences respectfully, religious differences are much more difficult to manage. This is so because religious differences challenge fundamental, personal truth claims and also may expose core dissonances between care providers (statistically more likely to be nonreligious) and care seekers.

Morgan and Sandage (2016) have found that religiously based prejudice is tenacious and subtle. Clinicians usually lack education in comparative studies of religion that challenge their own biases about religion and spirituality, making them less likely to see the need for what Doehring and Kestenbaum (2022b) have called *spiritual differentiation*. As a result, clinicians may feel confident they know how to practice spiritually oriented care because they have what they perceive to be healthy spirituality, or they may lack motivation or confidence to include religious and spiritual matters in therapy if they have not received education and training. The interreligious competency model proposed by Morgan and Sandage (2016) moves from *denial* to *integration* by way of four intermediary *attitudes*: *polarization, minimization, acceptance,* and *adaptation* that provide a helpful framework for a care provider to cultivate self-reflexivity. The final attitude of *integration* is "where 'one's experience of self is expanded to include the movement in and out of different cultural worldviews' (Bennett, 2004, p. 72)" (p. 136). According to Morgan and Sandage's (2016) research findings, "healthy integration requires wise coping strategies, effective self-regulation, and a mature differentiation typically combined with finding communities of support" (p. 136).

These developmental attitudes have distinct ways of relating to religious similarities and differences that assist a person in honestly mapping their reactions and capacities for spiritual differentiation and in identifying skills to be developed. Notably,

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development toward the ideal of *integration* is not guaranteed nor even necessary, and humility about personal limitations and honesty about religious location is the main goal. Rather, relationality is emphasized where an empathic phenomenological awareness of the religious other and one's humble self-reflective response is most relevant for competent interreligious care that builds spiritual trust. Morgan and Sandage (2016) have emphasized that the aim of interreligious development is "a constellation of capacities that permit individuals to have alternative experiences and encounter alterity with openness while still retaining their own cultural identity and values" (p. 137).

### *Spiritual Care: Intercultural and Interreligious*

Pastoral theologian Emmanuel Lartey (2006) has been identified as the founder of an intercultural approach to pastoral care. In Lartey's approach, "interculturality stands for an attitude that rejects both extreme relativism and exclusive absolutism. It inhabits different cultures but also seeks to transcend their narrow limits" (p. 124). Intercultural spiritual care has developed out of a rich Western history of pastoral theology that is punctuated by four paradigms. The four interinfluencing categories or paradigms of pastoral theological work that have emerged over the past century are *traditional/ classical clerical* (historically, since the beginning of Jewish and Christian traditions with designated/ordained faith community leaders); *therapeutic/clinical pastoral* (beginning in the1930s with the rise of therapies and behavioral healthcare), *communal contextual* (beginning in the 1970s with a reclaiming of communities of faith as caregivers); and *intercultural* (in the 1990s, with an emphasis on social and cultural context) (see Ramsay, 2004). The intercultural paradigm for spiritual care, built upon the preceding paradigms, is justice seeking, bidirectional with reference to cognate disciplines, and intersubjective

or dialogic (with an emphasis on alterity) in practice. The changes in pastoral and spiritual care across time reflect a growing sensitivity to power, difference, agency, contextuality, relativity, and relationality (Doehring, 2015; Dykstra, 2005; Lartey & Moon, 2020; Ramsay, 2004). Currently, pastoral work as spiritual care "draws on an ecological theme but responds more immediately to the fact and significance of cultural, racial, and religious pluralism as a context for practices of care" (Ramsay, 2004, p. 1). Doehring (2015b) has advanced a respectful, intercultural, and interreligious care praxis that is expressly body-based, cocreative, and informed by research from traumatology and the psychology of religion. It is primarily her approach to intercultural spiritual care that informs the praxis of this dissertation.

Where intercultural care refers to respect for every kind of cultural, subcultural, and contextual difference, interreligious care is the specific "ability to sensitively and effectively relate across *religious* differences" (Morgan & Sandage, 2016, p. 130). The important inclusion of specific interreligious competencies into spiritual care is that although religious prejudice may be reduced by an intercultural perspective, the care provider may "still lack skills in relating effectively to persons of other religious worldviews" (p. 130). This is of particular importance for secular and non-religious care providers who seek to provide cocreative and spiritually integrated care. Morgan and Sandage (2016) have noted that in one study, when religion was substituted for culture, trainees found the shift from "religiocentric to religiorelative perspectives as particularly challenging" and that "individuals were generally opposed to the idea of religious relativity" (p. 139). They therefore have based their developmental model of interreligious competency on a "transition into religiorelativism" (p. 139) by way of an

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understanding of the socially constructed elements in all religions that continues to affirm one's own religious preferences. They have stated,

> by keeping social construction and self-reflection in sight, we preserve the possibility of acceptance, adaptation, and integration as viable and potentially deep attitudes towards religious difference. Acceptance would therefore involve cognitive complexity and flexibility manifesting as an open and respectful curiosity about other religious practices and beliefs. (p. 146)

Because religious life, unlike other aspect of culture, pertains to the sacred domain in a distinct and communal manner, it evokes more tension across lines of difference and offers more fruits for cocreative spiritual care than other aspects of cultural difference. Furthermore, harkening back to spiritual struggles in the aftermath of trauma, both spiritual and religious life are unique sources of challenge and support worthy of competent means of engagement. Spiritually integrated trauma care ideally addresses religious obstacles and calls upon religious resources in a manner sensitive to theologies of trauma within religious traditions.

