

FAITH AND FLOURISHING **AMERICAN ASSOCIATION of CHRISTIAN COUNSELORS**

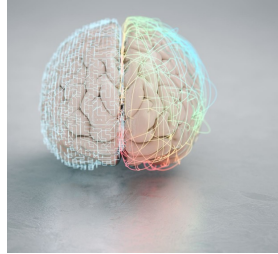
Traumatic Memory: Tools for Helping Clients Tolerate and Integrate the Past

HANDOUT



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Human Memory

Memory happens in 3 stages in the brain

1. Encoding – taking in sensory details from an event
2. Storage – Keeping the information in the brain
3. Retrieval – Pulling the memory back up when you need it

****If anything disrupts one of these steps, the memory changes.**

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Video

3



Traumatic Memory

Key Characteristics of Traumatic Memories
Because the brain is functioning differently during trauma (Acute Stress Response) trauma memories are encoded differently

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Trauma and the Brain

- High levels of stress hormones (adrenaline and cortisol) flood the brain during a crisis
- The Acute Stress Response impairs performance of the prefrontal cortex. Emotional regulation and reasoning shuts down
- Amygdala and survival instincts take over
- Time keeping is shut off and the ability to file data in a chronological sequence (story) is impaired

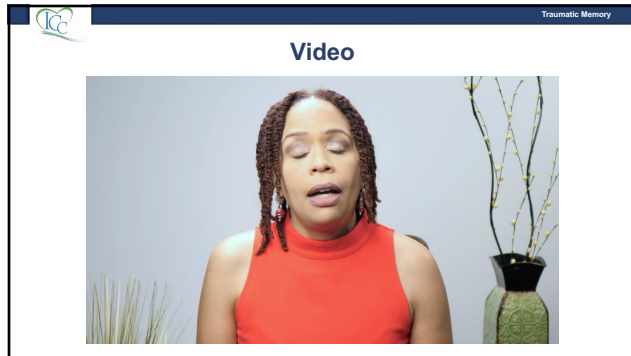
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Characteristics of Traumatic Memory

- **Sensory overload**- Memories are filled with intense sights, sounds, smells, physical sensations and strong emotion but without a logical order or process.
- **Intrusive recollection** (flashbacks) – Fragments of the memories or the sensory components can reappear without warning as flashbacks, nightmares or sudden waves of emotion
- **Triggers** – Everyday sensory inputs (sights, sounds, smells or sensations) can activate the body's flight-or-flight response making a person feel as though the danger is happening all over again

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Traditional Trauma Treatment

Evidence-based therapies for Trauma

- CPT – Cognitive Processing Therapy
- Trauma-Focused (or informed) Cognitive Behavioral Therapy
- Prolonged Exposure Therapy
- EMDR – Eye Movement Desensitization and Reprocessing

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New Techniques Developing at a Rapid Pace

- New techniques focus more on how trauma impacts the brain and the body
- Better understanding that trauma impacts the whole person and traditional “talk” therapies have limits in addressing trauma locked into subconscious/subcortical patterns

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Types of Memory

1. Explicit Memory – What we consciously remember (sometimes called declarative memory)
 - A. Semantic – facts and details of the memory
 - B. Episodic – stories and experiences with emotions attached.

Traditional talk therapies can assist with reframing feelings attached to the stories and experiences as well as the view of self or behavior that may have formed with those memories

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Types of Memory

2. Implicit Memory – is stored in the brain, but not in conscious memory. We can't retrieve it at will- it lives deeper in the nervous system.
 - A. Emotional – strong emotions triggered without a conscious connection to why
 - B. Procedural – things we do regularly and don't need conscious memory. These procedural memories create behavior that is repeated. Driving a car, riding a bike, etc.

