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VOL. 24 NO. 1

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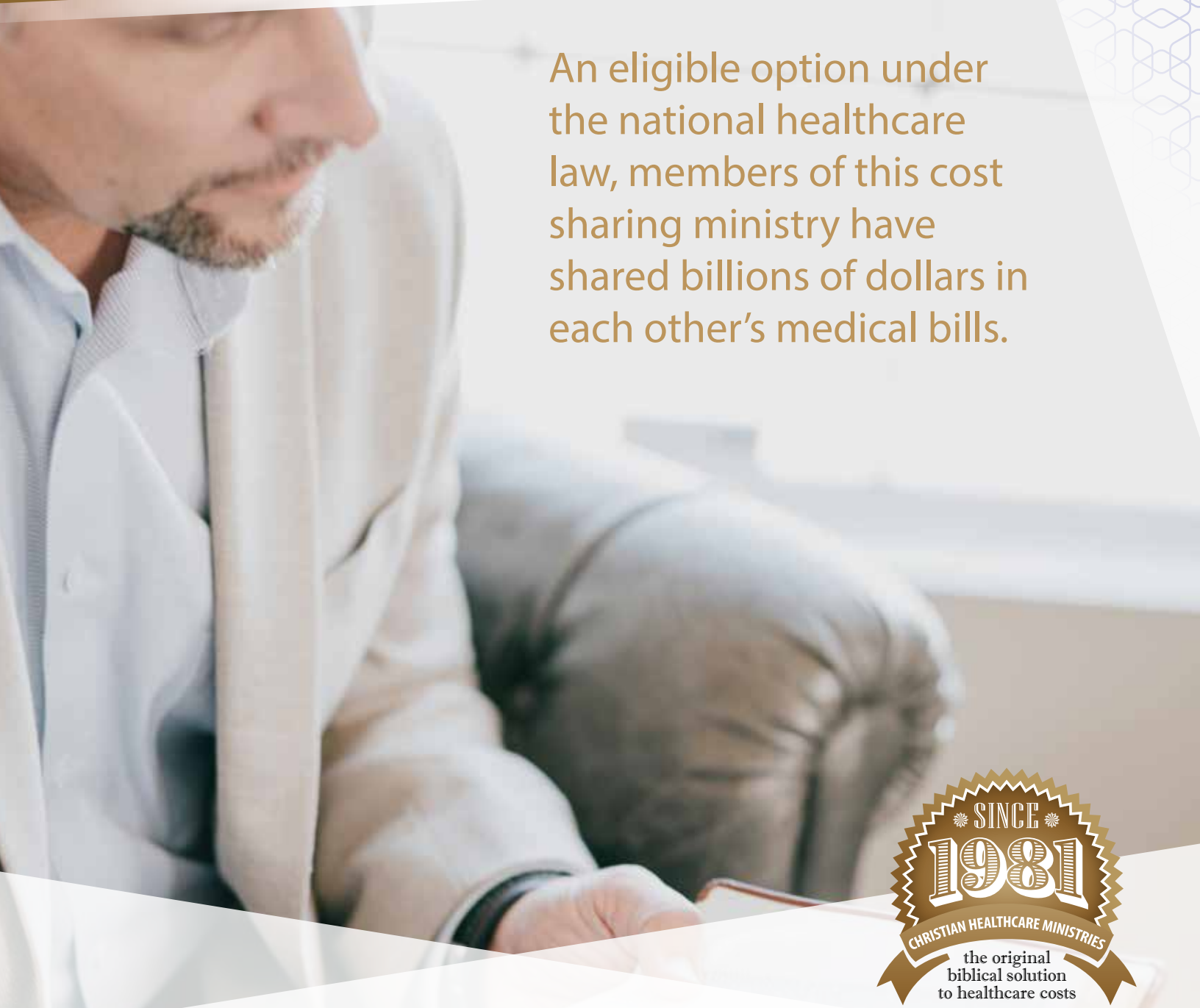

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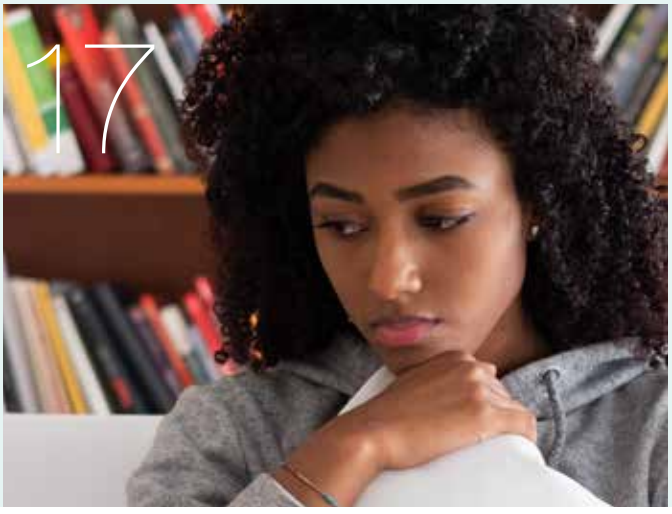

CHRISTIAN
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departments

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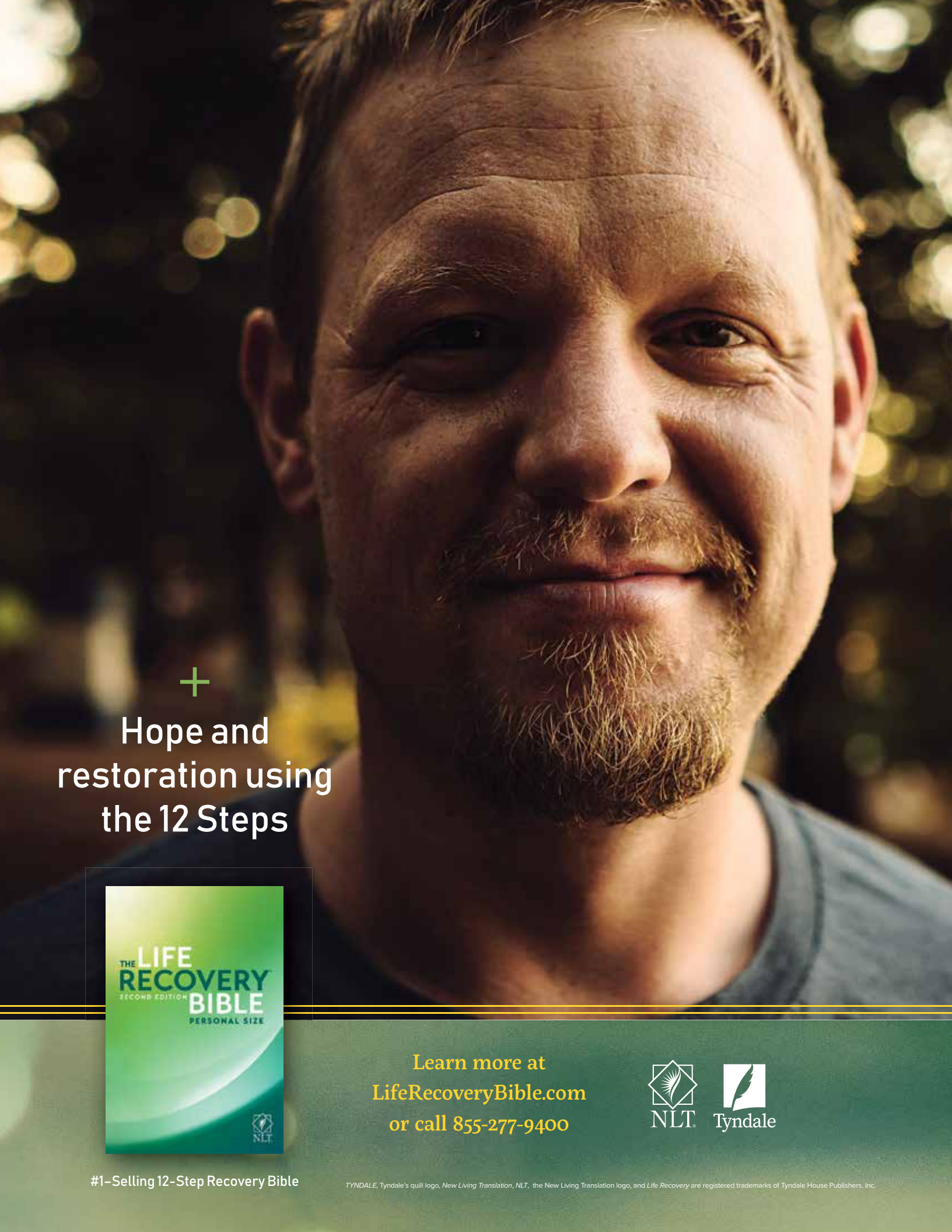
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« TIM CLINTON, ED.D., LPC, LMFT

Know Your "Why For"

"So teach us to number our days, that we may apply our hearts unto wisdom." – Psalm 90:12, KJV

It is often said that old sailors can smell land before they get there. My dad was like that.

One of those, who television journalist and author, Tom Brokaw, called "The Greatest Generation," was James Edward Clinton, who joined the United States Navy as a teenager and served on the USS Pennsylvania during World War II. In our old farm home next to the bathroom door, there used to hang a plague from his military service. I would often hold it and think it was just amazing that he served and fought in that war. It also started close family conversations about his scary memories of being on a warship in the South Pacific while being torpedoed and attacked. A young sailor who was shipped half-way around the world and, without question, shell-shocked by this patriotic service, he was so happy to get back stateside that he kissed the ground when they ported. Dad was so grateful to God to be alive and could not wait to get back to his roots in DuBois, Pennsylvania, and be at home with his family. A "God and country" man, my dad carried his Bible everywhere and flew an American flag in the yard until the day he died.

Growing up with Central Pennsylvania "coal country" patriotic roots, one of my favorite television commercials was of a soldier on a plane returning to the States with a

caption along the lines of, "Home... it's our favorite destination." I would envision my dad heading home... clutching a soldier's Bible, ready to live life to its fullest.

And he did just that—dad loved well and was the kindest man I have ever met. Firm in his beliefs, he preached with power and conviction, yet gently and wisely offered grace and encouragement to my mother, his eight children, and those he was called to serve. He loved to make us laugh, toot the horn at his neighbors, keep a bag of candy under the front seat of his old Jeep Wagoneer, take us swimming in the creek, and live life on purpose one day at a time. Dad inspired each of his kids to love, dream, and live in the moment.

His inspiration is probably what I miss the most about him—those simple, yet profound, moments… conversations over a hot fudge sundae while driving around the hillside… always ending a conversation with a prayer… and just showing up and being present. He had a way of making you feel like you were the only one in the room. Of course he wasn't perfect... who is? But I will say this; he was rare.

Never did this "way of his" become more apparent than when he lived out his last days on this earth. While my siblings have their own "dad" stories, and he has been gone now for more than a decade, mine are still stark and warm. I remember one time over a barbecue lunch in South Florida some things got etched in my mind: "Tim, if you serve God with all your heart, you will be blessed no matter what happens... I've learned that nothing else really matters," he said. Then, he pressed in and added, "Hear me on this… my life and ministry started with my family, and it is ending with my family; stay centered there…."

When dad could see land, he wanted to reach me by phone and be sure to chat. I can hear his words like it was yesterday. "I am going to the Kingdom of our God... just wanted you to know that I love you, son. It's because of Christ that I will see you again." I choked up hearing that, knowing the sobering day of his homegoing had come. I immediately left my family for a flight home to be with him during his final hours.

As I have worked my way through preparing for this article, you can tell that my mind went to personal reflection. That is because I believe YOU are the most important factor in mental healthcare. And if you know YOUR "why for," it anchors and guides everything else. Here is a little of what I am telling myself:

- **Keep the Main Thing the Main Thing.** "Now when David had served God's purpose in his own generation, he fell asleep…" (Acts 13:36a, NIV). What has God called you to do and be? If we took an inventory of you, I wonder what others would say... your family would say... your spouse would say... and, most importantly, what God would say? It is so easy to get distracted or lost along the way. I have many times. What is the Golden Rule? Love God and treat others as you want to be treated... and in that order.
- **Focus on Your Judea.** "For what shall it profit a man, if he shall gain the whole world, and lose his own soul" (Mark 8:36, KJV)... or his own family? I have seen so many Christian leaders, businessmen and women, athletes, and others sacrifice their own kids, marriages or relationships for busyness, another speaking assignment or one more social media follower. What is disgusting to me is how tone-deaf most Christian leaders are on this matter… only to later sit alone in life wondering where it all went wrong.
- **Manage Your Time.** Take inventory on where you are spending your time and to what you are giving your heart and focus. Psychiatrist, Curt Thompson, recently caught my attention with the following quote from his insightful book, *The Soul of Shame.* He said, "Ultimately, we become what we pay attention to, and the options available to us at any time are myriad, the most important of which being located within us." That takes intentionality and being deliberate. Start doing it, and I bet you will be amazed at what is going on in your everyday life. Most are unaware or under aware of what is consuming their minds. Often, we are ruminating over situations and lost in things that don't even matter. Grab hold of your mind and life by stepping into a new way of thinking, being and doing what God has called you to be and do. Yes, it will take work, but the freedom is exhilarating.

I am praying more now than ever that God will use the work we do, whether a researcher, practitioner or teacher, to help set the captive free. Let's always be encouragers and make sure everything we do is done to glorify the Lord. And back to a very personal note—when you SEE land… sweet Beulah Land, may the Lord say what I am confident He said to my dad, "Well done, thou good and faithful servant."

TIM CLINTON, ED.D., LPC, LMFT, is President of AACC, Executive Director of the James Dobson Family Institute, and cofounder of Light Counseling, Inc., a clinical practice serving children, adolescents, and adults. He served as a professor of counseling for more than 30 years and is the author/editor of nearly 30 books, including *God Attachment, The Popular Encyclopedia of Christian Counseling, Break Through*, and *The Struggle is Real.*

Research on the Efficacy of Christian Counseling

As a Christian counselor, I want to believe that treating my patients Christianly makes a difference relative to treating them as I might in a strictly secular counseling environment. It feels wonderful when I connect and patients leap forward in their mental health and spiritual formation. However, as a hard-nosed scientist, I also know that cognitive psychology (not cognitive therapy, but the experimental field of cognitive psychology) tells us how prone we are to distort our own beliefs, especially in self-serving ways. For example, it is easy to focus on the five patients this month who had good outcomes and forget the three who did not change, the two who simply quit showing up for counseling, and the one who seemed to deteriorate before my eyes. Yet, if I considered all the data together, I might not feel as elevated as when I focused on the best outcome.

So what do the statistics and clinical research data tell us? There is one purpose of clinical science—to take some of the subjectivity out of my judgments about what is and is not effective. First, I recall those days when I was actively seeing patients. Often, they would show up for the first session and it seemed like I was getting a theology test. Sometimes my theology test occurred on the phone before they even arrived for an intake. I remember one client—a pastor—who insisted that I say whether I believed in pre-millennial-post-rapture-dispensationalist eschatology before he and his wife would begin couples counseling. Usually, though, patients' "theology tests" were more subtle. However, those tests definitely removed some people from my client load. A lesson to learn from this is that declaring myself to be explicitly Christian can influence some people not to start counseling. Non-believers, as well as believers who do not share a compatible theology, might look at my Web site and say, "Not for me." So as we look at the data to follow, we must realize that the sample has already been positively biased by people who would not sign up for, and do not want to be in, a randomized clinical trial. The same selection bias is at work for all counselors who describe their approach publicly.

Second, lots of research has investigated "religiously accommodated mental health treatments." That is, treatments that counselors have tailored to religious patients. Almost 100 studies have been analyzed in a meta-analysis. A meta-analysis is a statistical comparison that expresses the amount patients change during counseling—regardless of the measure used to assess change—to a standard score (like percentage improved). In this case, an effect size (Hedge's *g*) is used to tell how much effect a treatment has compared to some other condition. To understand the general meaning of effect size, attending cognitive behavioral therapy (CBT) for depression weekly for a half year yields a *g* of around 1.2 to 1.0 (depending on sample sizes involved). Most of the research analyzed in our meta-analysis has been tailored to Christian clients, but not entirely. Regardless of whether the treatments were tailored to Muslims, Christians, or Jews—people of the Book—the efficacy was not different. So, we can assume that what is found in the meta-analysis applies to counseling tailored to Christians.

EVERETT L. WORTHINGTON, JR.,

Here's the good news, though. The religiously accommodated treatments had **much greater spiritual effects** on the patients than equivalent secular therapies.

The meta-analysis we did on religiously tailored treatments is part of a larger set of meta-analyses on the effectiveness of all sorts of patient factors. A joint task force of American Psychological Association divisions for psychotherapy, counseling psychology, and clinical psychology rated the strength of evidence that supported matching patient characteristics. Matching for religion/spirituality (R/S), culture, and patient preferences were judged to have the highest strength of support, called "demonstrably effective." If possible, counselors should try to take patients' preferences for religious matching into account.