Notably, "the field of pastoral care and counseling has long viewed the person as a 'living human document' that is of equal importance to the texts of theology or religion and its traditions and, by implication, is also interpretable (Dykstra 2005)" (Helsel, 2014, p. 692). The field of somatic traumatology as well as research into embodied cognition argues that embodiment holds stories of triumph and tragedy to be interpreted through somatically sensitive, empathic care. The contributions of pastoral theology and care to the growing literature on trauma are numerous, addressing such topics as moral injury (Doehring, 2018; L. Graham, 2017), systems of oppression, public mourning (Swain, 2011), religious metaphor (Jones, 2009; Rambo, 2010; Swain, 2011), spiritual/religious orienting (Arjona, 2017; Doehring, 2018; Hunsinger, 2015; Jones, 2009; Rambo, 2010;

Swain, 2011 ), embedded theologies of trauma (Doehring, 2015b), traditional ritual

practices in light of trauma (Arjona, 2017), redemptive forgiveness (Hunsinger, 2015),

and radical hope (McCarroll, 2014), to name just a few. These cited authors place their

subjects within the depths of felt experience or lived religion and spiritual meaning-

making, contributing to an informed rationale for the benefits of spiritual practices in the

aftermath of trauma not found in psychological literature.

### *Spiritual or Religious Location, Multiplicity, and Particularity*

Pastoral theologian and researcher Kathleen Greider (2015) is a strong advocate

for amending the clear deficit in religious competency in counseling psychology and

clinical practice as outlined in the multicultural competency requirements in both the

APA and ACA guidelines (pp. 246–248). Greider has suggested that a key to competency

is first and foremost self-differentiation in the form of *religious location*, meaning

cultivating the capacity to hold a provisional religiorelative stance committed to one's

own tradition while valuing the religious other as on an equally worthy path. She has

pointed out that being mindful of one's religious location is of paramount importance to

an ethical intercultural or interreligious care that affirms the dignity of the care contract

and the rightful alterity of the religious other.

Greider (2015) has noted that religious location is both explicit and implicit

(practiced and embedded), therefore "authenticity, vulnerability, and mutuality" (p. 236)

along with self-reflexivity is an ethical obligation not just for religious care providers.

Counselors and psychologists who do not consider themselves religious can have a blind

spot of bigotry in the form of an agnostic or atheistic arrogance about religious values

and beliefs. Greider has warned that "whether or not we are religious, all persons inhabit

a particular location relative to religion" (p. 235). This means that agnosticism or atheism *is* a religious location to monitor. Further, the particulars of a religious or spiritual life matter much more than universals, similarities, or religious stereotypes. Her method calls for an on-going self-reflexive awareness of one's religious location, an ethical sensitivity to countertransference or reactivity to religious particularities of the other, and a mindfulness of the influence of both upon the spiritual care. Greider has optimistically concluded that "our divergences can compel us to search together, for something *more,* perhaps something like wisdom" (p. 254).

Another compelling reason to move beyond a (sometimes multicultural) stance that regards cultures and religions as monoliths is the necessary acknowledgement that cultural and religious boundaries are fluid and have always been somewhat porous (Bidwell, 2018). Bidwell (2018) has argued that we are all, to some degree, influenced by multiple spiritual and religious influences at all times and that these multiple influences, commitments, and bonds are a rich part of human experience to be acknowledged, legitimized, and drawn upon in care. He has stated, "most people, in fact, are spiritually fluid to one degree or another, even those who identify with one tradition. All religions borrow from the cultures and forms of spirituality that surround and precede them" (p. 19). Noting that religious fluidity can become religious multiplicity by *choice*, *heredity*, or *collaboration*, he has referred to emerging religious multiplicity as "the experience of being shaped by, or maintaining bonds to, more than one spiritual or religious community at the same time" (p. 1). A respectful and curious focus on the particularities of a person's religious or spiritual world with mindfulness of one's own

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location moves care meaningfully beyond cultural and religious stereotypes too often obscuring the unique lived human experience.

Bidwell (2015b) has promoted a pluralistic comparative "caring across traditions" (p. 135). He has moved from an intercultural to an interreligious care paradigm centered on a "dialogic heart" and a spiritual or "virtuous friendship" (2015a, p. 8) whereby the emphasis on *being* (over doing) invites openness, depth, and surprise in relation to the spiritual other. His method is interreligious in that he listens for religiosity, religious fluidity, or multiple religious belonging as an asset worthy of humble respect and engagement. As practiced, "this stance is marked by humility, receptivity, gratitude, and non-triumphant behaviors, which can collectively be described as a 'dialogical heart'" (Adeney et al., 2012, p. 41).

