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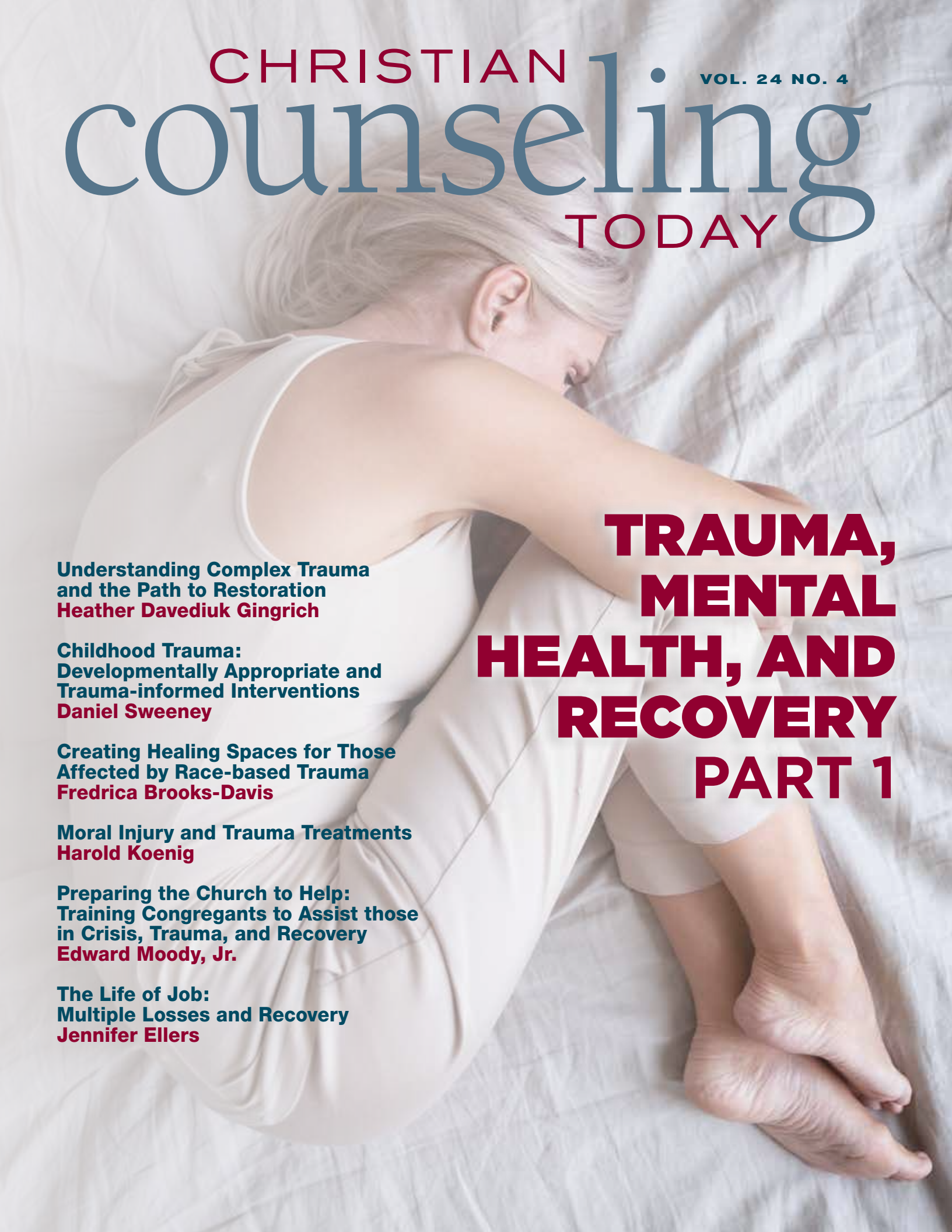

TRAUMA, MENTAL HEALTH, AND RECOVERY PART 1

Understanding Complex Trauma and the Path to Restoration
Heather Davediuk Gingrich

Childhood Trauma: Developmentally Appropriate and Trauma-informed Interventions
Daniel Sweeney

Creating Healing Spaces for Those Affected by Race-based Trauma
Fredrica Brooks-Davis

Moral Injury and Trauma Treatments
Harold Koenig

Preparing the Church to Help: Training Congregants to Assist those in Crisis, Trauma, and Recovery
Edward Moody, Jr.