Three characteristics had evidence showing they were "probably effective"—patient coping style, stage of change (along with differences from whether patients were just contemplating change to whether they were fully engaged in trying to change), and reactance level (the patient's level of trait resistance to change). One patient characteristic did not have strong evidence supporting matching—attachment—which was judged to be "promising but insufficient evidence." This does not mean it is unwise to consider the patient's attachment style; it means there have not been enough studies to say definitively that a counselor should consider attachment style. Also, two characteristics were newly added and, at this point, have not been investigated enough for the task force to take a stance: sexual orientation and gender identity.

I already "let the cat out of the bag" that the meta-analysis headed by Laura Captari, Ph.D. student in Counseling Psychology at the University of North Texas, along with Dr. Joshua Hook, Associate Professor and Associate Director of the Counseling Psychology Program at the University of North Texas, and meta-analysis-expert at the University of Wisconsin-Madison, Dr. William Hoyt (and others) found strong evidence that matching by R/S helps outcomes. Of course, it is always a bit more complicated than that direct statement. When compared to a no-treatment, retested, control condition, *g* was .74 at post-test and .81 at follow-up. So, Christian accommodated treatments have a *g* about three-fourths of what six months of weekly CBT for depression would yield—and most of these clinical trials involved only about six to 12 hours of treatment, not 26 hours! When compared to an alternative-treatment condition—that might be treatment-as-usual (TAU), relaxation training, active listening, etc.—*g* was .33 at post-test and .33 at follow-up. This is good. Often TAU is quite effective. So these effect sizes—that religiously tailored treatments are better than alternatives—are very respectable.

Finally, when compared to a secular treatment that is the same as the religiously accommodated treatment except for including religion, *g* was still .13 at post-test and .21 at follow-up. Those are not "statistically different" even though they are numerically better. This is a positive effect, and without getting deep into the statistics, let me say that if about 20 additional studies had been done, this would be considered a statistically significant effect.

Here's the good news, though. The religiously accommodated treatments had much greater spiritual effects on the patients than equivalent secular therapies. This was strongly evident for comparisons with no-treatment conditions and alternative-treatment conditions. Also, religiously tailored treatments were even starkly better in increasing patients' spiritual lives than were strictly similar secular treatments (g = .34 at post-test and g = .32 at follow-up).

So, as Christian counselors, we can hold our heads up, look licensing boards,

managed care corporations, and insurance companies in the eyes and say, "Christian accommodated treatments are just as effective or better than secular treatments in improving patients' symptoms, and they also do something for matched spiritual clients that secular treatments cannot—produce better spiritual well-being."

On the other hand, we do not want to be too smug. We need to remember those pesky cognitive psychologists who point out the unconscious biases we have about our self-interests. So, it is important that we recognize the limitations of this research. As I mentioned, some Muslim and Jewish interventions were in the mix, but there were other factors this research did not consider. For example, we cannot tell how much accommodation was effective, when it took place (early, middle, or late parts of counseling), and who really can benefit by what particular accommodations (e.g., Catholics might not want as much Scripture reference as do Fundamentalists and Evangelicals, progressive mainline Christians might want counselors to deal with principles and not quote Scripture at all, and Pentecostals and Charismatics might want direct prayer for healing). Also, we still do not know which specific ecclesiastical or pastoral counseling techniques should (or should not) be included, and for whom? These might be prayer for the client, prayer with the client in session, assigning clients to read the Bible, exegesis of scriptural passages, justifying interventions and conceptualizations with Scripture, dealing with direct questions regarding theology or God (e.g., "Where was God when my child was killed by a drunk driver?"), and dealing with anger or disappointment with God.

Like much of scientific research, this meta-analysis tells us some details we did not know. However, as the lake of knowledge expands, the shoreline of what we did not consider seems to lengthen. ✠

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"A man's spirit will endure sickness, but a crushed spirit who can bear?"
– Proverbs 18:14, ESV

Responses to trauma take many forms. Consider some of these scenarios based on my clinical experience (identifying information changed):

- John, a 49-year-old Vietnam veteran, faced horrendous experiences in Vietnam that included being shot at and killing others. He said he never knew where the danger was going to come from within the dense jungle. This was especially true at night when he could not see as well, and it was only intensified by the difficulty identifying who was a "friendly" and who was an enemy. After returning to the United States and moving back to his small, rural town, he suffered from intense anxiety and was overly sensitive to sounds, including voices, trucks, and barking dogs. He sought treatment when he found himself leaving his home at night and using night vision goggles to survey his neighbors' farms while holding his hunting rifle. He would put his rifle sights on his neighbors' animals and contemplate pulling the trigger.
- Alisha was a sophomore in high school when she and her family were in a tragic car accident. Her younger brother, who was sitting next to her in the car, was killed, and her arm was so mangled that it had to be amputated. Alisha had difficulty sleeping more than a few minutes at a time and experienced nightmares when she did, so her mother made her an appointment to talk to a therapist. It was difficult for her to go to school, and while at school, she could not focus and left early. She kept replaying the "video in her mind" of the accident and her brother dying while sitting next to her.

CLARK D. CAMPBELL

Trauma has a higher incidence of death associated with it than cancer, heart disease, or any other factor.

- Sandy, a 42-year-old mother, began experiencing panic attacks "out of the blue." She had no prior history and had never been in therapy. As we began to explore her current family situation, she described having a nine-year-old daughter (her eldest child) who had been asking to spend the night at her friend's house. Sandy acknowledged that she was more troubled about her daughter's request than seemed necessary because she knew the friend and her family. However, she could not help thinking about her daughter staying overnight away from home. As we explored her concerns, I asked her about her own experience staying overnight at friends' houses as a young girl. In the midst of that conversation, she burst into tears as she recalled an experience when she was 10-years-old while spending the night at a friend's house. During the night, she was sexually abused by her friend's father.
- Michael, a 12-year-old boy whose grades were failing, seemed to find any reason he could to avoid school and church activities. This was a significant change from his previously outgoing personality, record of good grades, and desire to have leadership roles. In talking with him about his withdrawal from others and intense focus on video games, he revealed a history of sexual abuse from ages six to nine by a man who worked at his school.

Different traumatic events can be triggers for subsequent trauma responses; there are many kinds of triggers and responses that we see in clinical presentations. Unfortunately, we can never protect ourselves or our children from the varied ways in which we are exposed to traumatic events. The symptoms, however, are often the same: intense anxiety and dread, intrusive thoughts, flashback memories, avoidance of triggering stimuli, and feeling out of control.

Trauma is ubiquitous. While it is the fourth leading cause of death for all ages, trauma is the number one cause of death in young people ages one to 46 (The American Association for the Surgery of Trauma, n.d.). Trauma has a higher incidence of death associated with it than cancer, heart disease, or any other factor. Likewise, the annual cost of trauma in the United States is $671 billion vs. $216 billion for cancer, $245 billion for diabetes, and $318 billion for heart disease (National Trauma Institute, n.d.). This includes the cost of care, as well as lost wages and other related expenses.

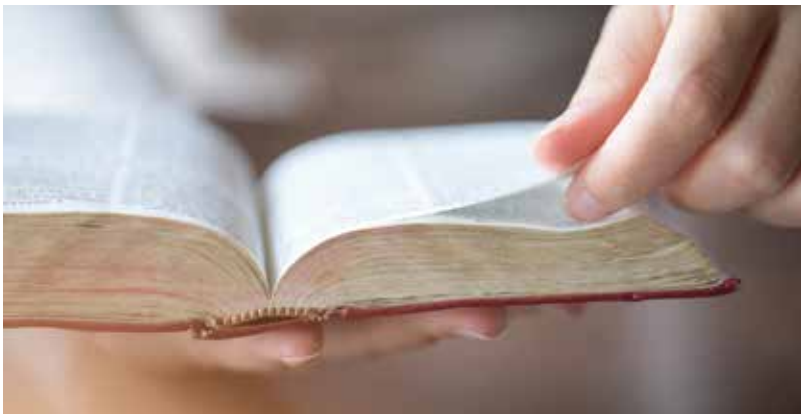
Diagnosing Trauma Responses

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) (American Psychiatric Association, 2013) places trauma responses in the diagnostic category of "Trauma and Stressor-Related Disorders." Disorders in this category include "Acute Stress Disorder," "Post-traumatic Stress Disorder," "Adjustment Disorder," "Reactive Attachment Disorder," "Disinhibited Social Engagement Disorder," and "Other or Unspecified Trauma Disorder." Post-traumatic stress disorder (PTSD) is probably the one that most people recognize, and the remainder of this article will focus on this disorder.

The characteristics of PTSD are complaints of recurrent memories, dreams, and flashbacks of the traumatic events(s); increased arousal, including sleep disturbance; intrusive thoughts of the trauma; low mood (depression); avoiding thoughts and places associated with the trauma; and impaired functioning. Additionally, these symptoms last more than a month. There are many traumatic events that can lead to PTSD, and it is important to note that trauma is defined as perceived by the patient, not what others determine to be a traumatic event. Thus, bullying and other forms of social isolation are traumatic if recognized as such by the patient. It is estimated that the lifetime prevalence rate for PTSD in adults is 3.6% for men and 9.7% for women; in adolescence it is 3.7% for boys and 6.3% for girls. Rates of PTSD are much higher in specific populations, such as veterans (U.S. Department of Veterans Affairs: National Center for PTSD, 2019). Risk factors for PTSD include lack of social support, a younger age when the trauma occurred, a previous psychiatric diagnosis, lower socioeconomic status, and traumatic childhood experiences (Amboss, 2019).

Causes of Traumatic Responses

We all respond differently to traumatic events, and everyone has a breaking point. These breaking points often vary according to the risk factors previously mentioned. It seems as though God has created us to withstand short-term stressors and trauma. Hans Selye (1978), a pioneering, Hungarian-Canadian endocrinologist, conducted scientific work on the adaptation to stress that showed we can adjust very well to short-term stress, but not to ongoing or long-term stress. The Diathesis-Stress Model of psychopathology (Goforth, Pham, & Carlson, 2011) supports this view, as well. Therefore, some people may experience a major stressful event (car accident, assault, rape, etc.)



and seemingly respond relatively well, while others appear to react poorly to what seems to be more of a minor event. In my experience, the kind of trauma that is the most difficult to recover from is simply general human meanness. This is especially true if the meanness comes from someone with whom a person is close (perhaps a family member) and is personal in nature (perhaps ongoing critical comments about one's appearance). Although one might think he or she should be able to cope with such ongoing, hurtful experiences, there is a cumulative effect that is not easily recognized by the person being traumatized or others. The impact, then, is exacerbated by the guilt and pressure one feels over not being able to handle such "minor things like my dad yelling at me regularly."

I see this most often in what could be called an invalidating environment. Children and adults cannot tolerate a world in which their personhood and identities are not validated. Some respond to this by engaging in more and more outrageous behavior simply to be recognized. Others respond by feeling shame, worthlessness, withdrawal, and self-harm.

Several studies have looked at Adverse Childhood Events (ACE) and the impact of these events on subsequent development in adolescence and adulthood. Clearly, adverse events (divorce, poverty, neglect, etc.), and not the typical traumatic incidents we commonly recognize, can lead to significant problems later in life (Centers for Disease Control and Prevention, 2019).

Another way of looking at trauma is to think of "Big T" and "Little t" traumas. Elyssa Barbash (2017), a licensed psychologist and leading authority on psychological trauma and PTSD, describes "Big T" traumas are those that leave individuals feeling powerless and having little control in their environments. These are incidents such as assault, rape, murder, domestic violence, etc. "Little t" traumas are events that exceed our normal capacity to cope. These include divorce, planning a wedding, loss of a job, having a first child, emotional neglect, etc. Whether "Big T" or "Little t," these traumatic events can have an impact on people, and they tend to accumulate in ways that are not always recognized.

Treatment of Trauma

As with most psychological disorders, various treatments have been developed. I will focus only on evidence-based treatments here, and I have found the PTSD Treatment Guidelines provided by the American Psychological Association to be very helpful (APA, 2017).

Medications. Sertraline, Paroxetine, and Fluoxetine are Selective Serotonin Reuptake Inhibitors (SSRIs), usually given for the treatment of depression. Venlafaxine is an SSNRI (Selective Serotonin and Norepinephrine Reuptake Inhibitor) often prescribed for depression also. These have shown some effectiveness in treating the symptoms of PTSD. Current pharmacological studies are evaluating the efficacy of some other drugs on preventing

memory consolidation of traumatic events (Burbiel, 2015)

Psychotherapies. Cognitive Therapy (CT) and Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), and Prolonged Exposure Therapy (PE) have been shown to be effective in treating PTSD. It is likely that most of the readers of this article understand the basic premise of CT and CBT, so that will not be discussed further. Readers may not be as familiar with CPT, which is a form of therapy developed in the last decade. It is a short-term therapy aimed at helping clients develop a new understanding of traumatic events they have experienced. It places more emphasis on processing the traumatic event itself and the associated emotions connected to the trauma than traditional CBT (Resnick, Monson, & Chard, 2014). (A free treatment manual is available online at: https://www.div12.org/wp-content/uploads/2015/07/CPT-Materials-Manual.pdf.) Another form of CBT that focuses on clients' avoidance of issues related to traumatic events is PE. This therapy takes aim at overcoming the avoidance and replacing it with ways to tolerate, and even embrace, the trauma as a life-changing event that has enhanced personal development in some way.

The Role of Faith

Most therapies help clients develop a new way of seeing themselves as they exist in the world. Of course, that is a large part of Christian faith—a way of understanding who we are and why we exist in relation to God. Thus, most clients who have experienced trauma are very open to a spiritual perspective on their experience. However, this perspective needs to be nuanced and thoughtful, rather than glib or cryptic. I have found clients to be more open to questions of faith after therapeutic progress has been made rather than a point of focus in the early phase of treatment. How we cope with life events has many spiritual aspects. Both religion and culture play a significant role in minimizing the effects of trauma (Murthy & Lakshminarayana, 2006). Jesus told us that we would have trouble in this world, and yet He also said that in Him we can overcome the world (John 16:33). As Christians helping others cope and find meaning in the midst of trauma, we can be assured that faith has a profound purpose in the healing process.

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Identifying Those in Need of Psychological Trauma (and Moral) Care

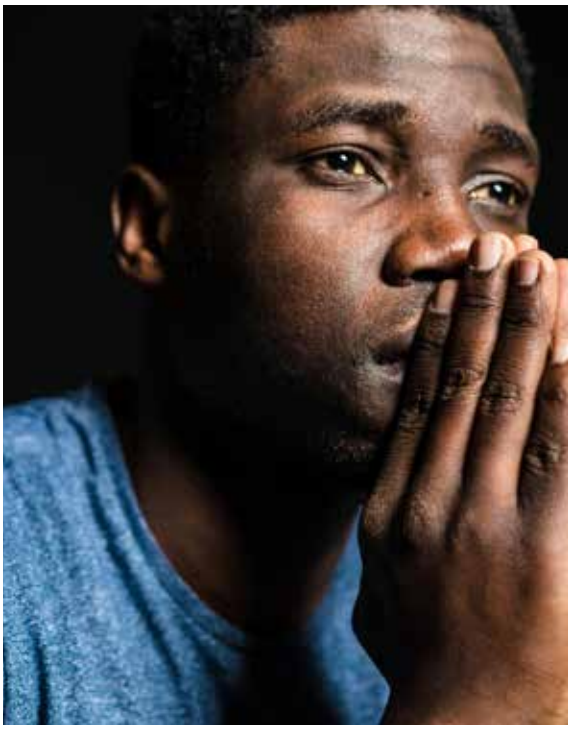
Just about everyone who seeks help from a Christian counselor has experienced some type of trauma. This article describes how to identify counselees who have suffered significant trauma that requires treatment.

By significant trauma, I mean those with post-traumatic stress disorder (PTSD) or subthreshold PTSD. Also discussed here are the "moral injuries" that often accompany severe trauma/loss and result in a syndrome that Christian counselors are ideally positioned to address. Religious beliefs and religiously-integrated interventions often play a crucial role in recovery from trauma-related disorders and moral injury (Koenig et al., 2019a). First, I will describe the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*), diagnostic criteria for PTSD, and then define subthreshold PTSD and moral injury. Second, I will discuss psychometrically valid measures that can be used to identify PTSD and moral injury. Third, I will briefly review religiously-integrated interventions and discuss how loved ones can help.

Post-traumatic Stress Disorder

A diagnosis of PTSD in *DSM-5* requires that a person be exposed to a severely traumatic stressor (Criterion A) (American Psychiatric Association, 2013). Stressors include violence experienced during wartime, sexual assault (rape at any age or severe abuse during childhood), physical assault (robbed or physically attacked), kidnapping, torture, natural disasters, or severe accidents (motor vehicle and others). The exposure can occur either through direct personal contact, witnessing the event happen to others, learning about the incident occurring to close family members or repeated exposure to details of traumatic events (as first responders might experience as part of their jobs). In addition, there must also be symptoms in all four of the following categories: intrusive recollections (Criterion B: nightmares or flashbacks), avoidance (Criterion C: avoidance of people, places or other reminders of the trauma), emotional symptoms (Criterion D: negative pessimistic thoughts, sadness, anger, impulsiveness, self-destructive or reckless behavior), and hyperarousal (Criterion E: easily startled, hypervigilant, irritable). These symptoms must have been present for at least one month and cause functional impairment.