All of these intercultural and interreligious competencies rely mostly on *pluralism.* Religious pluralism as defined by Morgan and Sandage (2016) is "the coexistence of diverse religious groups and individuals" (p. 130). In developing his interreligious dialogue method, comparative scholar of religion Paul Hedges (2010) has confronted an impasse in religious pluralism with a solution he has called *differential pluralism* that is achieved through a power-sensitive mutuality. His *mutuality model* seeks to bridge a religiously pluralistic stance reliant on *similarities* (espoused by most progressive paradigms) with a more radical particularistic stance toward religious *difference*. He has stated, "Radical openness and radical difference is the impasse and differential pluralism is on the way to a solution" (p. 228). He has emphasized the need to respect *plurality*, which horizontalizes religious and spiritual traditions as equal, and *particularity*, which honors and is even willing to be changed by the uniqueness of

differences. Hedges has proposed an image of *hospitality* as the route to such an encounter. His model's addition to Bidwell's concept of the interreligious *dialogic heart* is mostly in the explicit willingness to encounter difference and be changed by it. Hedges has called this *mutual fulfillment*. Spiritual care competencies are enhanced by a dialogic heart that listens for and honors spiritual multiplicity or fluidity (Bidwell, 2018) and a mutual, differential pluralistic stance to religious and spiritual difference that is willing to be transformed and fulfilled by the encounter (Hedges, 2010).

Communications scholar Lisbeth Lipari (2004) has drawn upon phenomenology, dialogic philosophies, and Buddhism in proposing her ethics of listening for the other (alterity). Bringing life to the idea of a dialogic heart, mutual fulfillment, and a call to differential pluralism, she has stated,

> In my dialogic encounter with you, I will not only listen for your radical alterity but I will open and make a place for it. It means that I do not resort only to what is easy—what I already know, or what we have in common. It means that I listen for and make space for the difficult, the different, the radically strange. (p. 139)

Informed by Hedges's (2010) idea of *differential pluralism* and Bidwell's concept of the *dialogical heart* (Adeney et al, 2012)*,* the spiritually integrated approach I propose explores the distinctive (differential) nature of a care seeker's spiritual world from a stance of somatic spiritual self-reflexivity and spiritually empathic receptivity (dialogic heart). This practice not only allows unique spiritual resources to emerge but also contributes to spiritual trust and cocreative discovery. I believe that spiritual integration in care is most advanced when one's spiritual practices are congruent with one's unique lived experiences and spiritual orienting system. A radical pluralistic, dialogic approach allows for cocreative spiritual practices to emerge organically in the space between

caregiver and care seeker, and especially from the care seeker's embodied wisdom out of

their own spiritual orienting. Hedges (2010)writes, "to be truly hospitable means not just

to let the Other enter our world but to enter theirs too" (p. 236). Whereas Hedges (2010)

has beautifully highlighted hospitality as the approach to a kind of mutuality, sharing,

deference, and care, Doehring's (2015b) image of entering the *spiritual home of the other*

offers a metaphor of respect for alterity that highlights the need for the interpersonal

competencies of *spiritual self-differentiation, spiritual empathy,* and *spiritual reflexivity*

(Doehring & Kestenbaum, 2022b).

### *Competencies in Action: The Spiritual Home of the Other*

How do you enter the home of another when invited in? Maybe reluctantly,

casually, with excited anticipation, or with hesitant care, or with some combination of

these depending on context. How much of your own home do you bring with you?

Maybe just the clothes on your back, a little bag, and possibly an offering of flowers or

food. Do you listen and look out for their house rules, possibly taking off your shoes at

the door or sitting in the seat you are offered and following the lead of your host? Do you

first notice familiar or unfamiliar items, and what do you comment on? Maybe you enjoy

a beautiful piece of art that appeals to your own aesthetic, or you get curious about an odd

object or unusual item and dare to ask about it. What religious or spiritual things do you

notice? What might you be missing that a few competencies and intentional attitudes

would allow you to stay open to?

In this metaphor, the entry room furniture is a deliberative or intentional theology

or philosophy with occasional lived artifacts of inheritance, culture, and shared humanity.

The back rooms contain embedded theologies or philosophies and deep, vulnerable

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meanings sometimes almost entirely outside of awareness, exerting an occasional implicit influence. Some rooms are too precious, too sacred for a casual visitor to enter. Other rooms are unknown to the host/ess, full of treasures not yet uncovered or pains, joys, and hopes locked off from view. The entire home makes up a spiritual orienting system that contains examined and unexamined values, beliefs, and practices. Spiritual self-differentiation is understanding that you are the guest and very little of your furniture is needed here. Acting accordingly and with an attitude of an honorable guest, requires spiritual self-reflexivity. Spiritual empathy emerges out of a felt sense of the spiritual other and a rising care about the struggles and strengths unique to this spiritual home.

In the Masters of Divinity Integration Lab course I teach and in the gestalt therapy workshops on spiritual care I have offered of late, I use the image of entering the spiritual home of the other (Doehring, 2015b) to offer a metaphor that invites cocreative dialogue. Out of these dialogues and the above intercultural and interreligious competencies, I have developed four spiritual care steps to entering the spiritual home of the other:

1. Somatic, *spiritual self-reflexivity*: Being keenly aware of what one brings to the spiritual/religious home of the other from one's own spiritual orienting system, with the somatic aspect being a felt sense about religious location and reaction, moment to moment.