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Traumatic Memory

- When trauma memories are not processed in a normal, healthy way – they can get stuck.
- In PTSD flashbacks, the nervous system does not differentiate between original trauma and flashback

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Language Matters

PTSI

VS

PTSD

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Trauma Can Affect Memory in Many Ways

1. Time keeping part of the brain is not functioning
2. Short term memory can be damaged
3. Episodic memory can be shut down
4. Emotional memory can be altered and painful emotions and sensations may be triggered without context

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Types of Memory

- Traditional therapy can assist with explicit memory
- What does it do implicit memory?
 - We must try to retrieve memory
 - This can be problematic for many reasons
 - -Retraumatizing
 - -False memory
 - -Sometimes the process can lock in emotions and procedural memories rather than release them

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Talking About the Trauma

- Traditional wisdom says you must talk about and relive the trauma
- Most trauma therapists will now say -that is not always necessary and can even be harmful in some cases

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New Approach to Treating Traumatic Memory

- Newer models may not involve trauma "story telling"
- Always look in the present for where trauma is showing up rather than starting by revisiting the past
- A great question "Have you ever fully told your story and is there any part that has been so painful that you have never been able to give voice to it?" (A horse and a timeline)

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Reasons Trauma Memories are Not Explicit

- Content is overwhelming
- Trauma happened with person was pre-verbal
- Brain was impaired

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Implicit Memory

- Can be stored by nervous system and the system responds to triggers without conscious awareness
- Can be stored as procedural memory – they “learn” to respond to emotions in a specific way – usually not rational or helpful

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Look for Trauma in Present

1. Movement
2. Vocal patterns and tone of voice
3. Breathing
4. Facial reactions/coloring
5. Thought processes

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TRAUMA-HELPING MODALITIES

A Field Guide for Helpers

Seventeen approaches — who developed them, how they work, and what they're best for

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One Nervous System, Many Doors In

Trauma is stored in both mind and body, so no single modality fits every person or every kind of loss. These seventeen approaches offer different doors into the same work: helping a dysregulated nervous system, and a wounded story, find their way back toward safety.

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Five Families of Trauma Treatment

1. **Cognitive & Exposure-Based**
Structured, talk-based protocols that directly process the trauma memory or the beliefs it left behind.
2. **Eye Movement & Bilateral Stimulation**
Approaches built on EMDR's discovery that bilateral stimulation helps the brain reprocess stuck memories.
3. **Body-Based & Somatic**
Work that starts in the body's sensations and reflexes rather than in words.
4. **IV: Parts-Based & Nervous-System**
Approaches addressing the internal structure of the psyche or training the nervous system's sense of safety directly.
5. **V. Emerging & Technology-Integrated**
Newer tools — EEG, virtual reality, and medication-assisted protocols — that extend or accelerate the work above.

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I

SECTION

Cognitive & Exposure-Based Approaches

The most heavily researched, guideline-recommended treatments for PTSD — often the first approaches you may have missed on a body-focused list.

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Cognitive Processing Therapy & Prolonged Exposure

- 1. Cognitive Processing Therapy (CPT) — Patricia Resick, developed late 1980s, manualized 1993**
A structured, typically 12-session protocol that targets "stuck points" — trauma-distorted beliefs about safety, trust, and self-blame — through guided cognitive restructuring. Grew out of Resick's work with sexual-assault survivors and Aaron Beck's cognitive therapy. Widely used by the VA/DOD. Best for: clients ready to examine and rework trauma-related beliefs in a time-limited format.
<https://www.va.gov/opa/pressrel/2006/p06-001.asp>
- 2. Prolonged Exposure (PE) — Edna Foa, developed 1980s, foundational trial published 1991**
Pairs deliberate, repeated revisiting of the trauma memory (imaginal exposure) with gradual real-world exposure to safe but avoided situations (in vivo exposure), based on emotional processing theory. One of the most well-supported PTSD treatments in the research literature. Best for: breaking an avoidance cycle that is actively shrinking someone's life.
<https://www.va.gov/opa/pressrel/2006/p06-001.asp>

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II

SECTION

Eye Movement & Bilateral Stimulation

A family of approaches descended from a single 1987 discovery — that bilateral stimulation, held alongside a disturbing memory, helps the brain finish processing it.