HAROLD G. KOENIG



Subthreshold PTSD

Subthreshold PTSD is more common than full PTSD, and definitions vary. There are, however, universal agreed-upon features that assist in the diagnosis. These include meeting Criterion A (exposure to a severe traumatic stressor) and two or three of the *DSM-5*'s Criteria B-E (previously listed) lasting at least one month or longer and causing significant distress or dysfunction in occupational, social or recreational activities (McLaughlin et al., 2015).

Moral Injury (MI)

Moral Injury (MI) involves distress over having transgressed or violated core moral boundaries, witnessing others do so, or feeling betrayed by those in authority (Koenig et al., 2019b). The symptoms of moral injury include both psychological and religious indicators. The psychological symptoms are guilt, shame, feeling betrayed, moral concerns, loss of trust, loss of meaning, difficulty forgiving, and self-condemnation. The religious symptoms include spiritual struggles and loss or weakening of religious faith. These struggles involve feeling punished by, angry at, alienated from, or unloved by God or one's religious community or leaders. Loss of faith reflects a weakening of belief in, trust in, or love of God due to traumatic experiences that clients feel God should have prevented. Moral Injury has been strongly associated with PTSD, depression, anxiety, substance use disorder, and suicide, as well as relationship problems. When MI occurs in the setting of PTSD, it may block the successful treatment of PTSD and other comorbid disorders.

Identifying Those in Need of Treatment

When conducting an initial mental health evaluation and spiritual history, it is essential to ask about prior traumatic events during childhood, adolescent/teenage years, and adulthood, as well as associated moral concerns. Since those with trauma-related disorders are trying to avoid memories or reminders of such traumas, obtaining a history is often difficult. Counselors may need to wait until a trusting therapeutic relationship has been formed before clients will be willing to reveal past traumas. This is also true for moral injuries that clients may feel ashamed or guilty about (especially in religious counselees). Some may be more comfortable completing self-rated measures that assess PTSD or MI symptoms privately, rather than revealing these warnings in-person to counselors. Besides being useful for identifying significant trauma or MI symptoms, evaluations of this type can also be used to monitor response to treatment.

The PTSD Checklist for *DSM-5* (PCL-5) is a 20-item scale used to identify symptoms. Each item is rated from zero (not at all) to four (extremely), which produces a score ranging from zero to 80, where scores of 31-33 or higher are indicative of probable PTSD. This is one of the shortest and best screening tools for use in office-based practices. The Moral Injury Symptom Scale (MISS) is psychometrically reliable and a valid measure of MI that assesses all 10 symptoms of this syndrome. There are two versions for use in veterans or active duty military—the 45-item MISS-M long form (MISS-M-LF; Koenig et al., 2018a) and the 10-item MISS-M short form (MISS-M-

When symptoms of PTSD or MI are severe, particularly if they are not improving with counseling or suicidal thoughts begin to emerge, referral for psychiatric care is necessary

SF, Koenig et al., 2018b). Items on both of these scales are rated on a one to 10 range, with total scores extending from 45-450 on the MISS-M-LF and 10-100 on the MISS-M-SF.

In the original study, the average score on the MISS-M-LF among military personnel with significant PTSD symptoms was 224 (SD=62, range 86-403), and the average score on the MISS-M-SF was 50 (SD=16, range 12-91). After reverse scoring of appropriate items, scores on the MISS-M-LF in military personnel of 225 or higher, or scores of nine or 10 on any one of 45 questions, warrants further clinical evaluation. Likewise, scores on the MISS-M-SF of 50 or higher, or scores of nine or 10 on any one of the 10 questions, indicates the need for further evaluation by the therapist. There are also civilian versions of both measures now available (MISS-C-LF and MISS-C-SF), although neither of these have been subject to psychometric testing (scales available from Harold.Koenig@duke.edu on request).

When symptoms of PTSD or MI are severe, particularly if they are not improving with counseling or suicidal thoughts begin to emerge, referral for psychiatric care is necessary. Likewise, for clients who score above cutoffs on the previously mentioned scales, serious consideration should be given to psychiatric referral and management. Co-treatment with a psychiatrist is often the best solution for both the patient and therapist. Traumatized individuals are known to have violent outbursts against others or themselves, particularly when confronted with reminders of the trauma. Thus, a timely referral is strongly recommended.

Available Treatments

First-line evidence-based treatments for PTSD and subthreshold PTSD are known to be effective based on hundreds of randomized controlled trials. Licensed counselors with appropriate training can conduct such therapies. These include Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT), which typically involve eight to 15, weekly, 60-90 minute, individual sessions. In PE, the therapist *gradually* guides the client to: 1) encounter the trauma by encouraging him/her to remember the event, situation, sounds, and feelings in as much detail as possible while in the office (imaginal exposure), 2) expose him/her to reminders of the trauma in real-life settings (in-vivo exposure), and 3) often a combination of the two. Cognitive Processing Therapy involves elements of PE and cognitive behavioral therapy to help change the way clients think and behave in relation to the trauma. Both PE and CPT are known to be equally effective.

Although there is no evidence-based treatment currently available for the treatment of MI, these interventions are now being developed. In particular, we have developed a manualized spiritually-integrated version of CPT for religious clients (including a Christian edition) designed for Licensed Professional Counselors (Pearce et al., 2018; Koenig et al., 2019a), and a manualized pastoral care intervention intended for non-licensed clergy and chaplains (Ames et al., 2019) that address MI in the setting of PTSD. Both of these interventions are now being tested in a randomized controlled trial. The Christian versions of these therapies, grounded on the Bible, involve 12, 50-60 minute, individual sessions administered over six to 12 weeks.

What Can Loved Ones Do?

How can loved ones and friends encourage fearful, resistant survivors of trauma to seek treatment? As previously noted, those suffering from severe trauma are often intent on avoiding anything that reminds them of the pain, including treatments that may help them confront the ordeal. Loved ones should be urged to provide support to those traumatized, encourage them to make and keep appointments, offer to take them to therapy sessions, and remain in the waiting room during those meetings. Being available to provide a listening ear, when requested to do so, is also essential. Post-traumatic stress disorder can also be associated with physical abuse of loved ones, so clinicians should not be afraid to ask about this possibility.

Conclusion

Trauma-related disorders and co-existing moral injuries are widespread among clients, whether acknowledged or not, and cause tremendous suffering and disability. Screening for these conditions, knowing when treatment is indicated, being aware of available treatments, and remaining mindful of when to refer are essential skills for all Christian counselors.

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ADDRESSING INTEGRATIVE ISSUES IN THE SERVICE DELIVERY OF TRAUMA CARE

As we write this article, the concept of trauma is more vivid and close than we would like—suicide, clients wrestling with childhood molestation, another family encountering an unexpected death, brothers and sisters in the Bahamas struggling to rebuild after Hurricane Dorian…. Both for those personally struggling with such wounds and those who attempt to care for them, the issue of trauma shatters our illusion of the world as a safe and good place. It forces us to wrestle with topics we might prefer to avoid. Why did God allow this? Where were His goodness and mercy? Where was He in the midst of our suffering?

Integrative Trauma Care

We write as professionals who have spent much time on trauma issues—one of us as a military psychologist and member of a trauma psychology team at a hospital for a subsequent decade, and another as a college counseling center psychologist. The importance of integrative trauma care was starkly highlighted when one of us (Hathaway) was serving on a trauma psychology team.

Our team did trauma psych consults for medical inpatients who suffered various life-altering physical injuries. The trauma psych team was often the first to talk to patients about the life impact of their injuries. In one case, a patient had become paralyzed after a motor vehicle accident. He had just been extubated a few hours earlier. Soon after engaging him in the intensive care unit (ICU), it was evident that no one had talked with him about paralysis or its meaning for his life other than to inform him he was paralyzed. The staff there was busily preoccupied attending to his and other patients' critical physical care needs. Despite having nearly two decades of experience working in medical settings, I quickly realized that my standard psychologist training in reflective listening was going to fall short in helping him at that moment. Our discussion shifted to issues of meaning in the face of such a devastating event. I drew more from pastoral counseling, existential, and coping studies than my standard clinical training. I was especially grateful at that moment, and many others during my clinical practice, for the graduate training in religion and coping I received from professor and author, Ken Pargament (2001), at Bowling Green State University.

Healthcare teams frequently value mental health professionals' ability to navigate the psychoemotional and other life impacts of trauma beyond mere physical recovery. We live during a time where evidence-based trauma treatments have made great progress (APA, 2017). While this is good news, the sad reality is that although humanity needs such treatment, it is often not received. In too many cases, we have been late additions to care teams—usually just a follow-up referral that only a minority of patients utilize. By functioning as part of an integrative care team in ICUs, step-down wards, primary care, and other medical care settings, we are much more likely to be a component of the whole person healing process that is needed for those who suffer trauma.

A Christian Calling

As Christian mental health providers, we are or can be uniquely positioned to take part in issues of faith and meaning in the midst of trauma recovery. However, it can feel tempting to skirt around tough questions or be overwhelmed by the lack of emotionally salient answers. Another case one of us (Stephens) navigated comes to mind that involved working with a young Pakistani woman who had been repeatedly molested by an older family member. When she cried out, wondering why God had allowed her to experience such cruelty and suffering, I felt at a loss. While theology and training provided intellectual answers for her questions, such responses felt blatantly inadequate during her pain.

Jesus demonstrated unparalleled grace and beauty amidst the horror of trauma. He appears at once, able to fully empathize with broken human reality with no platitudes or glib responses, and still capable of offering sober hope and solace. The vast majority of miracles re-

RACHEL STEPHENS AND WILLIAM L. HATHAWAY

corded in the Gospels find Jesus healing and providing for the physical needs of those around Him—curing illness (Mark 1:30-31, 40-45; Luke 8:43-48; Matthew 9:27-31; Mark 8:22-26), providing food and nourishment (Matthew 14:15-21; Matthew 15:32-39; John 21:1-14), and overcoming death itself (Luke 7:11-18; Matthew 9:18-26: John 11:1-46; Luke 24:5-6). Yet, despite this, the early Church did not expect an easy and trauma-free existence as followers of Jesus. Somehow, God's desire to heal and restore His creation co-existed with the "not yet" reality of waiting for the fulfillment of this promise.

The same is true in trauma work. We sit in the tension of grieving and lamenting the impact of sin. We cry out in protest of evil. We wrestle with how to move forward, yet declare God's sovereignty. We proclaim that He is in control, that He is faithful, and that He is good. To be proficient in a Christian trauma-focused specialty, out of necessity we need to be able to live honestly in the tension of the *yet and not yet* Kingdom. Effective integration involves more than appropriately correlating Christian phrases with the latest prolonged exposure technique. No matter how many techniques we learn, if we do trauma work, we should expect to hear jarring stories that will shake our personal securities and protective illusions. If we are called to enter the suffering of others, we must first be willing to acknowledge the pain and vulnerability encountered in our own lives and what it means to have the power of God permeate that experience.

The most transformative and powerful experience of God in the face of suffering has been encountered by us through presence. One of the foundational promises of God is that He will provide His presence. He does not leave. He does not neglect. He is "Immanuel," "God with us." He does not promise to transform our physical conditions, but does guarantee to be there in the midst of our struggles. As therapists, we, too, are ministers of healing through presence. We cannot help others move into healing until we fully understand the starting point. Although this may seem obvious on an intellectual level, the implementation can be difficult. Some research suggests that therapists tend to avoid the depth of their clients' pain through "muting" language, nonverbal cues, obvious discomfort, or silence out of feeling unsure how to respond (Dalenberg, 2000). To truly seek to understand a trauma experience involves intentional effort and work; it does not come naturally. Yet, we have a perfect example in the person of Jesus, the High Priest who sympathizes with our every weakness and human experience (Hebrews 4:15). He is a God who passionately takes part in our pain and suffering.

From Attunement to Healing

God has equipped our bodies to respond to horrific events in ways that preserve as much functioning as possible. The neurological processes involved in activating the body into fight, flight or freeze, the ability to disconnect and dissociate in the moment from brutally painful experiences, the capacity to scan the environment for danger and react on instinct—these are all gifts God has built into our bodies that allow us to survive experiences that no person should ever have to endure. Yet, these same responses become maladaptive and impairing when used rigidly in the aftermath of trauma… when an individual no longer has to flee, dissociate, or react in fear.

Herein lies the work of the trauma therapist. There is an opportunity for growth in acknowledging the adaptive response of the body and understanding this reaction. Clients experience such relief at seeing how their bodies and brains have been carefully designed to help them survive. They can express appreciation for the very trauma responses they are trying to change instead of fighting against them out of shame and anger. To acknowledge that such patterns may be a God-given gift to promote survival and now need

to change is an absolute paradigm shift. At its foundation, this conversation is built on a premise of God's providence. What a powerful, abiding reality. We have seen strengths-based framing of trauma symptoms included in Cognitive Processing Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Sensorimotor Therapy, and many other approaches. The specific method that helps individuals modify these trauma reactions and live more fully in the present varies for each person. The religion and coping research has similarly shown that trauma can be both a faith-threatening and faith-enhancing event. Christian trauma therapy must take care to develop the skills of presence and method that allow us to be a healing force to help our clients experience the shalom God desires. ✠

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Life is full of crisis and traumatic events, physical or sexual assault, extreme violence, combat, disasters, death, and terrorism. Severe anxiety, flashbacks, nightmares, and thoughts that are uncontrollable can be symptoms of those who are struggling with PTSD. Those who have PTSD will have difficulties in their everyday lives, and the problems can include job, relationship and physical issues. In this course, students will gain a further understanding of suffering and its relation to trauma while recognizing there is a purpose in suffering. *PTSD 2.0* covers the different types of trauma and PTSD, identifying symptoms and treatments for each, as well as distinguishing assessment instruments and therapies for PTSD. Anger and aggression, components of PTSD, are discussed in detail while examining anger management skills and therapies. The course concludes with evaluating the symptoms and treatments for both PTSD and Complex PTSD.

PTSD 101: Hope and Healing: Trauma, Stress, and Overwhelming Events, Part 1 — Presented by Laurel Shaler, Ph.D.

PTSD 102: Hope and Healing: Trauma, Stress, and Overwhelming Events, Part 2 — Presented by Laurel Shaler, Ph.D.

PTSD 103: Not All PTSD is Alike: Treatment of PTSD vs. Complex Trauma — Presented by Heather Davediuk Gingrich, Ph.D.

Luarel Shaler, Ph.D.

Heather Davediuk Gingrich, Ph.D.

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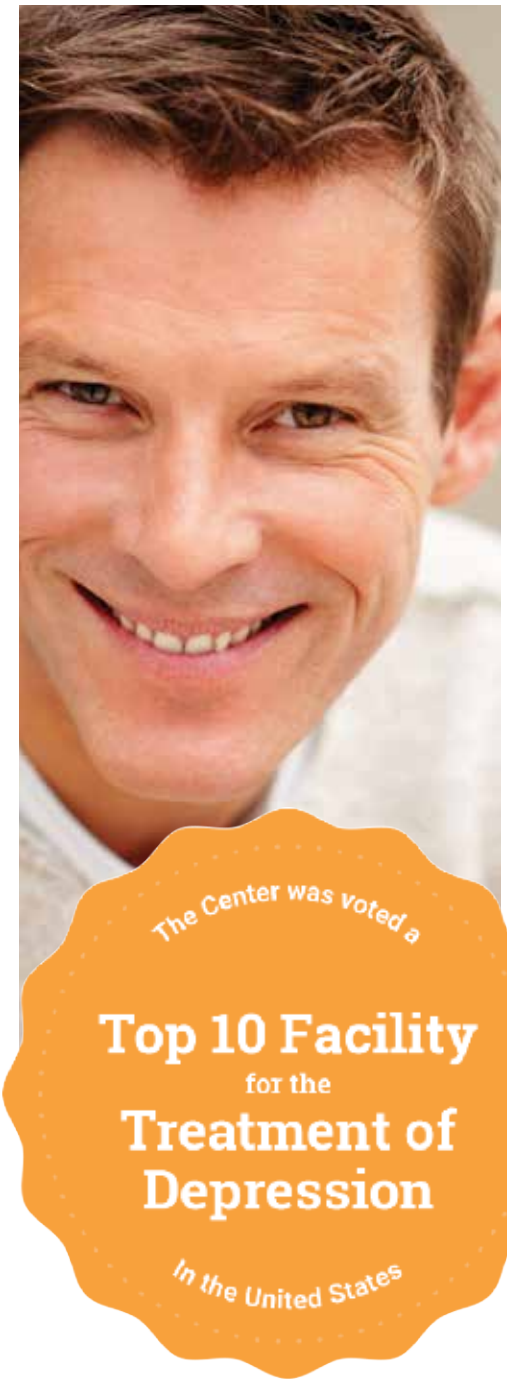

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For I know the plans I have for you," declares the LORD, "plans to prosper you and not to harm you, plans to give you hope and a future. Jeremiah 29:11

THE CHALLENGES OF WORKING WITH COMPLEX TRAUMA

Post-traumatic stress disorder (PTSD) work is challenging, but seeing someone with a complex trauma history is even more complicated. Unlike PTSD, where the traumatic experience can be a single event occurring at any age, complex PTSD tends to be chronic childhood physical, emotional, sexual, or spiritual abuse. In addition to exhibiting post-traumatic symptoms, complex trauma survivors struggle with emotional regulation, relationships, dissociation, and more as a result of normal child psychosocial development processes being derailed by early trauma. A more multifaceted treatment approach is, therefore, necessary.