2. Attunement: Being *spiritually empathic* and noticing the degree of welcome, openness or guardedness, and the struggles, strengths, and needs of the other.

3. Curiosity: Looking, listening, taking in the familiar, yet particularly the surprising objects of the rooms into which you are invited. Being available to difference (alterity, differential pluralism) and to the degree to which you can

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bear their difference without needing to pull back, judge, colonize or

convert. This is a step beyond being passively open but rather being actively

exploratory and requiring a high degree of *spiritual self-differentiation*.

4.  Cocreativity: Embodying your spiritual/religious values through personal

    spiritual integration and self-awareness that makes an authentic offering rather

    than an imposition. Allowing for alterity, mutuality, creativity, and the

    development of spiritual trust to reveal something more, something potentially

    sacred through dialogue.

Lipari (2004) has commented on a Hasidic parable that captures this spiritual cocreativity

well:

> Before every human being comes a retinue of angels, announcing "make
> way for an image of the Holy One, Blessed be He." How rarely do we
> listen for those angels when we encounter another human being.
> (Kamenetz, 1994, p. 233)
> It is with no small degree of wonder to learn that the Hebrew word for holy
> (Kaddosh) also means otherness (Armstrong, 1993). By listening for the other, we
> may encounter the holy. (pp. 138–139)

In summary, one can, through an attitude of reverence and curiosity that listens for the

other, encounter the holy in the spiritual home of the other. Where spirituality *is*

relationship with the sacred, such an encounter with the holy, has mutual fulfillment as a

potential and potent spiritual gift upon departure from the spiritual home of the other.

### *Sacred Relationship and Spiritual Practice*

Sitting next to a very anxious passenger on an international fight some years ago,

I noticed she was tightly holding a rosary. I assumed it connected her to her Catholic or

Russian Orthodox faith tradition. Upon speaking with her, I learned that the rosary was

from her beloved father, once a farmer in her natal Russia. The rosary reminded her of

their farm and her late father's protection and love. She told me she feared flying, was afraid to be out of Russia, and that the rosary gave her comfort. I speculate that her rosary connected her with a felt sense of the sacred aspects of earth, homeland, or transcendent familial love, while supporting physiological ease through self-regulation. I was merely on the porch of her spiritual home yet, if invited in further (which can happen on a long international flight!) I would be prepared to drop both my above assumption about her religious tradition and my more empathic speculation about what of the sacred the rosary was connecting her to, in preparation for encounter with the lived experience, the actual furniture in her home. What I would not set down easily is the lens of spiritual practice, where the intentional rotation of the rosary was potentially an attempt to connect with what one deems to be sacred.

A *felt* sense of the sacred implicitly includes embodiment; is unique to each person, as the above example indicates; and is a connection worth deliberately cultivating as a relationship that serves to advance spiritual trust in the sacred. This cultivation of sacred relationship is the *spiritual practice* in somatic spiritual practice towards integration and wholeness. Theologian F. LeRon Shults and psychologist Steven Sandage (2006) have offered a definition of spirituality as "ways of relating to the sacred" (p. 161), with a two-fold movement of either dwelling or seeking, depending on the oscillating need of the person and the context. *Spiritual practice is the intentional and even ritualized or operationalized seeking or dwelling aspect of spirituality where one engages in traditional or personal practices that cultivate a felt relationship with the sacred.*

Jankowski and Sandage's (2012) research on the fruitful connection between

spirituality and wellbeing has found that differentiation of self (DoS), whereby one uses

emotional, and I would add spiritual, self-regulation and self-awareness to become more

distinctly oneself while also more differentially connected to others, has a positive

mediating effect on wellbeing. In the correlation between spirituality and wellbeing with

spiritual differentiation as a mediating condition, Jankowski and Sandage have found that

"spiritual dwelling had a significant direct effect on increased positive mood" (p. 430) for

distressed individuals. Spiritual dwelling is ideally a positive sensate state of resting in

felt sacred connection that facilitates a sense of safety and spiritual trust. In the spiritual

oscillation between seeking and dwelling in a sense of the sacred, seeking behaviors and

practices were associated with higher degrees of both anxiety and growth; perhaps this is

due to the nature of seeking itself or to the elevated state of arousal that may compel

seeking behaviors. In Jankowski and Sandage's findings, spiritual dwelling and practices

that enhanced the experience of resting in sacred connection were associated with

wellbeing and ease. Spiritual practices that encourage dwelling in a felt sense of the

sacred may contribute significantly to a spiritually integrated approach to care in the

aftermath of trauma due to the heightened importance of self-regulation, sense of safety,

and a felt sense of trust.