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EMDR & Brainspotting

- 3. EMDR (Eye Movement Desensitization & Reprocessing) — Francine Shapiro, 1987**
An 8-phase protocol in which the client briefly holds a disturbing memory in mind while tracking bilateral stimulation (eye movements, taps, or tones), allowing the brain's natural information-processing system to reprocess and desensitize it. One of the most researched trauma treatments, endorsed by the APA, WHO, and Department of Defense. Best for: single incident and complex trauma alike.
<https://www.va.gov/opa/pressrel/2006/p06-001.asp>
- 4. Brainspotting — David Grand, 2003**
Discovered during an EMDR session when Grand noticed a client's eyes "stuck" on a spot tied to intense emotional activation. A "brainspot" — an eye position correlated with unprocessed activation — is located and held, with little verbal direction. Best for: clients who find sustained talk or continuous eye movement overstimulating.
<https://www.va.gov/opa/pressrel/2006/p06-001.asp>

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AIP Model & EMDR 2.0

- 5. The Adaptive Information Processing (AIP) Model**
Francine Shapiro's underlying theory of EMDR
Proposes that the brain has an innate system for processing experience toward adaptive resolution — much like the body heals a physical wound. Trauma disrupts this system, leaving memories "stuck" in raw, unprocessed form and driving symptoms of PTSD and related disorders. EMDR's protocol exists to reactivate this natural processing.
<https://www.va.gov/opa/pressrel/2006/p06-001.asp>
- 6. EMDR 2.0**
A refinement built on Working Memory Theory
Adds structured working-memory training tasks (visual, verbal, or motor) while a memory is held in mind. Because working memory has limited capacity, competing for it with a dual task reduces the vividness and emotional intensity of the memory — a mechanism confirmed in research since 2008. Best for: accelerating reprocessing on memories that feel especially "stuck."
<https://www.va.gov/opa/pressrel/2006/p06-001.asp>

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III

Body-Based & Somatic Approaches

Five approaches that work through the body's sensations, reflexes, and pressure points rather than through narrative alone.

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Somatic Experiencing, Sensorimotor Psychotherapy & TRE

- 7. Somatic Experiencing (SE) — Peter Levine, 1970s**
Grew from Levine's observation that wild animals discharge survival energy after a threat (through shaking and movement) and rarely show lasting trauma. SE renegotiates trapped activation through pendulation (oscillating between activation and calm) and titration (approaching distress in very small doses). Best for: freeze, shutdown, and dysregulated nervous-system states.
<https://www.va.gov/opa/pressrel/2006/p06-001.asp>
- 8. Sensorimotor Psychotherapy — Pat Ogden, early 1980s**
Co-founder of the Hakomi Institute. Ogden built a method that tracks body sensation and movement alongside cognitive and emotional processing, integrating mindfulness, Gestalt therapy, and Hakomi. Best for: attachment trauma, dissociation, and patterns held in posture and movement.
<https://www.va.gov/opa/pressrel/2006/p06-001.asp>
- 9. Trauma Release Exercises (TRE) — David Berceli, early 2000s**
Developed while Berceli worked in war zones and disaster areas, where he noticed people spontaneously trembled after acute stress. TRE uses a sequence of exercises to intentionally evoke this same neurogenic tremor, discharging stored tension. Best for: group settings and self-directed nervous-system release.
<https://www.va.gov/opa/pressrel/2006/p06-001.asp>

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DEFINITION & ORIGIN

A Fixed Gaze Point That Unlocks the Body's Story

Brainspotting (BSP) is a body-based therapy that uses a fixed eye position — a “brainspot” — correlated with unprocessed emotional activation. David Grand, PhD, discovered it in 2003 mid-EMDR session, when he noticed a client's eyes “stuck” on a spot tied to intense activation. Rather than continuous eye movement or sustained talking, the therapist attunes to the client and holds a single spot in the visual field, letting the body process with minimal verbal direction.

Grand Foster Curriculum — What is Brainspotting?

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THE MECHANISM

It Reaches Where Talk Therapy Can't

“It isn't just PNS activation that is facilitated, it is homeostasis.” — Robert Scaer

Focusing on the brainspot engages a retinocollicular pathway — from the eyes through the superior colliculi to the midbrain, thalamic pulvinar, and subcortical loops through the basal ganglia — reaching the amygdala, hippocampus, and brainstem: the same deep, pre-verbal structures where traumatic activation is stored as raw sensation, not narrative. This is why brainspotting can access material a client cannot yet put into words.