Phased Treatment

In previous decades, counselors were encouraged to dive right into memory processing. The assumption was that it would be painful, difficult work that could take many years, so the sooner it was started, the sooner the counselee would find healing. Unfortunately, this approach often caused clients to decompensate and become overwhelmed and less functional. The broadly accepted standard of care for complex PTSD is a phased approach to avoid such dangers. Following is a brief description of the phases which are more fully explored in my book, *Restoring the Shattered Self.*

Phase I: Safety and Stabilization

I look at safety as having three components. The first involves safety in the therapeutic relationship; the second, safety from external people; and third, safety from the counselees themselves.

Safety within the therapeutic relationship. Safety is critical. It can be excruciatingly slow to develop a solid therapeutic relationship with someone who has been deeply wounded by another person, perhaps even a Christian leader or counselor. You will need to use every foundational counseling skill you have to help the counselee feel safe. However, you also need to actually BE safe, and STAY safe, by being clear about boundaries and sticking to them, communicating any changes well in advance (e.g., when you need to cancel an appointment, make a change in office décor, go on vacation, etc.), and seeking consultation or your own therapy when you realize you may be in over your head.

Safety from others. You need to watch out for ongoing external danger. While the original trauma may have been within the family of origin, for example, it may currently be replaying in the form of intimate partner violence. Or, an abusive family member may no longer be raping your client, but may still find a way to rub up against her or otherwise subtly perpetrate at a family gathering.

Safety from self and symptoms. Often victims do not feel safe from themselves. They may self-mutilate or struggle with suicidal impulses. Out-of-control post-traumatic symptoms can also make victims feel unsafe.

I interpret symptoms such as flashbacks, nightmares, overwhelming anxiety, or terror as cries for help. Survivors usually attempt to push traumatic memories away. They may be successful, perhaps for many years, until the pressure builds up and the symptoms leak out or explode. Doing "parts" work can be a very effec-

HEATHER DAVEDIUK GINGRICH

tive means of contracting with survivors about these warning signs. The assumption is that some part of the individual is allowing the symptoms to surface, and he or she can make a choice to temporarily dissociate the indicators or push them away. Usually, with some psychoeducation about how disruptive the symptoms have been, and the promise to process the related memories in due course, the symptoms will dissipate for a period of time.

Phase I also involves teaching emotional regulation skills such as muscle relaxation, deep breathing, mindfulness, and grounding techniques (e.g., making use of the senses to keep clients in the here-and-now, such as rubbing bare feet against carpet, chewing sour candy, verbalizing five things they can see or sounds they can hear in your office, bringing in scented essential oils, etc.). Within session, these can be used to keep counselees within the optimal window of tolerance for doing therapeutic work. An over-aroused or under-aroused nervous system will prevent trauma survivors from making good use of counseling. Grounding techniques can also be practiced between sessions.

Phase II: Trauma Processing

Once a stable therapeutic relationship exists and counselees have learned how to better regulate, traumatic memories can be processed. It could take months or even years for counselees to be ready for Phase II work.

The containment and emotional regulation techniques developed in Phase I will be essential here, both for keeping clients within the optimal window of tolerance, as well as managing traumatic content between sessions. Adequate pacing of the material is critical for retaining functionality. A detailed, frame-by-frame narrative of the traumatic event must be recounted for full processing. Clients should be prevented from getting *lost* in the past (i.e., having a flashback in session), but instead have one foot in the past and one foot in the present. They must also re-experience, at least to some extent, the emotions, cognitive knowledge, physical sensations, and behavior connected to the traumatic event for the memory to become fully integrated. Also essential is working with the intense emotions of grief, loss, depression, anger, etc. that surface as a result of recognizing the damage that has been done, while also attempting to find redemptive meaning in what has transpired.

We must be careful not to offer quick solutions, even in the form of relevant Scripture passages or prayer, when the question is not a cognitive one, but rather one coming from a place of anguish.

Phase III: Consolidation and Resolution

The final phase looks much like counseling does with any other client. The focus is on helping the counselee make adjustments to living as a whole person. This may involve changes in relationships, church, employment, and developing new coping skills to replace the maladaptive ones.

"Wonderful Counselor"

Often counselees, even Christian ones, wrestle with where God is in this process. We must be careful not to offer quick solutions, even in the form of relevant Scripture passages or prayer, when the question is not a cognitive one, but rather one coming from a place of anguish. The Holy Spirit is the "Wonderful Counselor" and the ultimate source of comfort and healing for both therapists and clients. Aren't you glad we do not have to do this difficult work on our own? ✠

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WHEN TRAUMA HITS HOME:

TREATING MILITARY AND LAW ENFORCEMENT PAIN

It was an ordinary Friday morning at home following a busy week at my counseling office. Although I had lots of paperwork to get done, I was enjoying a cup of coffee while still in my cozy pajamas. At noon, I turned on the television for a change of pace. "BREAKING NEWS… Three officers down in Locust Grove!" The helicopters were circling the scene, as well as several deputy cars and ambulances. I had that horrible feeling in my chest that one of those officers was my husband.

As I turned to face the front door, I saw a sheriff's car pull into the circle drive. Out stepped two officers. Before they could even knock, I quickly pulled the door open and held up my hand like a stop sign. I did not want to hear them say the words that I feared—words that would echo in my head forever. They immediately asked me to quickly get dressed so they could drive me to a Level II Trauma Center in Atlanta to be with my husband.

Trauma was coming to our home… again. Our son had been deployed twice to Afghanistan as a combat soldier. Each time he returned home, we experienced vicarious trauma under our roof. My husband and I slept with our bedroom door open in case our son stirred at night. We were aware of his catlike roaming around the house during the hours after bedtime. His television was never turned off, and his room became increasingly full of weapons. When he could not sleep, he drank alcohol; we had to disable his truck so he would not be tempted to drive.

Once the deputies and I arrived at the trauma center, they had to push through the crowd of news media as we entered a long hall lined with officers from various departments around Atlanta. They tipped their heads, patted my back, and assured me of their prayers. One of the three officers shot, who was much younger, was killed at the scene. My heart felt lower in my chest than usual, yet my body experienced a sense of floating on a river of care.

LUANN CALLAWAY

My husband was already in surgery, but the trauma team was guardedly confident that they could save his life. From the time he played football at the University of Georgia, my husband had stayed in good shape, which helped him in his fight. For more than five hours, the surgeons pieced his intestines back together. A hollow-point .45 caliber bullet had hit its mark below his bulletproof vest.

Our son, also a police officer, arrived at the hospital in his police car with his canine partner. The highway had been cleared for his frantic arrival. My soldier/cop son held me in the hallway of the waiting room. We could not speak or reveal the fear on our faces. A tragedy like this was not supposed to happen to Pops. Trauma is a contradiction to our psyches. Our personal values, images of ourselves and others, beliefs, and realities are *static* until someone or something shakes them.[1] War and law enforcement are dangerous callings; however, an unexpected event will throw our minds into a spinning search for safety and protection.

Why do these flashbacks come back at bedtime, while driving, when having dinner with friends or during shower time? The mental pictures are an assault on the mind, and isolation becomes a way to avoid the triggers. Yet, we still have to sleep, go to work, eat, and bathe. How do we escape these influences? Unfortunately, addictions often become the way. These addictions might be fast cars or motorcycles, pornography, infidelity, spending, rage or sugar. The brain wants to comprehend what happened, but all the pieces to understanding are tied in knots. How do we, as clinicians, carefully and methodically unscramble the knotted chains?

More than 13 years ago, I began treating combat veterans with Post-traumatic stress disorder (PTSD). My previous trauma training was out of sync with the military, and it usually took several sessions before I was able to get past the cover story of what happened to my clients. When I asked soldiers to describe a feeling, they were unable to say anything more than *sad*, *mad*, or *bad*. However, when I finally handed them a feeling word list, they could see the word intelligently and actually *feel* the emotion. It was cathartic! I began asking pointed questions. What was contradicted in your mind and feelings? Were your family values challenged? How did the realities of your life change that day? Did you abandon beliefs that you held dear before the event? How do you look at yourself differently now?

Evidence-based Therapy (EBT) and the all-in approach suited soldiers and officers. The holistic modality made sense to them—they were willing to take vitamins,

but not medicine, because they were not "sick." Learning about brain science was empowering for these clients, and hope became part of their healing.

Austrian neurologist, psychiatrist, and Holocaust survivor, Viktor Frankl, recalled a record high death rate among Auschwitz prisoners during Christmas 1944 to New Year's 1945. Apparently, when they realized they would not be home before Christmas, they completely lost hope in life beyond the concentration camp and died. Frankl's assessment, "When we are no longer able to change a situation, we are challenged to change ourselves," rings true with today's veterans and law enforcement when the challenges and trials they face become a reality… but there is hope and healing with proper counseling and Christ's promise to always be with us in our greatest time of need.

Five years from his last deployment, with therapy and God's grace, our son is finally living a great life again as a husband and father. As I write this article, my husband just returned home after spending another 11 days in the hospital as a result of an intestinal bleed he encountered 18 months after the shooting that left him and one other officer with multiple injuries, and yet another dead.

The reality is that we live in a sinful world where bad things happen to good people. Much of the post-traumatic stress we see affecting today's veterans and police force is a result of the trauma they experienced while serving their country and communities. According to the most recent statistics from the U.S. Census, there are 18.2 million military veterans in the United States.[2] The U.S. Department of Veterans Affairs reports that PTSD among veterans ranges between 11 and 20% depending on which conflict they were involved.[3] Law enforcement is also dealing with PTSD at alarming rates. There are nearly 900,000 sworn police officers in the U.S., and some studies suggest that 19% of them possibly suffer from PTSD, while other findings indicate 34% experience symptoms of PTSD but do not meet the criteria for the complete diagnosis.[4] Regardless of the numbers, as counselors, we must be prepared to meet our calling and serve these veteran and law enforcement men and women just as they have served us. ✠

Much of the post-traumatic stress we see affecting today's veterans and police force is a result of the trauma they experienced while serving their country and communities.

LUANN CALLAWAY, M.A., PH.D., *is the founder of Lighthouse Counseling Clinic, Inc. in Stockbridge, Georgia. She is an international speaker, military installations consultant, and has appeared in three documentaries on post-traumatic stress and moral injury among veterans. LuAnn has been married for 39 years to a sheriff's deputy and is the mother of one son who is a combat veteran and police officer.*

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The MISSING LINK *of* MENTAL ILLNESS:

Identifying and Rehabilitating Brain Trauma

One of the saddest professional encounters I have ever had was with a mother who came to see me after reading an article I wrote on the link between head trauma and mental illness. She was grief-stricken that her 20-year-old daughter had killed herself several months earlier. Her daughter had been "the most ideal child a mother could have," she said. However, everything changed two years earlier when her daughter had a bicycle accident.

While riding her bike, the young woman hit a branch in the street, flipped over the handlebars, landed on the left side of her face, and lost consciousness for a few minutes. The bruises on her face healed, but something inside had dramatically changed. She became moody, angry, and started to complain of "bad thoughts" in her head. Her mother took her to see a therapist, but it did not seem to help. One evening, she heard a loud noise and realized her daughter had shot and killed herself on their front lawn.

In-between sobs, the mother asked me, "Do you think the bike accident had anything to do with her suicide?" Like most people, and even like many mental healthcare counselors, she was simply unaware that a seemingly mild concussion can have lasting effects. One of the most important lessons I have learned from looking at more than 160,000 brain scans is that mild traumatic brain injury (TBI) is a major cause of psychiatric problems, which very few people realize.

Head Trauma and Mental Health Problems

I dislike the terms, "mild traumatic brain injury" or "mild concussion," because it is implied they do not cause lasting damage, which is often not the case at all. A growing body of research shows that head injuries increase the risk of:

- Depression[1]
- Anxiety and panic disorders[2]
- Psychosis[3]
- Post-traumatic stress disorder[4]
- Drug and alcohol abuse[5]
- Attention-deficit/hyperactivity disorder[6]
- Learning problems[7]
- Borderline and antisocial personality disorders[8]
- Dementia[9]
- Aggression[10]
- Suicide[11]

We see these injuries firsthand in our clinics. In our database of tens of thousands of patients, 40% have experienced a significant brain injury prior to coming to one of our clinics to seek help. And they are not alone.

According to the Centers for Disease Control and Prevention (CDC), more than two million new head injuries occur in the United States every year. Even more alarming is that the number of concussions is on the rise, particularly among kids and adolescents. Concussion diagnoses among young people ages 10 to 19 have jumped 71% from 2010 to 2015.[12] This is setting up the next generation for serious mental health issues.

Healing Head Trauma and Helping Clients

What makes the tragedy of the young woman's suicide even more devastating is that it was likely preventable. It is

possible to treat and heal TBIs and minimize the psychiatric symptoms they can cause. In the mental health field, we must do a better job of identifying past head injuries and encouraging people to heal underlying brain trauma.

No amount of counseling can make up for a damaged brain. Even when clients are highly motivated to get well, having a head injury makes it harder for them to implement the helpful strategies counselors provide. Healing the brain is the foundation for success.

Here are five ways counselors can help their clients.

1. Ask clients—*repeatedly*—if they have had a head injury. Have they ever fallen out of a tree, been in a car accident or played tackle football? It is important to note that many people forget they have had a significant head injury or they deem it too insignificant to mention, so you need to ask multiple times. In some cases, it may be helpful for clients to get a functional imaging study, such as Single Photon Emission Computed Tomography (SPECT), which can help identify brain trauma.

2. Hyperbaric oxygen therapy (HBOT). This non-invasive treatment uses the power of oxygen to enhance the healing process. A 2013 study on 56 mild TBI patients with post-concussion syndrome showed that HBOT improved cognitive and emotional functioning and quality of life.[13]

3. Neurofeedback. This computer-based, interactive therapy helps people regulate their brainwave state. There are more than 1,000 scientific studies showing that neurofeedback can help people with TBI,[14] as well as many other mental health disorders.

4. Test hormone levels. Head injuries often damage the pituitary gland, which can lead to lifelong hormonal imbalances. In people who have sustained head injuries, thyroid, dehydroepiandrosterone (DHEA), and testosterone levels are often low, which can contribute to psychiatric symptoms.