Jankowski and Sandage's (2011) use of "differentiation-based spirituality as a

particular framework for relational spirituality rests on Bowen's ideas about intra- and

interpersonal differentiation" (p. 418). In an empirical study of relational spirituality and

the benefits of spiritual practice towards wellbeing, Jankowski and research psychologist

Marsha Vaughn (2009) have stated,

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The results of this study showed a positive correlation between differentiation and a general report of spirituality. Spiritual practices also predicted individuals' level of spiritual development. A common underlying concept, self-regulation, may explain the correlation between differentiation and spiritual development. Likewise, spiritual practices may support change in both areas. (p. 82)

The authors have also noted a "bidirectional understanding of the relationship between spirituality and differentiation" (p. 84), where differentiation can be said to enhance trust and promote healthy relating (along with self-responsibility, intimacy, healthy boundaries, and the capacity to self-regulate moderate distress). Primarily, however, Jankowski and Vaughn have observed "spirituality acting on differentiation through some mechanism of influence" (p. 84) that they have attributed to spiritual practices that enhance self-regulation. They have noted,

Both contemplative prayer [*dwelling*] and prayer for self [*seeking*] seem to assist individuals in their efforts at self-regulation, having the effect of calming or reorienting them within their relationships, thereby increasing differentiated functioning. (p. 94)

Jankowski and Vaughn have stated that "upward or contemplative prayer could serve as a way for clients to find comfort in distressing interpersonal relationships and, if practiced overtime, could result in improved functioning in those relationships" (p. 93). Further, this research indicates to me support for spiritual care providers utilizing spiritual practices to advance their own interreligious competency through spiritual self-care that centers on self-regulatory dwelling in sacred connection.

### Theologies of Trauma, Sacred Relationship, and Practices of Embodiment

Theologian Shelly Rambo (2010) has explored how the space of Holy Saturday, between the crucifixion on Good Friday and the resurrection appearances on Easter Sunday in the Holy Week narratives of Christian traditions, could represent the ways that

"the study of trauma [is] the study of what remains" (p. 15). In her theology of trauma, she has identified trauma as the remainder within life of an encounter with death. Rambo has not jumped ahead to redemption or remained stuck in reliving the events of the past but instead has identified a location in between: a place where life continues yet death remains, and where lament looms. In this middle place, one bears witness to terrible grief, utter weariness, and the survival of love as a sacred relationship that helps one bear the trauma. She has explained that love is a somatically sensed "middle Spirit" (p. 111) that assists in both *tracking* the undertow of trauma and *sensing* life. As the movement of the middle Spirit, sacred relationship here is maintained through dwelling in a Divine felt love that bears suffering with one as a "weary remainder seeking form" (p. 170). This literal sensing of life within the remainder of death that trauma has left behind is just that: a sensuous experience of body, breath, and a kind of ineffable trust in the presence of the sacred as middle Spirit. Middle Spirit does not look away from suffering, gloss over death's encounter, or too quickly rush in with new hope. This "one who remains", remains in love, prior to hope (p. 143–172). This middle Spirit that one encounters between death remaining and life continuing, altered permanently by death, is "where divine and human meet in the middle. … It is the point at which the silent human cry meets the silent divine cry. Spirit meets spirit in the depths" (p. 170), offering an opportunity to dwell in sacred relationship felt in tragedy. Rambo has attested that where death persists, love also remains. One can sense this love, this sacred relationship within suffering, far better bodily or somatically in heartbeat, breath, and aching vibrancy of living flesh, than with any other kind of knowing. It is a kind of tacit knowledge that can

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become revelation and serve as a relational point of both mysterious spiritual trust and a wholeness that includes brokenness.

Drawing on both seeking and dwelling in sacred relationship, theologian Serene Jones (2009) has looked to the crucifixion and a process of devastated yet enlivened embodiment in her theology of trauma. Just as the cross evokes mourning and wonder, similar to Rambo's (2010) idea of grief of the undertow (mourning) and sensing of life (wonder), so too with Jones (2009) does the suffering of trauma find its balm in the sensuous experience of both grief and awe held intimately together as a radical kind of wholeness (note polarity). Jones (2009) has described the world as full of suffering yet also infused with an awesome grace that one can seek, palpably encounter as a felt sense of the sacred, and dwell in through practice or intention. Sacred relationship is felt through grace and awe or wonder in the midst of grief, lament, and loss. To this relationship, Jones added the sacred dimension of cocreativity as participation with God in mystery, akin to participation in a friendly universe. Through her concept of *liturgies of flesh*, Jones has presented a set of somatic practices[73] to sense sacred connection in the aftermath of trauma. This bearing of mourning and awe through "liturgies of flesh" (p. 158) that connect her to grace is her "profoundly presentist vision of life" (p. 165). Jones has said,

> To mourn and to wonder, that is what the spirit yearns for when it stands in the midst of trauma and breathes in the truth of grace. … These are ... states of mind that open us to experience God's coming into torn flesh, and to love's arrival amidst violent ruptures. (p. 161)

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[73] Jones (2009) has outlined these various practices, from yoga to acupuncture, that she has engaged to approach her despair and her integration into a renewed theology of grace in a ruptured world.

Both Rambo's (2010) and Jones's (2009) theologies of trauma speak to Doehring and Kestenbaum (2022) description of the role of spiritual trust in sacred relationships, which I have elaborated as the yearning for a process of embodiment, and the sacred encountered available through the care seeker's weary, torn, and sorrowful flesh, again with brokenness and wholeness held *graciously* together.