The Life of Job: Multiple Losses and Recovery
Jennifer Ellers

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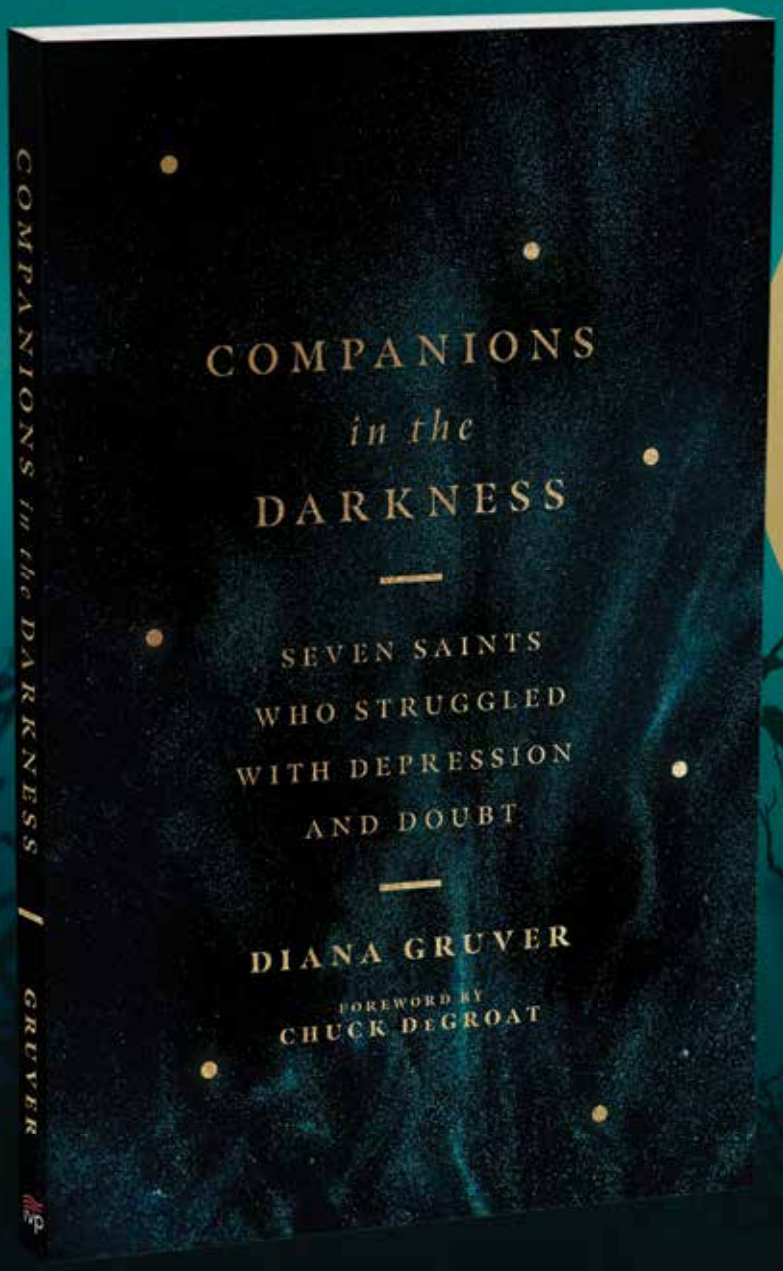

The church's relationship with depression has been fraught, and we still have a long way to go.

Drawing on her own experience with depression, Diana Gruver looks back into church history and finds depression in the lives of some of our most beloved Christian leaders. Without trying to diagnose these figures from a distance, Gruver tells their stories in fresh ways, taking from each a particular lesson that can encourage or guide those who suffer today.