5. Omega-3 fatty acids. In Dr. Michael Lewis' book, *When Brains Collide*, he explains that omega-3 fatty acids can enhance healing after a concussion and relieve symptoms without medication.[15]

By healing brain trauma, we can better help people repair the mind and the soul. ✠

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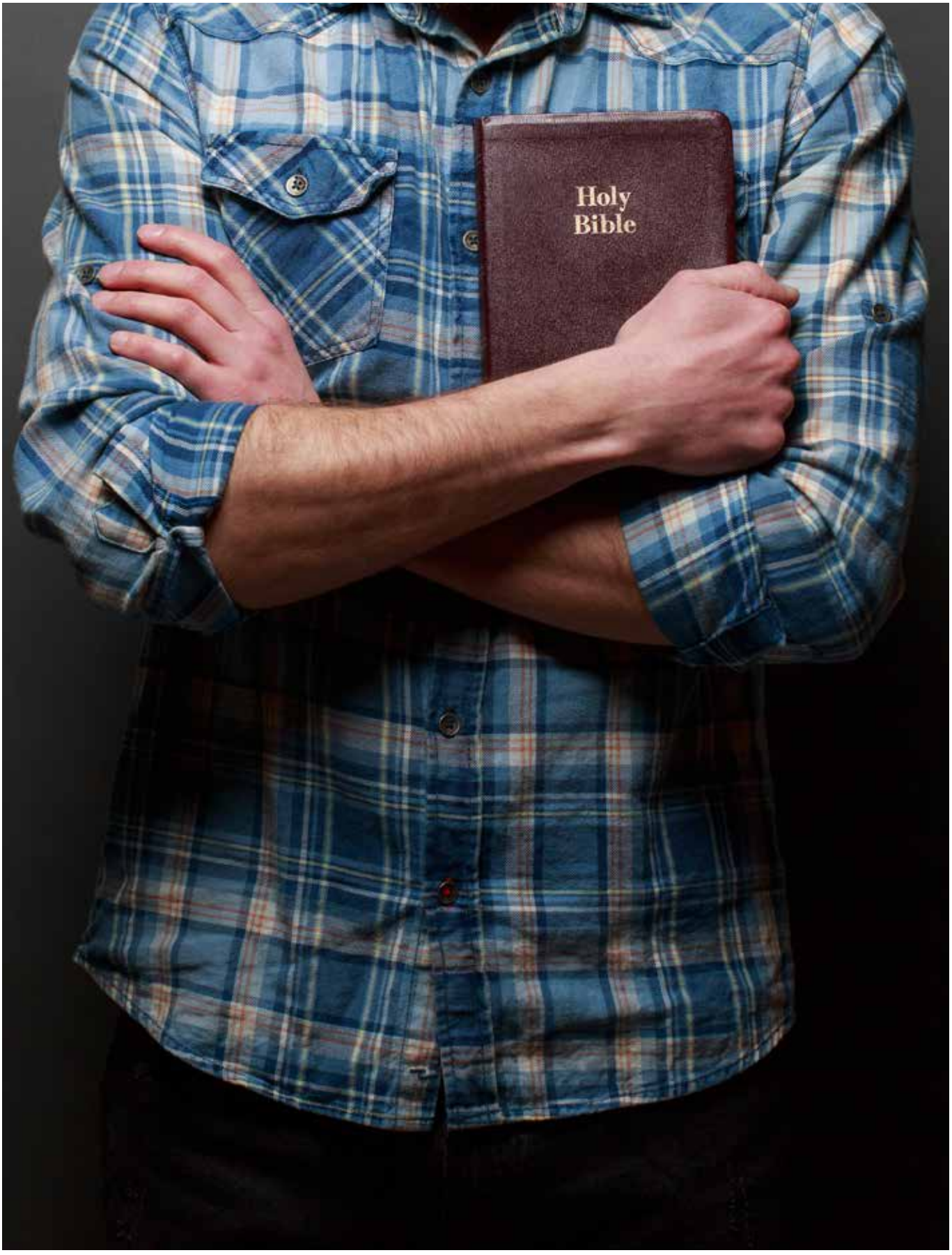
Holy
Bible

Redemptive Relationship in Treating Religious Trauma

"Every time I go to church, it feels like going to a funeral. Every Sunday is worse than the Sunday before. It's just so painful. But the church my dad screwed up is where all of my friends go, and they are sticking with me… and I want to be with my friends. I've lost a ton through this, but I don't want to lose my friends."

Those are the words of Amy, a 16-year-old girl whose father was the head pastor of a church of 3,000. His position there was terminated when it was discovered that he had been involved in an affair for seven years with a young woman on staff. He lost his church, his ministry, and his marriage. Some who attended there were enamored by this charismatic preacher, but lost their faith over the news of his unfaithfulness. His daughter lost much more, as she was forced to struggle with the impact of a unique form of religious trauma. Her father's actions left her confused and enraged. Although she was determined to survive, Amy was unsure of how to express her anger. She was furious at her father for what he did, her mother for not preventing it, God for not changing her father, and the church for kicking him out. Amy started questioning everything—from the existence of God to whether or not her father actually loved her. She was riddled with deep shame from her public humiliation. The severity of her depression and the subsequent drop in her grades caused her mother to seek therapy for Amy. Pursuing therapy was a bold move few members of their denomination ever made.

This teenager experienced a glaring example of religious trauma that comes from a faith leader falling into catastrophic sin. It is devastating because unlike the common transgressions that all of us commit, catastrophic sins have consequences for an entire organization, those involved with that organization, and individuals close to the leader who feel as though they were controlled, erroneously influenced by false teachings, or personally abused emotionally or sexually. In the aftermath, the common symptoms emerge as depression, shame, distrust, insecurity, and emerging agnosticism.

STEPHEN ARTERBURN

Most writings regarding religious trauma involve extreme and rare situations where a leader, who might also be a parent, is personally involved with the troubled individual. In the case of the previously mentioned seven-year affair, this includes the employee, the 16-year-old, and her mother. Those attending that particular church were impacted in varying degrees—some accepting that these things happen and moving on to another church and others never setting foot in a church again or believing that God is real. Thus, some were traumatized, and others just moved on. However, there are millions of healthy churches with wholesome leaders… and these types of situations are rare.

With the publication of the book, *Toxic Faith*, I began preaching in churches that were determined to present truth in a way that was healing rather than hurtful. The tour took me to Des Moines, Iowa. I had never preached there before and have not preached there since, but on that day, a woman came up to me afterward wanting to tell me her story. She told me that several years before, she was so sick that she became bedridden and required nursing care at home. The source of the illness could not be determined. She attended a charismatic church where members rallied around her in her home. The elders came to her house a few times and prayed for her to be healed, and some of the women came to minister to her with their time, food, and prayers.

After a few weeks, there were prayers for deliverance, and then prayers for her to confess the roots of bitterness that were making her sick. When her symptoms worsened and she was not healed, her depression intensified and the pastor told her she was no longer a member of the church. Members were not allowed to associate with her because there was unresolved sin that needed to be confessed. She said the pain she experienced as a result of the alienation was the greatest of her life.

There are many more examples of religious trauma due to excommunication because of a perceived lack of faith. This exclusion is actually how many churches continue to traumatize people just like this woman. Fortunately for her, one of the therapists she saw discovered the source of her illness and was able to treat it successfully. It took five years for her to become physically well, and the same amount of time for her to feel confident enough to take a risk to attend another church. After years of struggle, pain, and rejection, she picked the church where I happened to be the guest speaker that Sunday delivering the message, "The Sick Aren't Second Class in God's Kingdom." Coincidence? No way. God's Devine intervention? There is no other way to explain it.

These traumatizing churches have some common elements:

- Particular claims about character, abilities or knowledge
- Dictatorial leadership without accountability
- Performance-driven service enforced with punitive judgments
- Shame-based adherence of followers stuck in pain
- Hyper spiritualizing all problems and their solutions

Pointing out these commonalities may help clients see that they are not alone and help them identify how the traumatization with the organization or individual took place.

Additionally, the impact of religious trauma from these churches often includes the following:

- Lack of trust of all authority figures
- Confusion over what is real and healthy and what is fake and toxic
- Feelings of shame and self-ridicule over becoming an outcast and the sense of being duped
- Unwillingness or inability to belong in community with others
- Difficulty understanding the secular world
- Hyper-protective in relationships

As in the case of Amy, the 16-year-old previously mentioned, not all religious trauma comes from a strict code of beliefs or getting bad advice. The fall of a charismatic leader, whether that leader is your parent or not, can be devasting. Being sexually involved takes the trauma to a whole other level, much deeper and more hurtful. Beyond sexual involvement, there is also betrayal by a leader in a partnership, shaming and ridicule upon moving to another position at a different church, or being fired.

The goal of Christian treatment conducted by a competent therapist is to preserve or develop a healthy faith that is based on the truth of Scripture, while at the same time identifying the distortions of toxic practices that go far beyond the teachings of the Bible. The most important aspect of the treatment is the relationship between the Christian therapist and the client. There is a good chance the client has never been in a close, redemptive relationship, and the therapist will be the first if trust and respect can be established.

The goal of Christian treatment conducted by a competent therapist is to preserve or develop a healthy faith that is based on the truth of Scripture, while at the same time identifying the distortions of toxic practices that go far beyond the teachings of the Bible.

The extreme cases of religious trauma are unfortunate, and victims need great care from skilled Christian counselors. Victims of the most common form of spiritual trauma also require treatment from responsible caregivers. The most common type of religious trauma that I have witnessed over my decades of writing and talking with victims could be summed up as "*superficial and severely damaging advice*" to those in emotional, sexual, and physical abuse situations. More than a 3,000-year-old warning against this conduct is found in Jeremiah 6:14, "*They offer superficial treatments for my people's mortal wound. They give assurances of peace when there is no peace.*" Rather than seek safety first or arrange for an intervention to stop the abuse, the traumatized are retraumatized by being told to submit, pray more, confess what they have done to cause this reaction, and wait for a miracle. Victims take this advice and experience no healing, believing this is further affirmation that God either does not exist or does not care.

It is a privilege to help heal trauma and assist clients in developing a strong faith in a loving God who does not prevent abuse, but wipes away the tears of those who experience its impact. The following are some priorities in treating the religiously traumatized.

The Priorities of Treating Religious Trauma

1. **Safety.** Encourage the client to go against any advice that does not emphasize the need to withdraw from a system, organization, or church that is not safe. If the trauma is coming from someone at home, especially if kids are being impacted, finding a safe place to live or removing the abusive person from the home is essential.

2. **Grace.** Whatever grace the victim has experienced has been eradicated by the trauma. Grace does not excuse or approve; it frees a person to experience God's love through you, the counselor, rather than the authoritarian shaming that is so often expected. By offering genuine, godly grace, you reap the client's respect, which is a must for a redemptive relationship.
3. **Truth.** Toxic teaching and abusive behavior leave victims confused and unable to discern the heart of God or transformative truth. A clinician's theological perspective comes into play because questions will be asked to determine what truth is. If there is uncertainty, the client will sense it and the credibility battle will be lost. It is essential to know what the Bible actually says and be willing to seek consultation if necessary. Truth also needs to be experienced when returning to daily times of devotion, personal Bible study, and prayer.
4. **Time.** While time alone does not heal, it is needed for a complete restoration. Perhaps a client was pushed to forgive too quickly rather than entering a process of healing. Victims need help with realistic expectations of the length of time it takes to heal.
5. **Community.** The lack of supportive, healthy, same-gender relationships in communities may be part of the reason clients are attracted to unhealthy organizations or their leaders. Nurturing Bible studies, where one can be real and authentic, bridge God and His truth back into a victim's life. Grief Share (griefshare.org) groups and other recovery associations re-establish trust by allowing God's love to be communicated through others.
6. **Beauty.** God shows up in His creation, so reconnecting with, and experiencing, God is enhanced by just getting outside and soaking up nature. Simply encouraging new journeys where God's wonder is evident can be life-changing. Movement and exercise help elevate a person's mood, and training outside of a gym is far more impactful.
7. **Medicine.** Fear of psychotropic medication may have been part of the toxic teaching that facilitated the traumatization. Mistrust generated from religious trauma could lead to a lack of trust for anything suggested by any authority figure such as a doctor. Endorsing needed medication may unlock an essential element in treating trauma.
8. **Referral.** A trauma specialist may treat and resolve what cannot be improved in any other way. Consider Eye Movement Desensitization and Reprocessing (EMDR), a psychotherapy treatment, and its derivatives early in treatment rather than as the last option if nothing else works.

Fortunately, there are healthy churches and organizations that provide hope for those who have been traumatized. That was the case for John, a 17-year-old who was forced by his parents to attend a weekend that focused on biblical truth, character, and discipleship. John did not like church or the people who went there, and he did everything he knew to distance himself from anything religious. His entirely black Goth attire, shoe-polish black hair, and jet-black fingernails set him apart from everyone else who had come for an intense weekend of conservative Christian theology and male bonding. His 42-year-old group leader had been told about this young man and he was ready to deal with him.

In the first group discussion time, John was the last to introduce himself and did not have much to say. His group leader thought that might be the case, so he was ready when it happened. He told John that he noticed his black fingernails when he first walked in because while some of the other guys had on a black t-shirt or black jeans, no one else had black fingernails. The group leader asked the young man if he had brought any of that black polish with him, and he had. With that, the leader asked John if he would go back to his room to get the polish and bring it to the table.

When John returned with the polish, the leader had a simple request and a reason behind it. "Would you be willing to paint my fingernails black like yours?" "Yes," he replied. "Great. Let's do it. Then you won't be the only one here with black fingernails," said the group leader.

A smile quickly appeared on John's face. He would later say it was the beginning of his transformation of serving Christ faithfully for 10 years. God's truth is always redemptive, but each of us must exemplify it as we help people recover from trauma and restore healthy faith in their lives. ✠

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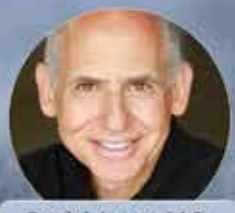
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BEST PRACTICES IN THE TREATMENT OF **DEPRESSION**

Depression is one of the most common mental health problems and one most commonly treated by counselors. However, far from being the "common cold" of mental health disorders, clinical depression is a deadly condition putting those affected at greater risk for a variety of poor health outcomes, including death by suicide.

Complicating matters is the fact that there is no one, single type of depression. Clinical depression takes many forms, including, but not limited to, Disruptive Mood Dysregulation Disorder (DMDD) that affects children, Premenstrual Dysphoric Disorder (PMDD) that affects women, Major Depressive Disorder (MDD), and Persistent Depressive Disorder (PDD). The symptoms of clinical depression are also experienced by people suffering from a variety of other maladies, including, but not limited to, bipolar disorders and post-traumatic stress disorder (PTSD).

For purposes of this article, I will focus on two, major types of clinical depression found in adults, Major Depressive Disorder and Persistent Depressive Disorder. I will also highlight important distinctions in how these two types of clinical depression may be treated.

Like nearly all mental disorders, susceptibility to major depression has a genetic component. We are all genetically hardwired to be predisposed to certain problems, including depression, anxiety, and other mental health problems. Some people are hardwired to be more prone to depression; however, MDD has the distinction of also being a direct response to stressful life events (Kendler, Karkowski, & Prescott, 1999).

A common response to a stressful life event is to withdraw. We pull back to marshal our resources so we can go back out and face the world again. Withdrawal also signals to others that we are hurting, in distress, and may need their help. However, God meant for us to live in community (Genesis 2:18; Hebrews 10:25). When withdrawal is a patient's response to depression, behavioral activation is often an appropriate frontline intervention. Behavioral activation is the "active ingredient" across a variety of depression treatments and the initial intervention of choice for many situations faced by clinicians (Cuijpers, van Straten, & Warmerdam, 2007).

While using behavioral activation when working with depressed patients, a typical approach used by clinicians is to ask clients what they are *not* doing that they would like to do and what they *are* doing that they must do. Then, therapists work with patients to schedule these particular activities, getting concrete commitments that include what will be done on what day and at what time. Clinicians also collaborate with those in their care to brainstorm on how to overcome potential obstacles to performing these actions.

Additionally, therapists will ask clients to rate several factors related to their scheduled activities. These often include assessing the importance and the patient's predicted and actual enjoyment of each action. When working with their clients, clinicians use an "experimental" approach that looks at the data results after patients have completed the activities, and then they refine the process as more information is gathered over additional therapy sessions. Clinicians will also measure patients' depressive symptoms over time to determine if the behavioral activation intervention is reducing depressive symptoms.

Of course, behavioral activation is not the only frontline approach to treating MDD. Sleep hygiene skills, various cognitive therapy interventions, medications, and other clinical tools may also be helpful in addition to behavioral activation strategies. Skillful clinicians will not engage in a one-size-fits-all approach but, instead, choose to tailor interventions to an individual's needs.

Contrasted with Major Depressive Disorder is Persistent Depressive Disorder. While the two disorders have much in common and can co-exist, the etiology of each looks quite different. Typically, traumatic, relationship-oriented stressors are at the root of PDD. Due to its chronic nature, different types of clinical interventions are needed to be effective.

Research has shown that the roots of PDD are often found in early developmental traumas. These can include conditions of outright abuse, but also neglectful environments in which patients were not able to form healthy attachment relationships (Cicchetti & Toth, 1998). Chronically depressed patients then develop interpersonal schemas that unconsciously influence how they interact with the world, themselves, and others. Two of the primary intervention targets are teaching patients emotion regulation and interpersonal effectiveness skills.

The effective clinician's role is to make what is unknown to the patient explicitly known. Therapists strive to help clients see how they view the world, teach them to recognize and regulate their emotions, make them aware of how their behaviors affect others, and instill practice skills to achieve better outcomes in day-to-day interactions.

TODD VANCE

Because the chronically-depressed patient often comes from a background of abuse and neglect, one of the clinician's first tasks is to help the client form a relationship with him or her that is built on a sense of felt safety so learning can begin. Clinicians achieve this by how they interact with patients. It is essential that therapists explicitly contrast how they treat their patients compared to the way others have interacted with them in the past.

The process of working with a chronically-depressed patient is often slow and can be challenging for clinicians. Christianity is an incarnational faith. God the Father came to man in the form of a man, Jesus Christ. By being Christlike in their exchanges with those in their care, clinicians can use these relationships as a tool that brings healing.

It is important to note there is no one cause of depression, as every mental disorder is determined by multiple factors. Therefore, there is no single best intervention to treat the various types of depression. Nevertheless, by being aware of best practices and evidence-based approaches, Christian counselors can have confidence in their technique.