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APPLICATION

How It Helps With Trauma

- Access without re-narrating the story.**
Because it works through the body and the visual field rather than verbal retelling, it can help survivors process trauma too overwhelming or fragmented to talk through.
- A gentler alternative for the overstimulated.**
Clients who find sustained talk therapy or EMDR's continuous eye movement too activating often tolerate brainspotting's single, held gaze point and slower pace better.
- A growing evidence base.**
A multinational study (Hildebrand et al., 2017) found brainspotting and EMDR similarly effective at reducing PTSD, depression, and anxiety symptoms; small trials with veterans and pilot samples show meaningful symptom reduction within just a handful of sessions.

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Traumatic Memory

What Is the Window of Tolerance?

The Window of Tolerance describes the optimal zone of arousal for a person to function in everyday life. It's the emotional “sweet spot” between being overwhelmed and shutting down.

For someone with PTSD, trauma reshapes the nervous system — the window itself becomes narrower, so ordinary moments can tip a person out of it far more easily.

WITHIN THE WINDOW, A PERSON CAN:

- Think clearly
- React rationally
- Feel and offer empathy
- Feel present and safe
- Adapt their response to fit the situation

The Window of Tolerance & PTSD — Grand Foster Curriculum

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Traumatic Memory

The Three Zones of Arousal

HYPERAROUSAL <i>fight / flight — alarm activated</i>	Above the window: the nervous system sounds an alarm and pushes activation up into hyperarousal.
WINDOW OF TOLERANCE <i>calm, connected, able to think and respond</i>	Below the window: an overloaded parasympathetic system pulls activation down into shutdown or dissociation.
HYPOROUSAL <i>freeze / shutdown — system overloaded</i>	<i>A person moves in and out of this window throughout the day — the goal of regulation work is to widen the window and shorten time spent outside it.</i>

The Window of Tolerance & PTSD — Grand Foster Curriculum

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Hyperarousal — Above the Window
Trauma reminders trigger an "alarm" response that pushes activation up

- Angry outbursts and impulsivity
- Fear and flashbacks
- Anxiety and racing thoughts
- Sleep disturbances
- Hypervigilance and panic
- Muscle tension and trembling
- Emotional overwhelm
- Difficulty concentrating
- "Deer in headlights" freeze responses

The Window of Tolerance & PTSD — Grief Center Curriculum

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Hypoarousal — Below the Window
An overloaded system shuts down, producing numbness or dissociation

- Depression and emotional numbness
- Physical lethargy and disconnection
- Memory loss and cognitive impairment
- Dissociation and a blank stare
- Shame and inability to speak
- Slowed digestion, dropped blood pressure
- Flaccid, collapsed body posture

The Window of Tolerance & PTSD — Grief Center Curriculum

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How PTSD Narrows the Window

Trauma literally changes brain structure. As a result, people with PTSD live with a narrower window of tolerance than others — seemingly ordinary, innocent triggers can readily activate hyperarousal or hypoarousal, and with greater intensity.

A WIDER WINDOW

more time spent regulated and able to cope

A NARROWED WINDOW (PTSD)

small triggers tip the system into hyper- or hypoarousal fast

The Window of Tolerance & PTSD — Grief Center Curriculum

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Key Factors in Effective Trauma Therapy Across techniques

1. Safety – How do you create safety with clients
2. Stabilization & Regulation – Helping clients regulate nervous system in and outside of sessions
3. Slow measured approach – First do no harm
4. Find where the past shows up in the present
5. Assist client with skills they can use to manage triggers and memories when they are not in session

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Safety

- Helper must be a safe person
- Christ-centered – Holy-spirit led
- Steady, compassionate and empathetic presence
- Don't have your own agenda