Baldwin (2020) has written about embodiment and sacred relationship as care providers:

> As we deepen our personal practice, combining the spiritual practices and disciplines of our traditions with fuller awareness of our embodied felt sense and compassionate curiosity toward the roles, fears, hurts, and wisdoms of our internal system, we become more attuned to the still small presence and voice of divine presence and flow. The more we are able to access this felt sense, the more resilient we become, and the more we can offer healthy leadership and connection to those in our care. (p. 83)

In my spiritually integrated clinical practice, I have observed that when a sacred connection is felt through somatic spiritual practice, a sense of spiritual trust in the sacred (Divine, God, Mystery) can become an abiding or underlying experience of the goodness or *friendliness* within life as well as a reliable relational home. This underlying spiritual trust can remain with one even as a sense of relative safety comes and goes and the care provider encounter ends. With a dynamic yet abiding sense of spiritual trust established through competent spiritual care and cocreative somatic spiritual practices that cultivate dwelling in sacred connection, I have observed that a care seeker is better equipped to navigate spiritual struggles, moral stress, and the complex journey of trauma integration.

**Refusing to Bypass the *Spiritual* in Practice**

Neuroscientific research is demonstrating a positive correlation between some yoga and meditation practices and the cultivation of relaxed alert brain-body states or

neuroplatforms (see Emerson, 2015). In fact, studies indicating the benefits of once

spiritual practices abound (e.g., Emerson, 2015; Gard et al., 2014; Kabat-Zinn, 2009;

Porges, 2017b; Tyagi, 2016). In a correlational study on polyvagal theory and yoga

therapy published in *Frontiers in Human Neuroscience*, Sullivan, Erb, et al. (2018) have

demonstrated a positive correlation between self-regulatory outcomes of yogic practices

and the mental health benefits of a growth in resiliency. The researchers have drawn on

the four gunas of yoga as a "translational framework" (p. 2) for the neuroplatforms

identified in polyvagal theory. They presented a defense of yoga therapy utilizing the

mechanics of ancient yogic practices and emerging evidence on the positive connection

between self-regulation and resiliency with no mention of the possible mediating factor

of spirituality. Although the fields of spiritually integrated psychotherapies and

transpersonal psychology utilize the term *spiritual bypassing*[74] as a way of discussing a

misuse of spiritual beliefs and practices to avoid exploring struggles and stressors, I argue

for caution with regard to *bypassing the spiritual*[75] in spiritually integrated care.

 Sullivan, Erb, et al.'s (2018) study and numerous others like it (see Holt, 2018)

highlight the tremendous health benefits of practices once deemed *spiritual,* thereby

creating an evidence base for the justification of spiritual practice in care. An obvious

utility of omitting the explicitly religious and spiritual aspects of such practices is that

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[74] Psychotherapist John Welwood (2000) has coined the term *spiritual bypassing* as a way to describe using "spiritual ideas and practices to sidestep personal, emotional 'unfinished business,' to shore up a shaky sense of self, or to belittle basic needs, feelings, and developmental tasks" (p. 107).

[75] This is my term drawn from discussions in an MDiv course I teach on spiritual integration. I coined the term as a way of noting how current research into meditation, yoga, chi gong, and other spiritual practices either deliberatively, skillfully, or unintentionally avoids the domain of spirituality. I believe that this omission comes at a cost: the minimization of the richest aspect of these once sacred practices.

age-old practices, once seen as tradition-specific, eccentric, esoteric, idiosyncratic, or simply inaccessible, can be made available for secular wellness consumption, yet omitting the religious worldviews or spiritual orientation and felt sacred relationship once intentionally cultivated through such practices creates an unaccounted-for independent variable—spirituality—in the research itself. Such practices were designed as a spiritual technology, emerging out of religious or spiritual traditions as specific pathways with distinct sacred aims worth acknowledging. Many of these practices are offered prescriptively in current clinical care. I do not take issue with this, yet I believe that competent spiritually integrated care is best served through a cocreative exploration of somatic practices intrinsically meaningful to the care seeker.

### *Cocreating Somatic Spiritual Practice as a Care Praxis*

Out of a felt sense of the sacred initiated in the Vedanta Temple at 19 years old, I sought out spiritual practices that would assist me in seeking deeper connection with and dwelling more fully in felt sacred relationship. Spiritual practices became meaningful anchors in times of distress and seemed to have a direct impact on a sense of trust in myself, others, and life. Such practices sustained me and beckoned me towards research, studies, and clinical care that could incorporate a felt sense of trust in the process of embodiment and sacred relationship. As a gestalt therapist, I have invited clients to dialogically develop personally meaningful, active, and embodied ways of engaging their life dilemmas, suffering, strengths, and untapped somatic wisdom out of the natural experientialism of gestalt therapy theory. Spirituality was not explicitly referenced yet presented itself regularly. For over 15 years, I have actively developed ways of utilizing

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somatic therapies to enhance a felt sense of sacred connection as a route to psychological

and physiological integration and spiritual wholeness.