TODD VANCE, PH.D., *is a licensed clinical psychologist. He is the founder of Breakforth Counseling and Consulting, LLC, a group practice serving Southwest Virginia. Dr. Vance specializes in psychological assessment and evidence-based treatments for complex PTSD, persistent depression, and anxiety disorders.*

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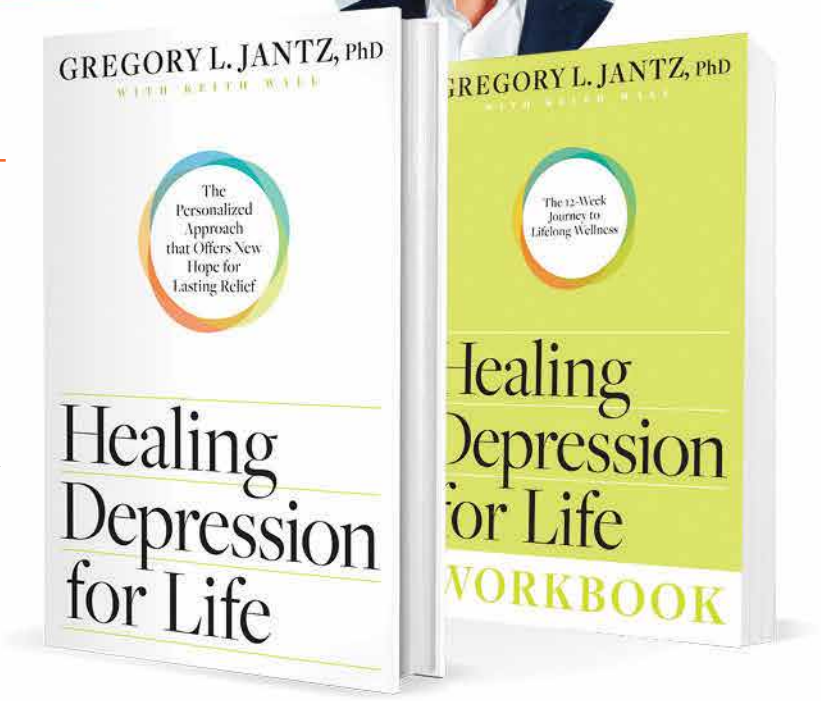

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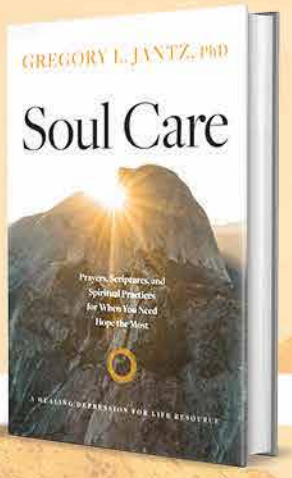

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« TED CUNNINGHAM, MACE

Listening is the Key to Understanding

"Though good advice lies deep within the heart, a person with understanding will draw it out."
– Proverbs 20:5, NLT

We get our news today from algorithms on social media and cable news networks that reinforce our biases. That means we primarily listen and watch news that corresponds with our values. However, our listening skills suffer as a result. Our grandparents watched the news to find out what was going on in the world, but now we tune in to find out what we should be mad about on any given day.

Proverbs 18:2 says, "Fools find no pleasure in understanding but delight in airing their own opinions." It is okay to have your own opinions, but not at the expense of understanding. For example, social media allows us to express our views without sticking around for a conversation. We spew and then scroll on to the next post. Proverbs 18:13 teaches, "To answer before listening— that is folly and shame." A person of understanding listens before expressing opinions, insight or experience.

One occupational hazard of experts, in almost any field, is allowing their experience to rush them into expressing their knowledge on best practices. They start solving problems and helping before fully understanding what is going on. If we want to help people, we need to slow down, lean in, and listen well.

Have you seen the movie, Patch Adams? In an early scene, Patch, a physician, rushes into his therapist's office and announces that he would like to check out from the hospital because he wants to help people.

Patch says, "I want to help people… I want to listen. I want to really listen to people." His therapist says, "That's what I do." Patch confronts him with the truth that he stinks at his job and says, "You don't even look at people when they talk to you." Ouch! When it comes to best practices, listening is at the top of the list for therapists, counselors, pastors, and coaches.

Listening and helping go hand in hand. If you want to get to know someone, keep your mouth shut and incline your ear. If you want to identify with a person's struggles, listen with emotional responsiveness. When you create a safe, judgment-free zone, people automatically open up and share. Listening is powerful!

Listening does not mean I necessarily agree with you, and disagreeing does not suggest I dislike you or your principles. I pray our culture will once again embrace this fundamental communication principle. I can listen to you without seeing your opinion as an attack on mine. I can also validate your feelings while disagreeing with your views. **Bottom line:** *Healthy people are not threatened by the opinions or feelings of others.*

In order to become a more understanding person, I must become a better listener. To do so, I need to be aware of some bad listening habits that keep me from inclining my ear. Here are 10 bad listening habits that threaten the safety of our conversations, congregations, and counseling practices. Allow the following "bad listeners" to help you identify ways to improve your listing skills.

The **Nodder** is the listener who took a management course at work that taught how to be emotionally responsive when someone is talking. As people share, give cues to let them know you are "listening." The Nodder takes it too far and gives a nod to each statement made. It is a mark of insincere listening.

The **Eye-roller** shows contempt. In my opinion, out of all 10 bad listeners on this list, this is the most disrespectful. Eye-rolling shoots right past a person's stories, ideas or opinions and goes straight to his or her character. It attacks the core of someone's personhood. The Eye-roller screams, "You don't matter!"

The **Bored** listener does not show contempt, but has a difficult time connecting with body language and facial expressions. The vibe is, "I don't want to be here" or "I'd rather be somewhere else, doing something else."

The **Distracted** listener comes in two forms. One, this person is distracted by his or her environment (people, devices, setting, etc.). Two, this person is distracted in his or her mind (thoughts, lists, errands, etc.). In either case, the lack of focus keeps this listener from dialing in to another's words and feelings.

The **Eye-wanderer** is on the lookout for something better to do or someone else to engage in conversation. This person looks over your shoulder to see who is coming. When an Eye-wanderer glazes over you, but then lights up when someone else walks by, it is difficult not to take it personally.

The **Watch-glancer** needs or wants to be somewhere else. As the little girl on Full House would say, "How rude!" A quick glance says to your spouse, "I need you to wrap this up" or "You've taken enough of my time."

The **One-upper** is a competitive listener. This person has met more famous people, been to more beautiful destinations, and purchased more extravagant items than most. In marriage, the One-upper tries to outdo his or her spouse. Comparing their strengths to another's weaknesses fills them with pride. However, trying to beat your teammate should not be the goal, so there's no need to outdo your partner.

The **One-downer** is close to the One-upper, but goes in the opposite direction. This person tries to make his or her life appear more difficult than yours. If you come home from work and say, "I had a rough day," the One-downer spouse responds with, "You think your day was rough, you should see what I had to put up with today."

Have you ever posted a picture on Facebook or Instagram of your family vacation? It does not have to be a fancy vacation in an exotic location to receive a comment like, "It sure must be nice to go on vacation. I cannot remember the last time I was able to go on a vacation. I wish I had the money to afford to go somewhere so nice." That's the One-downer.

The **Over-validator** has been where you are and experienced everything you are going through at this very moment. This person does not try to outdo or undercut your feelings, but he or she knows "exactly what you are going through."

The **Bottom-liner** needs you to cut to the chase. This is a time-oriented listener who needs enough, not too much, information to get the gist. Even if you are an excellent communicator and quickly get to the point, the Bottom-liner will cut you off when he or she feels you should be finished. Beyond the essentials, he or she only hears, "Blah, blah, blah."

May the people we help never say of us, "You stink at listening. You do not even look at people when they talk to you." Instead, we want them to hear and sense from our listening, "What you think and feel matters. You matter to me." ✠

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« DIANE LANGBERG, PH.D.

Seeking God's Research on Our Lives

According to the *Cambridge English Dictionary*, research is a detailed study of a subject, especially in order to discover (new) information or reach a (new) understanding.

Some of you are researchers. You study humans, disorders, health, clinical outcomes and practice. I am grateful for your work, as it informs and benefits my clinical outreach. I used to think of myself only as a clinician and not a researcher. However, given the previous definition, I, too, study a subject in detail for the purpose of new understanding. This is precisely what I do every time I sit with a client. I am studying the person in front of me intently, checking out my hypotheses, receiving feedback, altering my course, and refining my work. I need to learn what it is like to be him or her.

Counseling, however, is far more complex than the description mentioned earlier. Therapy is not simply about facts and outcomes, though these certainly matter. It is about a person created by the hand of God and in His image. Therapy is also about the twistings and turnings, and often the destruction, of that image. It is about relationships and suffering… wounds and despair. All of this and more are present in an individual life that matters eternally. We see and hear clients, and we work hard to understand life in their skin and with their history, but we also never fully know.

Given such complexities and significance, it is clear that part of my "research" needs to focus on me. I need to study myself in detail and continue to increase my understanding of myself. Where am I blind or deaf about others? Where and when do I retreat? What leads me to serve and protect myself rather than the one sitting across from me? Where am I arrogant, lacking the humility to say, "I do not know?" Where do I need integrity or play loose with ethical guidelines? How do my own history and current life circumstances affect me? When am I tempted to feed off the one who came for help? Who knows what I am doing behind closed doors with vulnerable people?

If I am to be a safe place for others, to have integrity of character and serve suffering and vulnerable people well, I believe there is another subject I need to research faithfully and deeply. I need to perennially study and come to new understandings of Jesus Christ. How else will I continue to grow in likeness to Him? Where else can I find an infinite pool of wisdom, trust, and love? As we study our Savior, the ongoing outcome should be that our knowledge and understanding of Him result in a maturing character of ever-increasing Christlikeness. He will not let us dodge truth or hide in "a little bit" of darkness. He will not allow us to choose a wrong to "protect" a good. He longs for us to seek Him out. He died so that we might bear His likeness.

These musings sent me to Psalm 139. The ultimate research is actually *God's research of me*. It is a piercing, thorough research leaving nothing hidden. It goes far beyond my "research" of myself. The Psalmist says, "You have searched me and known me… you know my thoughts before I do… there is not a word on my tongue that you do not know… where can I go… where can I flee that you are not there?" We are known in our mother's womb and

are never hidden from you under any circumstance. "Search and know my heart; try me and know my thoughts and see if there be any wicked way in me." Have you ever asked God what His research of you has exposed? Do you want to know what He sees?

God sees things in us that we do not see. He sees motives. He sees our cover-ups. He sees where we speak or question to feed ourselves rather than another. He sees how we use others. He sees how we flee from hard places—in ourselves or others. He is El Roi, the God who sees me. When we are in need, as Hagar was, we are eager for the God who sees. When we are deceiving, manipulating, or feeding ourselves with the lives of others, we do not want to see what He sees.

I suggest that you and I are not safe shepherds of the sheep unless we are willing to be "researched" by our God. If the feedback we give ourselves and our self-assessments are sufficient for us, we have chosen blindness instead of truth. I encourage us to ask God for His point of view. What does He see that we do not? What do we think that is not in accord with His thoughts? From what light do we run? What truth do we push away? To what pricking of the conscience do we anesthetize ourselves? We do so at our own peril… and the jeopardy of those who seek us out for care. We become the blind leading the blind and both will fall into a pit.

This work we do, this thing called counseling, should lead to a constant seeking of the God who sees, a hunger for His truth in our lives, a burning desire to be shaped into His likeness, and a steadfast pursuit of Him, simply for Himself. We need not be afraid of the searching of our God because we also know that He bore anything He finds hidden within. We also know that the exposure that results from His searching is always driven by love with the unchanging goal of making us more like Christ.

DIANE LANGBERG, PH.D., is globally recognized for her 45 years of clinical work with trauma victims, having trained caregivers on six continents. She directs a group practice in Jenkintown, Pennsylvania, and her most recent book is *Suffering and the Heart of God: How Trauma Destroys and Christ Restores*.

« GARY W. MOON, PH.D.

Cycle of Grace

I can take you to the place that changed my life. It happened 40 years ago. My wife, Regina, and I had a reservation for a retreat center in Santa Barbara, but mistakenly called a different location for directions. Long story short, we showed up at the wrong place and saw a pretty surprised-looking nun. But we looked even more surprised. The nun was wearing blue jeans and then announced, "Well, I just had a cancellation for a room that typically has a six to eight-week waiting list, so welcome."

The first stage of our cycle of grace had begun.

We were escorted to our room—which seemed larger than our entire apartment in seminary housing. The nun oriented us to the lavish location and, at some point, in the conversation proudly announced that Henri Nouwen, internationally renowned priest, author and professor, enjoys staying in this room when he visits. I had never heard of Henri Nouwen, but it seemed appropriate to read one of his books that evening. I read *Out of Solitude*. Then I read it again before going to sleep, and again the next morning. His descriptions of an unhurried Jesus—who moved in rhythms of solitude and engagement, silence and proclamation, becoming a reservoir for grace before pouring out love and miracles—changed my life. Well, perhaps I should have said, it gave me an insight that has lasted a lifetime. The actual life-changing part did not come for another few decades.

More than 30 years later, Regina and I were living in the paradise of Santa Barbara—only about two miles as a crow might travel from the retreat center that began to change our lives. By this time, we had been part of hosting and teaching in many retreats at that special place. I had talked a lot about solitude and silence; rest and rules of life; becoming a reservoir for grace instead of a canal. But there was a problem. I had become burned out. Decades of juggling projects and keeping dozens of plates spinning had taken its toll. I kept my inner angst and exhaustion a secret from most, except Regina and a few close friends. In the words of my friend and mentor, Christian philosopher, Dallas Willard, I had arrived at the "end-of-my-rope.com."

And it was from that vantage point that I heard a longtime friend, Trevor Hudson, as he offered a healing talk titled, "The Cycle of Grace."[1] Trevor had great credibility with me ever since I found out he had done some jail time with Desmond Tutu, South African human rights activist, for fighting against apartheid. So when he mentioned there would be a

connection between his words and a cure for burnout, I was riveted.

Trevor explained that many decades ago, a large mission board in India was experiencing a major problem. The missionaries they recruited and served were exiting the mission field after only a few years of service. The problem was that they were burning out faster than hummingbirds on crack. As a result, the mission board brought in a British psychiatrist, Frank Lake, and a Swiss Reformed theologian, Emil Brunner, to study the problem. The famous pair did something quite brilliant. They began their investigation by studying the life of Jesus presented in the Gospels. After all, His mission was more significant than all the mission boards that had ever been created, and He neither burned nor rusted out. Was there something to learn from the creator of life's approach to living?

What Lake and Brunner observed from the life of Jesus was that He devoted a lot of time to becoming a reservoir for grace before becoming a canal. They observed in the Gospel accounts that Jesus' life was filled with the grace of acceptance and sustenance. And, from this full reservoir, He poured out the grace of being and fruitfulness.

Accepting Grace. Before His first day of public ministry, Jesus, in His humanity, knew that He was accepted. He was nurtured in the womb of a loving mother, raised by parents who provided protection, guidance and care, demonstrated surprising self-confidence as an adolescent, and then, before His mission even began, He heard the affirmation from heaven, "This is my Son, chosen and marked by my love, delight of my life" (see Matthew 3:11-17, ESV, in its entirety).

Sustaining Grace. Lake and Brunner also observed, in passage after passage, that Jesus took the time for each aspect of His personhood to be sustained. He prayed, worshipped, memorized Scripture, and spent regular time in solitude talking and listening to His Father. He took time for friendship, table fellowship, and camping out. He went for long walks and knew the value of rest—even at least once during a storm. He welcomed, valued, and was drawn to children and outcasts. And He never seemed to be in a hurry. The word hurry could never be used to describe the life of Jesus.

The Grace of Being. After His reservoir was filled with grace, Jesus did pour out love. But this outflow, they observed, was always consistent with the very essence of His being. He did not minister while subtly seeking the world's form of significance—who I know, what I have, what others think of me. He knew the root significance of His life, His core being, and simply lived that out in the world. He knew and lived the secret of an easy yoke. His ministry was purely being who He was in the world.

The Grace of Fruitfulness. Finally, Lake and Brunner observed that Jesus did indeed produce. He was fruitful, but in the way that an apple tree is fruitful. The apple tree is just being an apple tree. And Jesus was simply being who He was—love. His fruitfulness was the essence and core character of His life. And His character was the Fruit of His Spirit. The fruit of His ministry was the natural result of His unhurried being in the world.

It was at this point in his talk that Trevor let us in on the second part of the really big discovery of Frank Lake and Emil Brunner. Instead of living in Jesus' cycle of grace—a cycle of experiencing acceptance and sustenance that flows out into being and fruitfulness—the missionaries had turned the cycle of grace into a cycle of works. They were living the cycle the wrong way around. They started with achievement, trying to produce and be fruitful; and then they hoped that if they achieved, they would be significant… and that their significance could be bartered for sustenance and they would be accepted. They had turned the cycle of grace into a treadmill of works.

And so had I. After what has now been a few years of attempting to create a very different lattice for living, a rule of life if you will, I am finally beginning to feel the truth in the words of Bernard of Clairvaux, the French abbot and leader in the reform of Benedictine monkhood.

> "If then you are wise, you will show yourself rather as a reservoir than as a canal. For a canal spreads abroad water as it receives it, but a reservoir waits until it is filled before overflowing, and thus communicates, without loss to itself, its superabundant water. In the Church of the present day, we have many canals, few reservoirs."[2]

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Endnotes

1 The talk was based on the book, *The Cycle of Grace: Living in Sacred Balance*, by Trevor Hudson and Jerry P. Haas. Nashville, TN: Upper Room Books, 2012.