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author of *When Life Goes Dark*

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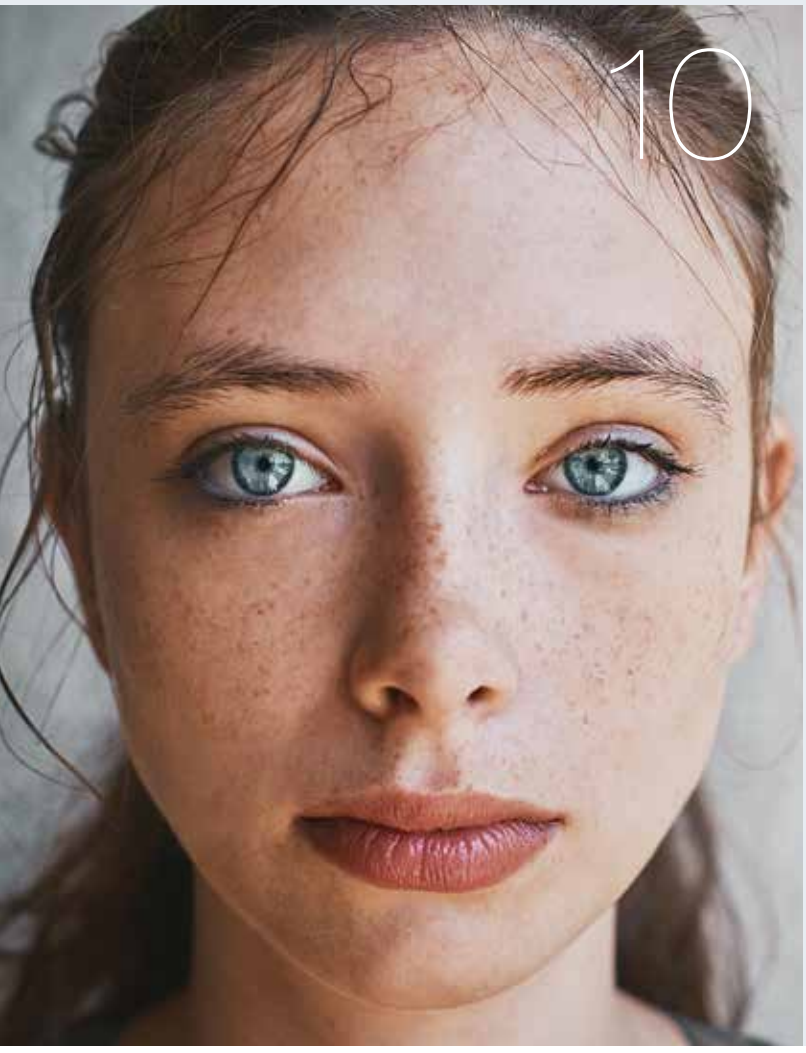

23 Creating Healing Spaces for Those Affected by Race-based Trauma *by Fredrica Brooks-Davis.* Racial discrimination and the ensuing disorders that accompany it are real and very present today. Fredrica Brooks-Davis, clinical psychologist and Founder and Executive Director of the Restoration Center, Inc., describes the reality of race-based trauma, how to create a healing space to reduce the pain and pressure on those who are currently experiencing the impact of these unjust incidents, and the urgency to initiate change.