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Safety

- View client as a whole person
 - Look at all aspects of a person's life- not just their diagnosis or symptoms
 - Other aspects of their life where trauma is manifesting?
 - Lifestyle or habits that are keeping trauma locked in rather than releasing?
 - Find and utilize their strengths – see their gifting

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Traumatic Memory

Safety

- Hold their story safely
- Listen with compassion
- Hear without judgement
- Give them time and space

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Traumatic Memory

Safety

Collaborative approach

- Be careful about being highly directive
- Be more collaborative in problem-solving
- Solicit client to find solutions that work for them with the new knowledge there are gaining from psychoeducation

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Traumatic Memory

Safety

- Convey value, worth and care to the client
- See them as God sees them

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Traumatic Memory

Regulation

1. Build resources for client
2. Increase coping and regulation skills
3. Grounding
4. Shifting to parasympathetic

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Traumatic Memory

Regulation

- Focus more on this with highly emotionally reactive/angry clients
- They will create more life problems and trauma if they don't learn to regulate
- Change self-talk
- Change internal self-evaluation
- More self-compassion

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Traumatic Memory

Regulation

Survival Skills

- Enhance positive coping
- Decrease maladaptive strategies
- Shift from sense of powerlessness to "I've got this"

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Regulation

- Build the power of imagination
 - Can they envision what healing looks like?
 - Can they see themselves reacting differently? How would you like to respond?
 - Experiential work - somatic experiencing - inner child work - psychodrama

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Regulating the Nervous System for Grief and Trauma Work

Sympathetic & parasympathetic balance, the vagus nerve, and practices that help

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Two Branches, One System

S Sympathetic Nervous System
"fight, flight, or freeze"

- Mobilizes the body for threat or action.
- Raises heart rate and blood pressure; diverts energy away from digestion.
- Necessary and protective — the body's "gas pedal."
- In grief: activated by acute loss, triggers, anniversaries, sudden reminders.

Source: American Institute of Stress; Simply Psychology (AAS overview)

P Parasympathetic Nervous System
"rest, digest, and connect"

- Conserves energy and restores the body.
- Lowers heart rate and blood pressure; supports digestion and healing.
- The body's "brake pedal" — returns the system to baseline.
- In grief: needed to feel safe enough to process, remember, and integrate loss.

Source: American Institute of Stress; Simply Psychology (AAS overview)

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Why Grief Work Needs the PNS

- Grief work happens in the body, not just in conversation.**
Processing loss means feeling it in a nervous system that can tolerate the feeling — not just talking about it from a safe intellectual distance.
- The "window of tolerance" (Dan Siegel) names the zone that makes this possible.**
Inside the window, a person can feel real grief — sadness, anger, longing — while staying connected to themselves and others. Outside it, they can't.
- Grief pushes people toward both edges of the window.**
Hyperarousal looks like panic, agitation, or anger; hypoarousal looks like numbness, dissociation, or collapse. Neither can do the deeper work of grief.
- Helping someone reach the PNS isn't a detour from grief work — it is what makes grief work possible.**
A regulated body can stay present with pain long enough to move through it, rather than around it.

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The Polyvagal Ladder

- Ventral Vagal — Safety & Connection**
Calm, socially engaged, present. Grief can be felt and shared here — talking, crying, connecting, remembering.
- Sympathetic — Mobilization**
Anxious, agitated, can't sit still, irritable or angry. The threat response is active; grief work stalls.
- Dorsal Vagal — Shutdown**
Numb, frozen, dissociated, collapsed. The system has gone offline; the person may seem "not there."

Regulation practices move you up.

Source: Porges, S. W. — Polyvagal Theory (2004, 2011). Frontiers in Behavioral Neuroscience (2012) clinical review

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II

Practices That Help People Regulate

Breathwork, meditation, spiritual practice, and simple vagus-nerve techniques that help move someone from threat toward safety.

"Be still, and know that I am God."

Psalm 46:10

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PRACTICES - BREATHWORK

Breathwork

1

Physiological Sigh

Two inhaled through the nose (the second short, topping off the lungs), then one long exhale through the mouth. A 2023 Stanford RCT (Cell Reports Medicine) found this pattern improved mood and lowered resting respiratory rate — 3-3 breaths can shift state in real time.