My dissertation has explored the interconnections among (a) somatic

traumatology and (b) spiritually oriented, intercultural, and interreligious care of spiritual

struggles arising from trauma, and (c) a praxis of cocreating somatic spiritual practices

that encourage a felt sense of trust. The process of cocreating somatic spiritual practices

has three essential ingredients: (a) an available (dwelling) or desired (seeking) sense of

the sacred, (b) an applied somatic (interoceptive) awareness of the felt experience of the

sacred as intrinsically meaningful to the care seeker, and (c) an intentional self-regulatory

method for staying (dwelling) in the felt sense for a period of time. The short-hand way I

describe this process is with these three words: *Sacred, Sense, Stay*. These three tasks are

supported by the process of embodiment and best engaged relationally after an

intercultural and interreligious exploration of the spiritual orientation or the spiritual

home of the care seeker. Through somatic self-reflexivity and spiritual self-differentiation

advanced by the care provider's personally meaningful spiritual practices and

interoceptive awareness, the care provider utilizes spiritual empathy, dialogic heart, and

active mutuality to invite cocreativity. This collaborative exploration is somatic as much

as conversational, experimental, respectful, risky, and enabled by relational and spiritual

trust.

### *The Process of Cocreating Somatic Spiritual Practices with Josie*

*Sacred:* Josie and I searched together for an intrinsically meaningful sense of the

sacred. Josie believes in a Higher Power and is powerfully connected to nature. Sacred

connection is found currently for her through nature. I invited her to bring an image to

mind of sacred landscape and we explored and continue to modify what comes closest in her memory or mind's eye to a sense of Higher Power active through nature. What started as an image of a sunlit blooming rose garden transformed into pure sunlight. I asked her how she knows this is a sacred experience and she responded that "she just knows because she *feels* it." My somatic sense was in resonant synchrony with her at that time. I, too, sensed sacred or the holy, which often comes to me as goose bumps on my arms.

*Sense:* I asked Josie to draw out any and all sensations that connect her with nature, sunlight, and sacred presence. I asked her where she felt it most in her body so that her interoceptive awareness was activated. Through exploratory sensate guided visualization led by spiritual empathy, I assisted her in somatically feeling into and filling out the experience: "What does sunlight feel like on your skin. What other senses get activated as you sense sacred connection through sunlight? Is there a sense you could bring in to enhance the feeling of goodness?" With Josie, a felt sense of sacred (and maybe the ease that comes with spiritual trust) relaxes her. Relaxation often has led her to fall asleep, and so my task was also to keep her alert and on task as she experienced the growing parasympathetic ease or felt goodness of sacred connection.

*Stay:* As a practice, benefit comes from intentionally deepening the experience and remaining in it for a length of time. I encouraged Josie to dwell or linger in the felt sense of the sacred for a time frame of about 5 minutes to start. I utilized deepening breath through instruction to "breath the experience in" and "lengthen the exhale as you yield more fully to the sense of sacred connection" (to sunlight). I continued to touch on embodied awareness or the *felt sense* through spontaneous invitations like "Feel how the sunlight warms every cell in your body starting with your face, as Higher Power touching

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your life directly through sunlight." I encouraged physical cues such as "Place your hand on the part of you where you feel most connected to the sacred" or "See if you can linger in this touching experience a bit longer."

I invited Josie to choose a time and pick a location to practice this somatic spiritual practice each day. I also reminded her to let it evolve or change as is natural and spiritually relational between her and her Higher Power. It keeps evolving. At one point, Josie reported that intentionally standing outside with sunlight on her face was a felt sacred connection that reminded her to trust in her Higher Power.

**Conclusion: Community Care**

The current evidence base of trauma care explicitly names embodiment, or the role of the body, as central to cognitive, emotional, and sensorimotor integration post trauma. The potentially positive role of the body as a nexus for spiritual integration in the aftermath of trauma has been proposed in this dissertation, yet a question remains regarding intercultural or interreligious embodied spiritual care in the aftermath of traumatic events that rupture *whole communities*, as found in contemporary secular society. How does an intrinsically meaningful somatic and cocreative invitation to lament that generates provisional spiritual trust occur in a small or large group of people?

I sit five blocks from the Boulder, Colorado mass shooting of 2021, where 10 people lost their lives at a local supermarket. Attending the south Boulder (the neighborhood where the shooting took place) community vigil just days after the shooting, I experienced a wave of piercing sadness unlike the private sadness in which I previously had been emersed. On this day, the sense of grief was not solely for the lives lost and directly terrorized but more distinctly for the lost community to which I was

bearing witness. What I observed across a few hours was a community grappling for meaning, strength, and connection through political and psychological tools utterly incapable and wholly unworthy of holding the magnitude of despair, terror, and confusion present in the crowd of over 4,000 neighbors.

As we grappled together at the vigil with secular psychological frames of reference such as psychological trauma theories, lost sense of safety, therapeutic support resources, and political outraged pleas such as for gun control reform, I felt a growing emptiness and a sharp longing emerge. Self-reflexively careful not to paint my own longing across the crowd, I judiciously enquired with those around me. As I listened to my neighbors, the speakers, and later reached out to my local friends and clients, an insight arose: As we empty psychological and cultural frameworks of philosophical and moral inquiry and spiritual/religious meaning-making, we are left with an inadequate way of holding those events and aspects of existence that supersede, rupture, and utterly rock shared communities.