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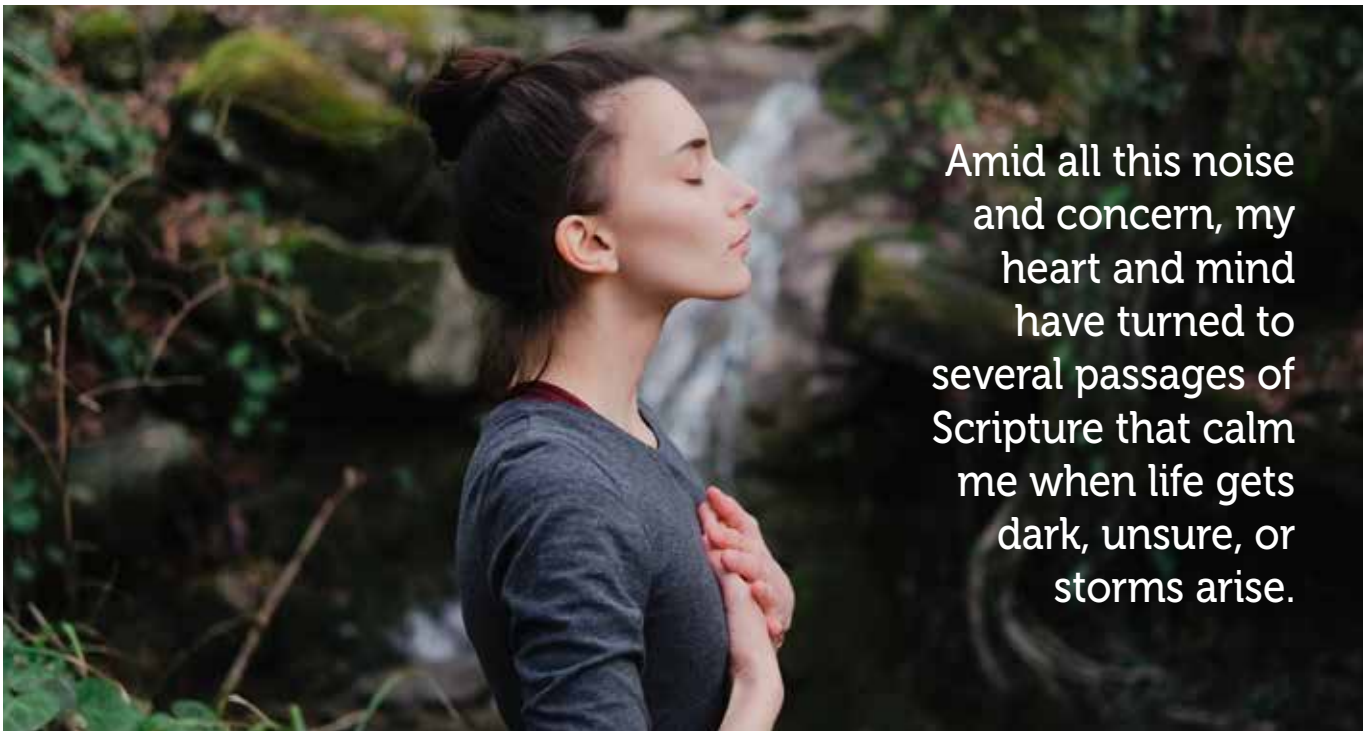
« TIM CLINTON, ED.D., LPC, LMFT, BCPCC

PEACE, PEACE



This issue of *Christian Counseling Today* (*CCT*) could not have come at a better time. What a ride it was in 2020—the COVID-19 pandemic, lockdowns, losing loved ones, racial tensions, rioting, job loss, the election chaos, the push for and distribution of a COVID vaccine, the Georgia Senate runoff, the horrific U.S. Capitol breach, the suppression and censorship issue, round two of the presidential impeachment proceedings, the transition of power to a new White House administration... and who knows what is next!

I have yet to talk with even one person who could not wait for 2020 to be over… to put it all behind and move on to brighter days. However, so far, 2021 seems as though we may have jumped straight into the proverbial frying pan. The journey has been rough and very traumatic for most. I believe the American people are emotionally drained and deeply divided—crying for a break, for peace, and praying for God to come down and bring hope and healing to our land.

Some are claiming things will get better, while others believe the judgment of God may be coming soon. It reminds me of the passage in Jeremiah 8, where the false prophets claimed things were going to be fine… that there will be peace, peace. It reads, "… From the least to the greatest, all are greedy for gain; prophets and priests alike, all practice deceit. They dress the wound of my people as though it were not serious. 'Peace, peace,' they say, when there is no peace" (Jeremiah 8:10b-11, NIV). I do not know what the future holds for America, but I am praying for, and believing in, peace. Psalm 20:7 brings a calming word, "Some trust in chariots and some in horses, but we trust in the name of the Lord our God." Peace, however, I have learned starts with you and me.