2

Extended Exhale

Simply making the exhale longer than the inhale directly stimulates the vagus nerve and signals safety to the body — one of the most consistent, evidence-backed calming techniques available.

3

Box Breathing

Inhale 4, hold 4, exhale 4, hold 4. A simple, teachable pattern that slows heart rate and gives an anxious mind something concrete to follow — useful to teach directly to grieving clients.

Source: Berman, M. S. et al. (2023). Brief structured respiration practices enhance mood and reduce physiological arousal. Cell Reports Medicine, 4(5).

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PRACTICES - MEDITATION & MINDFULNESS

Meditation and Mindfulness

Heart Rhythm Meditation

A slow, deep breath paired with attention on the heart. A 2024 study found effects approaching significance for HRV and vagal tone, with well-being gains for those practicing 10+ minutes a day.

Mindfulness meditation

Generally supports vagal activity and stress recovery — but effects vary by style. The slow-breathing component appears to matter more than the “mindfulness” label itself.

Self-compassion & emotion-regulation training

Research shows better HRV recovery specifically after a stressful moment — directly relevant to the sudden emotional spikes that come with grief triggers.

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PRACTICES - SPIRITUAL PRACTICE

Spiritual Practices

Prayer & Contemplative Prayer

Centering prayer, lectio divina, and similar practices are slow, repetitive, and often paired with breath — a spiritual discipline that is, physiologically, also a nervous-system practice.

Singing, Chanting & Hymns

The extended exhale and vocal vibration of singing or chanting engage the same throat and vagal pathways as humming — worship and vagal regulation share a mechanism.

Sabbath & Rest Rhythms

A built-in cultural permission to stop mobilizing and let the body rest — a corporate, repeated practice of moving the whole community toward the PNS.

Meeting people in their own language

These practices matter in grief work because they offer a doorway into regulation that fits a person's own faith and tradition, not only a clinical technique.

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PRACTICES - VAGUS NERVE HACKS

Vagus Nerve Hacks

1

Cold Exposure

Splash cool water on the face, or a brief cold shower. “Dips the face reflex” — heart rate drops almost instantaneously, deepening with breath conditions.

2

Humming & Singing

Vibration in the throat (known as “humming bee”) excites the vagus nerve, heart rate variability and vagal tone.

3

Gargling

Vigorous gargling with room-temperature water, “old remedy,” a few times a day — engages the same throat muscles as the vagus nerve.

4

Slow Exhale

Exhaling longer than you inhale is one of the simplest, most direct evidence-backed vagal activation exercises anywhere, anytime.

5

Touch & Co-Regulation

A steady hand, a hug, or simply sitting with a calm, regulated person are one nervous system borrow sitting from another.

Effects of humming, singing, and gargling are real but subtle and short-lived — low risk, good as a repeatable daily habit rather than a one-time fix.

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PRACTICES - SELF-REGULATION

Regulate Yourself First

- 1** **You cannot lead someone to a state you cannot access yourself.**
Co-regulation starts with the facilitator's own regulated nervous system — your calm is the intervention before any words are spoken.
- 2** **Before a hard conversation, settle your own system.**
One physiological sigh, a slow exhale, or a moment of prayer or centering can shift you back toward ventral vagal safety before you sit down with someone.
- 3** **The nervous system reads safety from another nervous system.**
A person in distress often regulates faster in the presence of someone calm than through any technique alone — presence is the delivery mechanism.
- 4** **These are supportive tools, not medical treatment.**
For clients with cardiac conditions, trauma-related dissociation, or panic disorder, coordinate with their medical or mental health provider before introducing new techniques.