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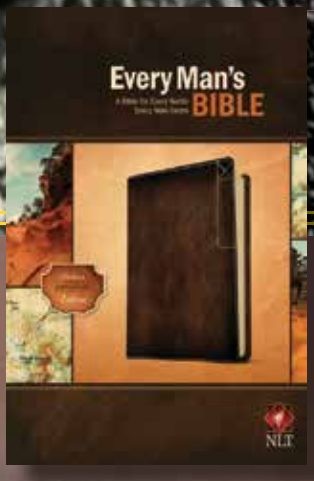

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« MICHAEL R. LYLES, M.D.

Medication and Assisted Treatments for Opioid Use Disorder

Results from the 2017 National Survey on Drug Use and Health by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 4.2% of the United States population over the age of 12 misused opioids in 2017 (p. 19). According to the Centers for Disease Control, opioid misuse accounted for 67.8% of the overdose deaths in this country in 2017 (Patel and Kosten, 2019). Medication-assisted treatment (MAT) involves the usage of medications as part of a comprehensive program to address opioid use disorder. The goals of MAT include preventing relapses, reducing cravings, avoiding overdoses, lowering infectious complications (e.g., human immunodeficiency virus (HIV), hepatitis), and keeping the patient sober and involved in treatment.

Drugs of abuse and prescription medications can both act by fitting like a key into a lock (receptor). If a drug stimulates the receptor, it is called a full agonist. If a medication fits into the receptor but does not stimulate, it is called an antagonist because it blocks the receptor from working. A drug may fit into the receptor and partially stimulate it, leading to the designation of partial agonist. In other words, an agonist turns the lights on, while an antagonist turns the lights off. A partial agonist is a fader switch that adjusts the intensity of the lights as needed. Opioids act as agonists with mu-opioid receptors in the brain. Mu-opioid receptors are a key molecular switch triggering brain reward systems and potentially initiating addictive behaviors. The drugs used in MAT act as agonists, antagonists, or partial agonists at these same mu-receptors. The following is a synopsis of commonly used drugs in MAT.

Methadone is a synthetic opioid that functions as a full agonist at mu-opioid receptors, binding so tightly that abused opioids do not have access to the receptor. It works well to prevent withdrawal symptoms and as a maintenance treatment to reduce cravings. Methadone can be used for short-term detoxification tapers, but is less effective in this manner. It has a long half-life in the body and can accumulate, making it an overdose risk if combined with alcohol or benzodiazepines. With a relatively short analgesic effect of approximately four hours, methadone is also used for pain management. However, it can only be prescribed in opioid treatment programs that have been certified by SAMHSA and registered by the Drug Enforcement Administration. Methadone is available in tablet form and liquid concentrate. Side effects include constipation, nausea, vomiting, sedation, decreased libido, and the potential for cardiac arrhythmias.

Naltrexone is a mu-opioid receptor antagonist that blocks the euphoric and analgesic effects of opioids, but can potentially trigger withdrawal by displacing opioids off the mu-receptor. Thus, a patient would have to be opioid-free for seven days before starting this medication to avoid the risk of withdrawal. Usually, patients begin taking naltrexone orally and then transition to the once-per-month injectable form after reaching stable oral dosages. Potential side effects include liver enzyme elevations and injection site reactions. The absence of any mood elevation reduces the compliance rates, especially with the oral forms of naltrexone.

Buprenorphine is a partial mu-opioid receptor agonist that can have some mild mood elevation and analgesic effect. The mood effect can be helpful when one considers the high rates of depression in this population. Both the mood and analgesic properties level off at moderate dosages and create a "ceiling effect" that reduces the risk of overdose and respiratory depression. Also, buprenorphine minimizes the risk of withdrawal and craving that patients refer to as "dope sick." It is available as a buccal film, sublingual film, implantable form, long-acting subcutaneous injection, and sublingual tablet. Since it can be misused or diverted for intravenous injection, buprenorphine is usually combined with naloxone, which is an opioid antagonist. If taken orally, the buprenorphine absorbs, but the naloxone does not. However, if crushed and injected, the naloxone will rapidly precipitate an opioid withdrawal syndrome.

Buprenorphine can be prescribed by a provider in a regular office that has completed an approved, eight-hour certification course. The provider is allowed to treat 30 patients in the first year with increasing numbers in subsequent years. There is a shortage of providers who are certified to prescribe buprenorphine. Side effects include nausea, vomiting, constipation, irritability, insomnia, and muscle cramps. It does not work well with patients who are addicted to fentanyl or carfentanil, which work on different parts of the mu-receptor.

Naloxone is also used alone to treat

opioid overdoses by reversing respiratory depression within two minutes. It can last 30-90 minutes, which may require repeated dosages to cover the duration of a long-acting opioid. Naloxone is available through intravenous therapy, intramuscular injection, and nasal spray forms. Many states are making it accessible to friends and family who are at high risk of witnessing an overdose or in a relationship with someone on high dosages of opioids.

Lofexidine and clonidine are two drugs that are used to reduce withdrawal, which is characterized by high levels of noradrenaline activity such as hypertension, increased pulse rate, muscle aches, gastrointestinal cramping, nausea, and sweating. These drugs are alpha-2 adrenergic agonists that stimulate presynaptic autoreceptors that can serve as brakes to turn down the release of adrenaline-type substances. Lofexidine and clonidine are pure acute detoxification drugs.

The goal for clinicians in opioid detoxification should be compassion and striving to prevent unnecessary discomfort and suffering. Providing proper medical treatment and care will create a therapeutic alliance that helps patients avoid prematurely exiting therapy and begin focusing on getting healthy.

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« JEANNEANE MAXON, J.D., ESQ.

Using Best Practices Helps Limit Legal Liability

Even the law is not always black and white, especially when it involves the relationship between a counselor and his or her clients. Some laws are clear. For example, if you fail to report known physical abuse of a minor client committed by his or her parent, you will likely be subject to fines or sanctions in accordance with your state's child abuse reporting statute. This is *statutory law*. Non-statutory law, however, is a world of gray, with few clear lines—this is the world of civil liability. For example, if a client expresses an intention to harm a third party and you fail to warn the third party or report it to authorities, you may be found liable under *civil law*. Our society places trust in counselors to use their professional judgment when it relates to care of clients or other individuals impacted by the counselor's relationship with the client. Because of this, more often than not, counselors who find themselves in legal trouble are in the gray world of civil law.

When a counselor faces a civil lawsuit, the Court will typically look at four factors to determine whether he or she is labile: Duty, Breach of Duty, Causation, and Damages—usually in that order. These factors are discussed further as follows:

1. Duty. *Did the counselor owe a duty to the client/individual?* The answer to this question, in the context of a counselor/client relationship, is almost always, "Yes." Both the American Association of Christian Counselors (AACC)[1] and American Counseling Association (ACA) Codes of Ethics[2] indicate that counselors owe their clients certain duties of care and confidentiality. "Duty" may also extend to third parties, such as the duty to protect third parties from harm.[3]

2. Breach of Duty. *Assuming the counselor owed the client/individual a duty, was the duty breached?* For this question, the Court will likely consider the circumstances leading to the issue in question. For example, if a counselor is sued for failing to report suicidal ideation of a client, the Court will determine whether the counselor's professional judgment was correctly exercised. To prove that a duty was not breached, a counselor should carefully document the reasons for his or her decision within the client's files. In cases involving psychiatrists, courts have sided with the psychiatrist 80% of the time when the psychiatrist can justify his or her reasons for choosing not to report suicidal ideation.[4]

3. Causation. *Assuming the counselor breached a duty owed to the client/individual, was the breach the cause of any damages suffered by the client/individual?* Even when a counselor breaches a duty, his or her actions may not have led to, or caused, the injury suffered by the client. Let's consider this example: A counselor has failed to maintain proper boundaries and agrees to meet a client for coffee outside the counselor/client relationship. The client slips and falls because of ice on the sidewalk at the coffee shop and breaks her arm. While the counselor acted outside of best practices and in violation of the Codes of Ethics previously mentioned, his actions did not cause the client's injury. If, however, the meeting took place in the counselor's home, a court would likely determine that the causation factor is met.

4. Damages. *Assuming the three previous factors are met, what monetary value would adequately compensate the client/individual for injuries suffered?* Damages may include physical/mental injury, lost work, pain and suffering, and other losses.

Most civil cases will "settle" rather than going to trial, meaning that the counselor/defendant will make a payment to the client/plaintiff at some point before trial. While the purpose of a "settlement" is typically to avoid the costs and uncertainties of a verdict in a trial, settlements can still be costly, particularly if the counselor does not have adequate malpractice coverage.

Recommended best practices outlined in the AACC Code of Ethics, which are not necessarily black and white laws, include, but are not limited to:

• **Maintaining a safe and confidential environment** for counseling sessions.[5] This includes ensuring that the area is free of potential hazards (e.g., objects or pictures that are not secured), maintaining a safe, ice-free entryway, and keeping clients' paper files in a locked and secure location. Also, if applicable, it is essential to "childproof" your counseling room and waiting area.

• **Refraining from sexual misconduct,** which can lead to sexual harassment, assault, and other serious charges.[6] Out-of-office contact, especially engaging in a romantic relationship with a client, can prove to be very costly. Sadly, the Healthcare Providers Service Organization (HPSO) and Continental National American Group (CNA) reported that "… approximately 40% of the professional liability claims in [a report they conducted] involved the counselor engaging in an inappropriate sexual/romantic relationship. These claims resulted in indemnity payments of $2.2 million."[7]

• **Failing to consult or "refer out" where client issues are beyond the counselor's expertise,**[8] which may cause the client to engage in a dangerous action based on sub-standard advice. In one documented case, *Hungerford v. Jones*,[9] an inadequately trained social worker attempting to treat repressed memories was sued after inadvertently leading a patient to believe her father had sexually abused her when he had not.

• **Failing to secure informed consent,**[10] which can result in a myriad of misunderstandings related to billing, confidentiality, and counselor limitations, to name a few.

• **Failing to protect third parties from harm,**[11] which is a common cause of civil liability for counselors and can lead to very costly damages.

Of course, these issues just touch the surface when it comes to the importance of maintaining best practices for counselors. Using best practices, following the AACC Code of Ethics, and keeping adequate malpractice insurance will help protect counselors from costly civil liability and lawsuits. More importantly, as Christians, we are called to serve others as if we are serving the Lord Himself (Colossians 3:23-24). ✠

The information contained in this column is provided for educational purposes only. Nothing in this column should be construed as legal advice, and readers should seek advice from a qualified attorney within their jurisdiction for concerns/questions on specific matters. Law varies from jurisdiction to jurisdiction.

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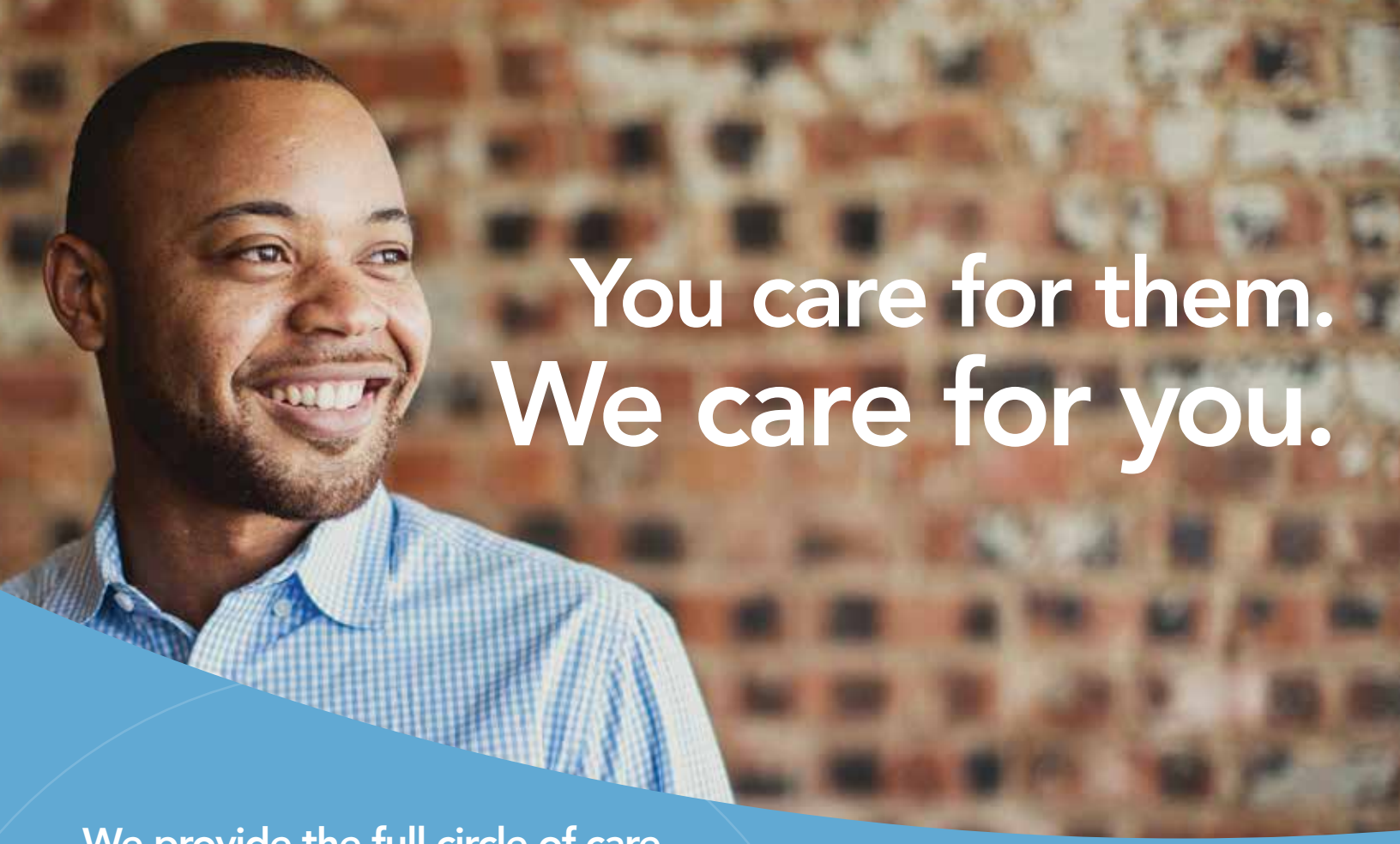

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« GREGORY L. JANTZ, PH.D.

When Everything Isn't Enough

I recently went to a gathering honoring an 18-year-old. As I stood in line to sign the guest book, I walked past pictures of her displayed on tables along with pieces of her writing and artwork. The photos I saw showed her at different ages, with various family members, and in several locations—in each one she was always smiling, sometimes with a goofy expression. If I had not known better, I would have thought I was at a birthday or graduation celebration instead of a funeral.

The gathering was at a church full of family and friends—family and friends who sat in grief and shock over losing someone so young from suicide. One female who spoke recounted the pain of hearing the news and the torment of wondering, "Was there something more I could have done? Did I do everything I could?" In the weeks that passed, she realized she had done everything she could. Looking around the church at family, friends, and the community of support, she concluded those surrounding this young woman before her death had also done everything they could. She acknowledged the terrible truth that, sometimes, when you do everything you can, it still isn't enough.

Such, I think, is the dilemma of the counseling profession. There are no quick fixes, no magic wands or pills, and no guarantees. There are plenty of times when it seems no progress is being made, when you are working harder than the person sitting across from you, and when all your insights and suggestions seem to fall on deaf ears. I will admit I have felt like Sisyphus, pushing a client's doubt and mistrust up a steep hill, reaching the top—the breakthrough

I was hoping for—only to have him or her roll down into relapse and setback. Even when things go well, I will admit to being jealous of Jesus—that out of the 10 lepers He healed, at least one came back to thank Him. There are days I would gladly settle for 10% gratitude.

In those times, I can find it hard to muster the energy for going to one more seminar, logging in to one more Webinar, traveling to one more conference, pouring over one more book or study. I will ask myself, "Why am I going to all this trouble? Why spend time researching a new strategy or reading about a promising new approach?" Who really knows what constitutes "best practice" anyway, when there are no X-rays for anxiety, no dissections for depression, no brain mapping for motivation? Ours can be an inexact science. Therapists do not read black-and-white pathology reports; we read the words, emotions, actions, and reactions of those we serve.

Everything is a big word, and it isn't always enough. However, when that "everything" isn't enough to change the situation, perhaps "everything" can be enough to change you.

As a leader, I try to keep those times to myself. Partially, because I am embarrassed by them and do not want to influence those I lead negatively. The last thing I want is to give the impression that professional development is just a box to be checked for state licensing requirements or additional study is something you only do when you have the inclination, time or energy.