Amid all this noise and concern, my heart and mind have turned to several passages of Scripture that calm me when life gets dark, unsure, or storms arise. Isaiah 26:3 (NKJV) says, "You will keep *him* in perfect peace, *Whose* mind *is* stayed on *You*, Because he trusts in You." However, there are several challenges and steps to finding and living in personal peace.

Problems, Past, and Pain. I have learned through the years that problems are inevitable. Job 5:7 (NIV) says, "Yet man is born to trouble as surely as sparks fly upward." No matter how hard we try to ignore or avoid difficulty in life, somehow it finds and disrupts us. A broken past… physical pain… emotional

heartache… relational distress—they can all run very deep and blind the eye. Add in suffering, and it reaches even deeper. It took me a while to understand how the past really isn't the past, especially if it affects the present. Sometimes the pain of life is extreme and of another sort, and we consider that in this issue of *CCT*. In the end, I believe what we do with our problems and pain will determine our road forward. If we invite God into those moments, those places, I know He can, and will, use it for our good.

Presence. Practicing the presence of Christ, our "audience of one," keeps the heart and mind focused on the eternal. I have found that my sense of calm is often directly related to holding on to "… the Lord is near" (Philippians 4:5) and that He is in the midst of it all. I often read Psalm 46, which reminds us that "God is our refuge and strength, an ever-present help in trouble…."

Prayer. Prayer takes us to God—His thoughts, His ways, His presence—to the One who says, "Come unto me, all ye that labour and are heavy laden, and I will give you rest" (Matthew 11:28, KJV). It is interesting to me that Paul understood and challenged us on the power of prayer when he said, "… do not be anxious about anything, but in everything by prayer and supplication with thanksgiving let your requests be made known to God. And the peace of God, which surpasses all understanding, will guard your hearts and your minds in Christ Jesus" (Philippians 4:6-7, ESV). Prayer fuels peace.

Perspective. I remember an old song by Johnny Nash that my sister, Ruthann, used to listen to and sing called, "I Can See Clearly Now" (the rain is gone). Darkness… storms… pain… confusion—they can profoundly influence how we see and live life. What you see, your perspective, is everything. Notice the words of Jesus in John 16:33 (NKJV), "These things I have spoken to you, that in Me you may have peace. In the world you will have tribulation; but be of good cheer, I have overcome the world." My mother would always remind us that behind the clouds, the sun is still shining—wise words that have helped me through some tough spots.

Plan. The road forward, the pathway to change, is a continuum that we must assess and target our efforts to somehow, someway move forward. It may start with insight or clarity and establishing short and long-term goals. Too often, we rush in with a specific "quick-fix" strategy when the healing is going to take time. Sometimes it is best to simply sit and be with the person going through the storm. Hearing and following the lead of the Spirit of God are essential.

Priorities. If we do not know the road forward, then we cannot possibly begin to prioritize how to get there. Wisdom shows us the way. Progressive steps under the guidance of the Spirit of God, anchored in the Word of God, and salted with clinical knowledge and insight are paramount.

Present. In our fast-paced, drive-through, microwave society, it is all about instant gratification and the "cult of the next best thing." Being distracted by our phones, social media, and all the FOMO (fear of missing out) has led to a culture of profound disconnection. How many times have we found our minds drifting while in prayer or during a meaningful conversation, and in that very moment decisively reaching for our phones? Get off the phone. Get rid of the distractions. Disconnect, and be present. Be in the moment.

Positive. I have heard the expression, "choose to be positive," so much that it has lost its significance. However, there is so much negativity today, even hate, that positivity is something we could all stand to incorporate into our lives. Let's focus on putting a filter on what and who we allow in our heads and lives… what we take in—thoughts, emotions, actions, and people. And by the way, do not waste any time or energy on trolls or haters! They are not worth a moment of your attention… keep moving forward.

People. I have learned along the way that the antidote to pain and trauma is relationships, healthy relationships—people who pull you up, not down. Without question, every Timothy needs a Paul. And every Paul needs a Timothy, too. We all need someone who is there speaking truth, mentoring, encouraging, and helping. If you do not have a person like this in your life, ask God to bring you someone now.