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PRACTICES - TIMING

Timing

- First, do no harm
- Don't retraumatize
- Don't overwhelm the nervous system
- Clients can't process when dissociated
- But if it happens- use it to teach stabilization skills

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The Past in the Present

- Where is the trauma showing up today?
- In real time- in the session – notice shifts and changes in the client
- What just happened?
- If it shows up in life- at work – with spouse- deal with that in real time

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Skills to Manage Triggers and Memories

- Help clients see the patterns of coping that thwart their ability to learn new ways to manage memories
 - Self-medication
 - Isolation
 - Destructive self-talk

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Help Clients Manage Triggers and Skills

- Develop healthy coping and lifestyle choices
 - Habits to calm nervous system and reset
 - Healthy social support
 - Prepare for hijacking that can't be avoided
 - Avoid highly dysfunctional situations and people

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Gratitude & Healing

How Gratitude Supports Recovery From Trauma and Grief

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Gratitude

- **Growth and Flourishing through Gratitude:** Dr. Catherine Hart Weber
- Chapter 6: Gratitude in hard times challenges, suffering grief and resilience
- Practices that re-wire the brain and body



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How Gratitude Helps the Brain Heal

"Gratitude shifts the nervous system from isolating survival mode into one of connection."

Gratitude activates the prefrontal cortex and anterior cingulate cortex — regions tied to reward, bonding, and emotional regulation — helping shift the brain's focus from threat detection toward recognizing safety. Trials link gratitude practice to measurable increases in heart-rate variability and vagal tone over time: the same shift from sympathetic mobilization toward ventral-vagal safety this curriculum has traced throughout grief and trauma work.

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Gratitude in Grief & Trauma Work

- 1 It supports post-traumatic growth.**
Survivors who practice gratitude are more likely to find meaning after loss or trauma — one thread of the growth this curriculum has covered elsewhere.
- 2 It coexists with grief — it doesn't replace it.**
Bereaved parents describe gratitude as a complex source of comfort alongside pain, not instead of it; holding both predicts greater resilience over time.
- 3 Caution: don't force it early.**
For a trauma survivor, gratitude can initially feel foreign or triggering. Healing begins with safety, not manufactured positivity — gratitude works downstream of acknowledgment, never as a bypass around it.

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Two Kinds of Change

- 1 First-Order Change**
 - Change within a system — the system's structure stays the same.
 - Doing more of the same, or less of the same.
 - Aims to reduce the symptom, not change the rules underneath it.
 - Grief example: "I'll just stay busier."
"I'll try to feel normal again."
- 2 Second-Order Change**
 - Change OF the system itself — the structure and rules shift.
 - Qualitative, discontinuous — a leap to a new way of functioning.
 - Cannot be reached by doing the old strategy harder.
 - Grief example: building a new identity and worldview that includes the loss.

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Big Godder or Little Godder?



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What if...? How big is your God and how are you connected?

Romans

8:28

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¹⁸ I consider that our present sufferings are not worth comparing with the glory that will be revealed in us. ¹⁹ For the creation waits in eager expectation for the children of God to be revealed. ²⁰ For the creation was subjected to frustration, not by its own choice, but by the will of the one who subjected it, in hope ²¹ that the creation itself will be liberated from its bondage to decay and brought into the freedom and glory of the children of God.

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²² We know that the whole creation has been groaning as in the pains of childbirth right up to the present time. ²³ Not only so, but we ourselves, who have the firstfruits of the Spirit, groan inwardly as we wait eagerly for our adoption to sonship, the redemption of our bodies. ²⁴ For in this hope we were saved. But hope that is seen is no hope at all. Who hopes for what they already have? ²⁵ But if we hope for what we do not yet have, we wait for it patiently.

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Traumatic Memory

²⁸ And we know that in all things God works for the good of those who love him, who¹⁴ have been called according to his purpose. ²⁹ For those God foreknew he also predestined to be conformed to the image of his Son, that he might be the firstborn among many brothers and sisters. ³⁰ And those he predestined, he also called; those he called, he also justified; those he justified, he also glorified.

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Traumatic Memory

²⁶ In the same way, the Spirit helps us in our weakness. We do not know what we ought to pray for, but the Spirit himself intercedes for us through wordless groans. ²⁷ And he who searches our hearts knows the mind of the Spirit, because the Spirit intercedes for God's people in accordance with the will of God.

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Traumatic Memory

Resources

- Flourishing through adversity podcast
- www.resetlifecoaching.net
- Click the **Resources** tab for handouts

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