As I think about what is required to keep up on the newest research or integrate the latest psychotherapy best practice, I am reminded of Proverbs 11:14 (NLT) that says, "Without wise leadership, a nation falls; there is safety in having many advisers." Or, in my favorite version (NASB), "Where there is no guidance the people fall, but in abundance of counselors there is victory." When I am in my office counseling others, I have behind me the accumulated wisdom of many advisors and my bookshelves attest to my abundance of "counselors!" Wise leaders know they need the guidance of others to gain victory. I am grateful for the ways such guidance can be obtained today, in person as well as online. Others have put forth the time, energy, expertise, and effort to make that guidance available to me; my responsibility is to avail myself of it—even when what I would rather do is unplug, tune out, and turn off.

As therapists, we are not expected to fix every person, heal every wound or fill every void. Those were never in our job description. Our job, as I see it, is to equip those we work with to discover their own fixes, create their own healing, recognize their own voids, and help them find a way to fill the holes. Our work, I am so often reminded, does not include magic or guarantees. We work with, maddeningly often, imprecise people who feel something is wrong but are not sure what it is; and although we are confident as therapists what their problem is, they refuse to trust our judgment. Because of this, we need many voices, many advisors, and many counselors to come alongside us to help us find that one healing pathway for that one hurting person. Therein lies the victory.

The speaker that day counseled those gathered to grieve that they did everything they could for this young woman and, sadly, it was not enough. She went on to say, "But, you still did everything you could." Everything is a big word, and it isn't always enough. However, when that "everything" isn't enough to change the situation, perhaps "everything" can be enough to change you. Instead of dwelling on the "what ifs" and "could I haves," know you did what you could, which is all anyone can realistically expect.

Thankfully there have only been a few times when everything I could do for someone wasn't enough. I have played that "what if" game myself, which is a terrible game to play when you are grieving and in pain. If such a time comes for you, when everything isn't enough, I hope you will remember that you did what you could. You took the time to research. You read the newest book. You kept up on the latest strategy. You listened to one more presentation on your way to finding an answer. Maybe none of that was enough for this time, but perhaps it will be enough for the next.

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« FERNANDO GARZON, PSY.D.

Exploring Evidence-based Practices in Community Mental Health, School Settings, and Child Integrated Medical Center Treatment

What Influences Evidence-based Treatment Implementation in Community Mental Health Settings?

Marques, L., Dixon, L., Valentine, S.E., Borba, C.P.C., Simon, N.M., & Wiltsey Stirman, S. (2016). Providers' perspectives of factors influencing implementation of evidence-based treatments in a community mental health setting: A qualitative investigation of the training-practice gap. *Psychological Services, 13*(3), 322-331.

Evidence-based treatments (EBTs) are rarely practiced in community mental health settings. Marques and colleagues sought to learn about the impediments and facilitators to implementing such strategies in an ethnically diverse community mental health site preparing to receive evidence-based training. They also wanted to learn how to make EBT training better for these settings.

The researchers interviewed 28 mental health providers who worked in a center located in the highest poverty and crime-rated area of Massachusetts. Sixty-one percent of the population in the area was Latino. Ten social workers, five psychiatrists, three psychologists, one nurse, and nine mental health-related student trainees participated in individual, 1.5-hour, semi-structured interviews. The researchers applied qualitative directed content analysis principles to the transcriptions.

Clinicians expressed significant concerns. Where does one find the time to learn EBTs? Many community mental health centers have high productivity expectations. What about the clients themselves? Therapists worried about potentially harming clients with trauma-focused EBTs since most clients were living in settings with ongoing violence. Providers believed EBTs were not flexible enough to handle the numerous crises and emergencies that their clients faced. Therapists assumed that their clients, with limited education and literacy, could not benefit. They added that no-shows and non-attendance were frequent occurrences in their setting, so the sequential nature of EBTs would be jeopardized.

Marques and colleagues highlighted how the above misperceptions could impact community mental health clinicians' motivation to learn and apply EBTs. The findings the researchers emphasize should inform EBT training in such sites. Without adjustments, EBT training could easily fail to deliver meaningful results in the community mental health setting. For example, the researchers recommended that clinics should lower productivity requirements during the training week or provide a stipend to remove the work pressure. Evidence-based treatment programs themselves should make use of case examples fitting the situations of community mental health clients. Studies exist that support the effectiveness of EBTs

with severely distressed populations like the ones these centers serve, so these should be presented to undermine negative assumptions. Evidence also exists supporting improved client attendance with such structured treatments. Post-training should include ongoing consultation as well.

The qualitative nature of the study has inherent limitations in producing generalizable results, but the findings may be consistent with many community mental health therapists' experiences. The lesson for Christian mental health professionals, and secular alike, is clear. Evidence-based treatment training must be contextualized to fit the types of clients seen in the community mental health setting. Therapists' underlying concerns about EBTs must be discussed openly as a vital part of the education process. Research information and case examples can be presented to address these concerns.

Can Evidence-based Trauma Interventions Work in School Settings Statewide?

Hoover, S.A., Sapere, H., Lang, J.M., Nadeem, E., Dean, K.L., & Vona, P. (2018). Statewide implementation of an evidence-based trauma intervention in schools. *School Psychology Quarterly, 33*(1), 44-53.

Increasingly, schools support students exposed to numerous traumas—physical and sexual abuse, domestic violence, community crime, natural disasters, and other ordeals. Hoover and colleagues describe the implementation of an innovative, statewide approach to incorporate evidence-based trauma treatment into Connecticut's elementary and high schools. Part of the impetus for this project was the Sandy Hook Elementary School tragedy in 2012.

The approach applied was Cognitive Behavioral Intervention for Trauma in Schools (CBITS), an empirically-supported, school-based strategy to help students in grades five through 12. The method combines 10 group sessions, one to three individual sessions, two-parent psychoeducational sessions, and a teacher educational session to aid students identified as showing symptoms of trauma or psychological distress.

The researchers described the careful way the Connecticut Department of Children and Families and the Child Health and Development Institute worked with schools statewide to implement the program. District and school leadership were oriented to the program. Twenty school-based clinicians in different schools trained over a nine-month period in the model. Biweekly clinical consultation calls occurred, and feedback was given on randomly selected audio recordings of sessions. Outcome measures evaluated trauma symptoms, psychological distress, and academic performance. Three hundred sixteen out of 350 children statewide (90%) completed the program.

The researchers noted the students demonstrated "marked improvements in PTSD symptoms and behavioral problem severity, as well as modest improvements in functioning. In addition, caregivers were very satisfied with services" (p. 49). Significant implications occur from this program. Multiple barriers commonly exist in treating traumatized children in community mental health settings. For example, it takes time out of caregivers' schedules, involves transportation and, many times, community mental health centers have waiting lists. Providing intensive, evidence-based intervention in schools reduces issues regarding access to care and potentially increases the quality of care. State and local efforts to implement such treatments in school settings are strongly supported by this study.

How do Evidence-based Treatment Protocols Fit with the Realities of Child Mental Health Treatment?

Whiteside, S.P.H., Leffler, J.M., Hord, M.K., Sim, L.A., Schmidt, M.M., & Geske, J.R. (2018). The compatibility of clinical child mental health treatment and evidence-based treatment protocols. *Psychological Services.* Advance online publication.

Whiteside and colleagues examined the compatibility of evidence-based treatment (EBT) for children and the characteristics of medical center community-based child therapy. In a large, Midwestern medical center, they reviewed medical records of the mental health therapists and medical professionals for new child patients who had symptoms capable of being addressed by common EBT protocols. Specifically, they wanted to know the percentage of children receiving enough sessions to complete a typical EBT protocol.

The researchers grouped billing records for new child patients into nine categories (depressive disorders, anxiety disorders, ADHD, adjustment disorders, eating disorders, disruptive behavior disorders, medical disorders, learning disorders, and other). The 495 children identified through this review were predominantly white (80%), from a variety of socioeconomic backgrounds, and balanced regarding gender (51% female).

To estimate the average number of appointments a child EBT takes, the researchers reviewed meta-analytic studies, the session number for a large clinical trial for childhood depression, and the number of sessions for an empirically-supported behavior management training protocol. Together, the data suggested 13 sessions (12 plus an assessment session) was a reasonable average number for most EBT protocols.

Their findings were startling.

While many children had symptoms amenable to EBT treatment, only 7% attended sufficient sessions to complete a typical protocol. The researchers also identified many children who did not get referred from a medical provider to a clinician for therapy. Such cases were sometimes managed pharmacologically or by other means. When referred for treatment, the average number of appointments was between two and six, depending on the disorder. The researchers emphasized the problems this reality presents. Most EBT protocols teach skills sequentially. If clinicians adhere to the manuals, very few children will attend enough sessions to master the critical components of the EBT treatment.

The present study was limited in that it did not include fidelity or outcome data, so it is uncertain whether the treatment goals for the children were met in the number of sessions provided. The extent of assessment to arrive at the diagnosis was also unclear.

The study findings, however, point to the disconnect between child EBT treatments and medical center and community mental health center conditions. Many settings do not see children for the treatment length of the typical EBT protocol. For Christian and secular mental health professionals who want to incorporate EBT strategies into their work with children, creativity is, therefore, needed. Child therapists in short-term treatment settings must identify key EBT protocol components and adapt the treatment presentation to fit the likely number of sessions. As further studies are done, researchers must develop protocols that correspond better with the short-term nature of many child treatment settings. ✠

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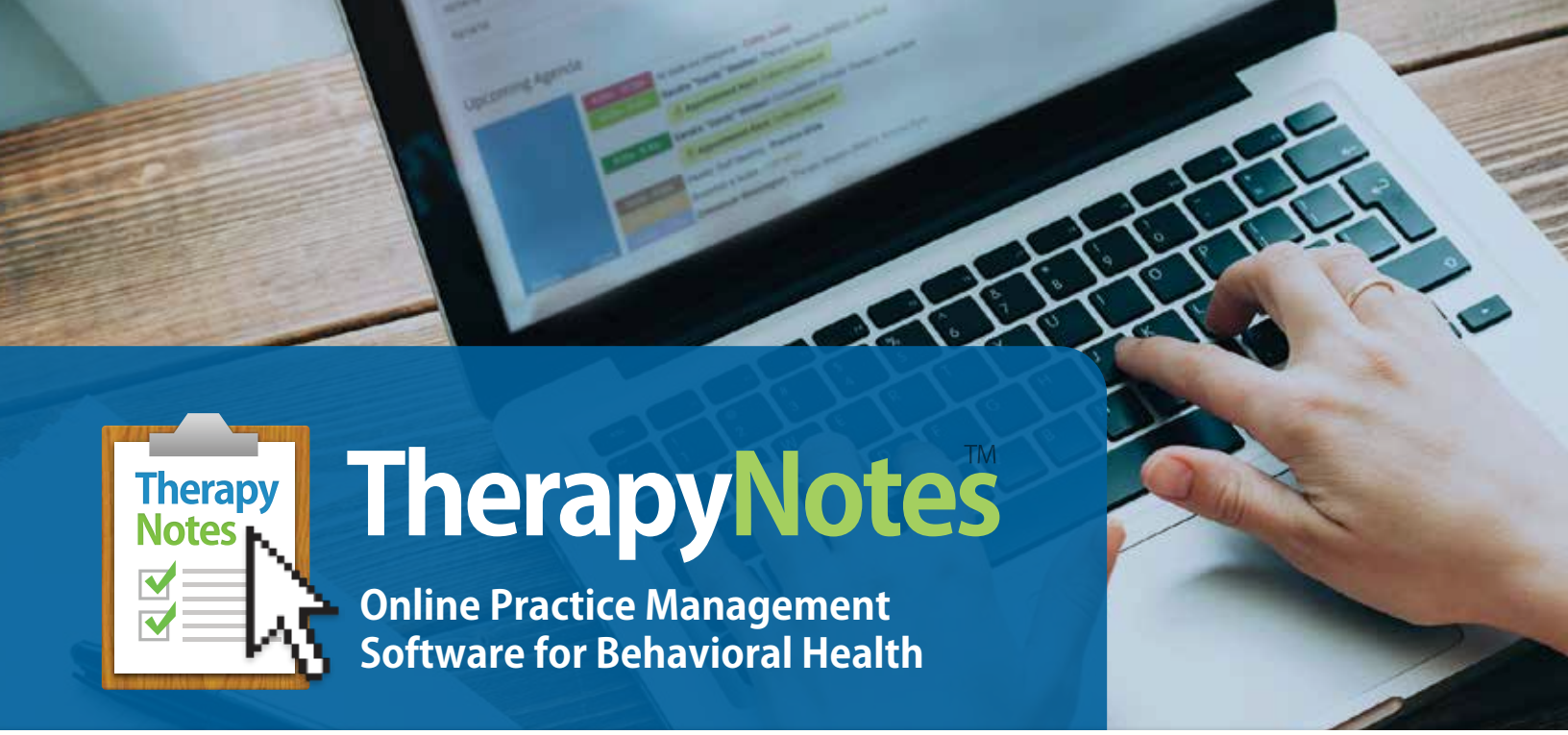

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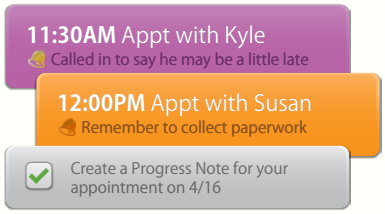

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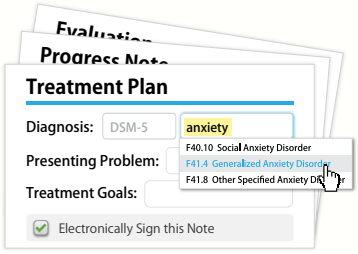

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Addressing Integrative Issues in the Service Delivery… – Rachel Stephens and William Hathaway

1. Trauma victims experience relief at seeing how
   - O a. their bodies and brains have been carefully designed to help them survive
   - O b. trauma will self-heal eventually if given enough time
   - O c. they can heal by learning to adaptively dissociate from trauma
   - O d. trauma and suffering are necessary to growth in life

Best Practices in the Treatment of Depression – Todd Vance

2. Typically, traumatic relationship-oriented stressors
   - O a. are the cause of most major depression
   - O b. are at the root of PDD
   - O c. are generally treated with medication alone
   - O d. are not responsive to emotion regulation strategies

Current Research Trends Regarding Best Clinical Practices… – Clark Campbell

3. Cognitive Processing Therapy (CPT) is a form of cognitive therapy that
   - O a. uses long-term exposure to similar trauma
   - O b. reconditions the brain using brain imaging
   - O c. is similar to EMDR but less intensive in nature
   - O d. helps clients develop a new understanding to their traumatic events

Identifying Those in Need of Psychological Trauma Care – Harold Koenig

4. Which of the following is NOT true?
   - O a. there are currently no evidence-based treatments for moral injury
   - O b. subthreshold PTSD is more common than full PTSD
   - O c. prior traumatic events do not impact current trauma
   - O d. moral injury is strongly associated with PTSD

Redemptive Relationship in Treating Religious Trauma – Stephen Arterburn

5. Traumatizing churches have which common elements?
   - O a. dictatorial leadership without accountability
   - O b. performance-driven service enforced by punitive judgments
   - O c. hyper-spiritualizing all problems and their solutions
   - O d. all of the above

When Everything Isn't Enough – Gregory Jantz

6. Jantz offers comfort by reminding us that when everything we do isn't enough
   - O a. we can try harder next time
   - O b. people are still responsible for their own actions
   - O c. we did what we could
   - O d. all of the above

Seeking God's Research on Our Lives – Diane Langberg

7. Langberg asserts that the ultimate research is
   - O a. God's research of me
   - O b. counselors seeking to truly research their clients
   - O c. study done to understand the root feelings of others
   - O d. our researching the hidden things of God

The Challenges of Working with Complex Trauma – Heather Davediuk Gingrich

8. Phase 1 of complex trauma work involves
   - O a. processing traumatic memories
   - O b. adjusting to living as a whole person
   - O c. safety and teaching emotional regulation skills
   - O d. safety and developing new coping skills

The Missing Link of Mental Illness… – Daniel Amen

9. From 2010-2015, the diagnoses of concussions
   - O a. have increased 71% in young people age 10-19
   - O b. have decreased 51% in people age 10-19
   - O c. have been on a general increase of 25%
   - O d. have increased 71% for boys in sports programs

Listening is the Key to Understanding – Ted Cunningham

10. Cunningham says that healthy people are
   - O a. completely sure of what they believe
   - O b. not threatened by the opinions or feelings of others
   - O c. quick to see an attack on their value system
   - O d. able to correct false teaching quickly

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Participants will:

1. Increase awareness and content expertise on current trends in mental health practice.
2. Be able to articulate a more comprehensive understanding of this issue's core theme.
3. Be able to integrate spirituality and faith-based constructs into the delivery of care.

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Please rate the following on a scale of 1–5 (1 meaning **Poor** and 5 meaning **Excellent**):

1. _____ This issue of CCT is relevant to my practice as a mental health professional.
2. _____ The articles in this issue are comprehensive and well written.
3. _____ I would recommend this home-study program to other professionals.

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