May the peace of God rule in your heart. Remember, peace flows from the heart of God and is ours if we will pursue it. Soak in it, and then share it with others. That is why I love what we do. We get to help change the world one session, one life at a time. I hope you enjoy this edition of *CCT*, and may God continue to lead and bless your life and counseling ministry. Thanks for being a member. We love being a part of your life!

TIM CLINTON, ED.D., LPC, LMFT, BCPCC, is President of AACC, Executive Director of the James Dobson Family Institute, and co-founder 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 *Break Through, The Struggle is Real,* and *Peace for Your Mind, Hope for Your Heart.*

Understanding Complex Trauma and the Path to Restoration

Most of us have a sense of what trauma is, but what is complex trauma? As the name implies, it is a type of trauma that presents with a greater degree of complexity in symptoms than post-traumatic stress disorder (PTSD). While PTSD can result from even a single traumatic event, such as a natural disaster, complex PTSD (C-PTSD) is a consequence of chronic, relational trauma. Usually, the traumatic experiences related to C-PTSD take the form of child physical, sexual, emotional, and/or spiritual abuse at the hand of someone who is supposed to be a protector (e.g., parent, coach, church leader). The fact that such abuse occurs during the developmentally sensitive years of childhood, the ongoing nature of trauma, and the accompanying sense of personal betrayal are all factors that impact survivors. Therefore, both C-PTSD symptoms and the path toward healing share similarities with PTSD while also differing in some significant ways. This article is more fully developed and referenced in my book, *Restoring the Shattered Self* (2020), and the co-edited book with my husband, Fred, *Treating Trauma in Christian Counseling.*

Post-traumatic Symptoms

Survivors of C-PTSD exhibit many of the same post-traumatic symptoms that people with PTSD manifest, such as nightmares and flashbacks, avoiding people or situations that could trigger a trauma response, and undergoing nervous system hyperarousal. Additionally, both experience changes in how they think and feel (e.g., self-blame, depression).

Both PTSD and C-PTSD survivors could potentially fit the *Diagnostic and Statistical Manual's* (*DSM-5*®) diagnostic criteria for the dissociative subtype of PTSD. However, those with C-PTSD are more likely to describe the prerequisite symptoms of depersonalization (i.e., sense of detachment from their bodies/distorted perception of self) or derealization (distorted perception of other people or the external environment).

Impact of Childhood Trauma on Development

Psychologically healthy adults have a solid perception of self, including a positive sense of identity, the ability to regulate emotion, the capacity to integrate life experiences, and the skill set to establish strong relationships. This foundation allows them to bounce back more easily from a traumatic event that occurs in adulthood. However, C-PTSD survivors usually do not evidence such qualities because normal developmental processes have been thwarted due to childhood trauma.

Healthy development depends on attentive primary caregivers. When a newborn cries, a good parent strives to figure out the problem and alleviate it. Does the infant need food? A diaper change? Is he or she in pain, or does it merely need soothing through being held or rocked? Emotional regulation by any of these means initially comes solely through such external mechanisms since newborns are unable to take care of themselves and are totally dependent upon their caregivers. In time, though, if their caregivers have consistently helped them regulate, infants begin to learn how to self-soothe.

I remember watching in awe as my five-month-old's arm compulsively moved around his crib until he could

HEATHER DAVEDIUK GINGRICH

find his pacifier and push it into his mouth successfully! When he was three, he hugged his teddy bear for comfort, which allowed him to fall asleep without me in the room. Once he learned to talk, he could begin using words to self-soothe. For example, if I told him he could not have a snack because it was too close to dinner, I might overhear him reassuring Teddy by saying, "I know you're hungry, but Mommy says we'll get to eat soon."

Not only does attuned, responsive caregiving help give children the skills they need to regulate their emotions in adulthood, but it also helps them develop a secure attachment style. This sense that other people can provide safety and security is necessary for developing intimate relationships throughout life.