I felt the yearning that day to receive and offer *intercorporeal* (Sigurdson, 2008) and cocreative community spiritual care judiciously informed by religious traditions that have grappled with suffering across thousands of years and that hold the potential to deeply activate the embodied lament, spiritual trust, and varied connection to the sacred of the community before me. I felt the desire to contribute, not to hopelessness or the "data of despair" (McCarroll, 2014, p. 12), but rather to engage trustworthy practices of lament together. Lament does not offer psychological tools or political answers. Lament places a demand directly upon spiritual resources and moves us beyond human agency alone. I felt the desire to lament with my neighbors in ways that cried out to and called

upon whatever we each could find personally spiritually relevant and worthy of holding

the magnitude of such a tragedy. I felt the desire to share in sacred relationship where one

can encounter, even demand, Divine response.

A *felt* sacred relationship is a relationship with some aspect of what one deems

sacred, not in belief, thought, metaphor, or wish alone, but rather within and reaching

from one's very cells as a spiritually trusted, relational aspect of life. This is a feeling of

connection with mysterious kindness, grace, Love, tenderness, encouragement,

compassion, radical hope,[76] and *friendliness* occasionally vividly palpable in times of

tragedy. In Rambo's (2010) theology of trauma, for instance, she has narrated the

emergence of the middle Spirit the day after Christ's disciples were brutally robbed of

their teacher and prior to hope of his redemption. In their silent despair, there remained a

broken, weak, and witnessing *Love*. The love in the form of middle Spirit did not take

away any pain, did not offer a cheap solution, did not make any promises yet whispered a

trustworthy, felt sacred connection as a relationship capable of holding the magnitude of

the traumatic grief.

Witnessing an image of two planes crashing into the Twin Towers on September

11, 2001 from the campus of Naropa University, Treneater-Nur Horton spontaneously

stood up on "the green" and began to loudly sing *Amazing Grace*. As their powerful

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[76] *Hope* is, broadly, a "feeling of expectation and desire for certain things to happen" (Oxford University Press, 2021, def. 1). Philosopher Jonathan Lear (2006) has defined *radical hope* as a present rather than future goodness that transcends all ability to understand it, a kind of "imaginative excellence" (p. 117) that seems to require a felt sense outside of what is reasonable or expectable. Radical hope is a holding out of hope in a rationally hopeless situation. It is rooted not in an expectation or desire but rather in a felt sense of trust beyond all proof or reckoning. This is a kind of spiritual trust that I link with sacred relationship due to its awesome, immanent–transcendent, and confounding nature.

voice boomed over and then wrapped around the dazed 300-plus students, faculty, and

staff, I felt something like the middle Spirit move within and between us as we swayed,

cried out, sang along, chanted, prayed, meditated, practiced tong-lin, and grappled

together with what was unfolding. I yearned for something like this brave and risky,

interconnective, cocreated and sacred movement at the neighborhood vigil but found

instead the tentative offering of mental health tools and social activism pleas. In speaking

of the need for religious and spiritual life to more fully engage trauma healing, Baldwin

(2020) has stated,

> Reorienting our spiritual-community care and liturgy leadership from a word-
> oriented and centered practice to a body-oriented and centered practice can be a
> significant shift, especially for those of us who were trained to privilege language,
> message, and "left-brain" leadership over "right-brain" practices. (pp. 84-85)

As intercultural and interreligious spiritual care providers, how can we offer or suggest

cocreative, somatic spiritual practices in the aftermath of community trauma where

sacred relationship is evoked while honoring both alterity and common intercorporeal

humanity? Although the field of practical and public theology is endowed with the

resources to continue to answer this question much better than I can, the unique

contribution of this proposed praxis is to invite the process of embodiment to inform

lament and integration through an evoked felt sense of spiritual trust.

As the sun set across *the green* that day in 2001, the rays kissed the mountain tops

red, orange, and gold, soothing those of us that remained. In the aftermath of the South

Boulder shooting last year, my small sons climbed the trees framing the high school

parking lot vigil and remarked that the thousand points of candlelight looked as beautiful

as the setting sun on the Flatiron Mountains. A shock of love coursed through me with

their innocent words. I recalled the words of Sri Aurobindo (1995), "Mountains and trees stood there like thoughts from God" (Book V, Canto III, pp. 404–406). and softly chanted a prayer to the sun—a prayer for us all, a prayer of reverence for Her trustworthy return.

<div align="center">

Om Bhur Bhuvaḥ Swaḥ

Tat-savitur Vareñyaṃ

Bhargo Devasya Dheemahi

Dhiyo Yonaḥ Prachodayāt

—Gayatri Mantra[77]

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[77] Gayatri or Savitri (Sun) Mantra is an ancient Vedic chant from the Rig Veda. Sri Aurobindo's (2007) translation is "We choose the Supreme Light of the divine Sun; we aspire that it may impel our minds" (pp. 58–59).

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## Appendix

## Dedication

To my mother, Angela Creaven, who allowed me to be a free-thinker and to live unmoored by convention and supported this project with her own labor and generosity; and to my Godmother, Emma-Shivani Brown, who taught me to be a deep-thinker and to live with reverence and supported this project by being a reminder of my most beautiful spiritual discoveries. I am deeply grateful for these *Two Mothers*.

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