Good parenting also allows children to integrate behavioral and emotional states. For example, newborns instantly shift between a distressed state (e.g., full-fledged crying) to a peaceful, contented state as soon as a particular need is met (e.g., offering a breast or bottle when hungry). The example previously given of my three-year-old talking to his teddy bear kept him from entering a dysregulated state and meant more continuity in his emotions and behavior before and after he noticed hunger pangs; these states were more integrated.

Now imagine that a child is abused (emotionally, physically, sexually, or spiritually) or neglected (emotionally or physically) multiple times a week over many years by someone who is supposed to be safe. The trauma is not only dysregulating in itself, but the child also is hindered from learning how to manage his or her emotions and behavioral states in general because abusive parents are not generally appropriately attentive caregivers.

Even if the abuser is someone from outside the family, children assume their parents know what is happening and wonder why they are not stopping the abuse, which results in insecure attachment that impacts all future relationships. Without intervention, abused children often grow up still unable to self-soothe or integrate their experiences. The inability to manage emotion and/or behavior is associated with many *DSM-5* diagnoses and/or symptoms (e.g., anxiety and depression, substance abuse, impulse control, personality disorders, etc.).

Even after all trauma memories have been processed, it can still be a challenge for a complex trauma survivor to learn to live life as a whole person. Old ways of doing things no longer work, and experimentation takes place with new ones.

The Path to Restoration

Post-traumatic symptoms are only part of the picture for survivors of complex trauma. The negative impact of chronic, childhood, relational trauma on the normal development processes means these survivors have a great deal of catching up to do. *In addition* to processing their trauma, they need to unlearn unhealthy coping strategies and learn how to manage their emotions and thrive in relationships. This progression can take a long time (think months or, more likely, years). A three-phase approach to counseling is the standard of care. This methodology allows for the development of safety and symptom stabilization prior to entering the second stage of trauma processing, followed by the third phase involving the consolidation of gains and restoration of relationships with others and society.

Phase I

Phase I focuses on safety within the therapeutic relationship, safety from others (i.e., both past and potentially current perpetrators), and safety from self-destructive behaviors and post-traumatic symptoms. While a sense of security may be established relatively easily with some counselees, those with C-PTSD were hurt at the hands of another person (or people) who was thought to be safe but was not. As a result, counselors will have to work diligently, with much patience, understanding, and sensitivity, to navigate the pitfalls of Phase I work.

Phase II

Trauma processing is excruciating work. The counselee is encouraged to talk about the trauma in frame-by-frame detail while re-experiencing cognitive, behavioral, emotional, and physical aspects to further integrate all facets of the experience. However, this is different from having a full flashback within the session; the survivor has likely suffered plenty of that trauma at home. The goal is to help clients keep one foot in the past and one in the present as they recount the specific trauma narrative. The new coping skills and grounding techniques that were the focus of Phase I are also put to good use in this phase, as they are used by the counselor to help adequately pace the trauma processing and serve as an aid to containment between sessions. Each traumatic memory is processed in a similar way and integrated into the survivor's sense of self and identity rather than remaining compartmentalized or dissociated.

Phase III

Even after all trauma memories have been processed, it can still be a challenge for a complex trauma survivor to learn to live life as a whole person. Old ways of doing things no longer work, and experimentation takes place with new ones. Former relationships are now often recognized as unhealthy, so boundaries may need to be set or new, healthier friendships formed. Often a survivor's view of God has been distorted, so new ways of relating to Him will need to be established.

There is Hope!

There is good news! What Satan set out to destroy through trauma and abuse, God can restore! The bad news is that it is often a painful and slow process. Unfortunately, despite the promise of healing, not all C-PTSD survivors are willing or able to engage fully in the process. I used to try to encourage survivors by telling them the work could be excruciating but would be worth it in the end. Then I realized this was not my decision to make—it was theirs—and I needed to rely on the Holy Spirit for their guidance. I also recognized that timing is crucial. Survivors need to have the mental space and time in their schedules to reflect on the changes taking place, as well as adequate relational support to benefit from Phase II work. Meanwhile, knowing that restoration is a possibility for the future is encouraging. ✠

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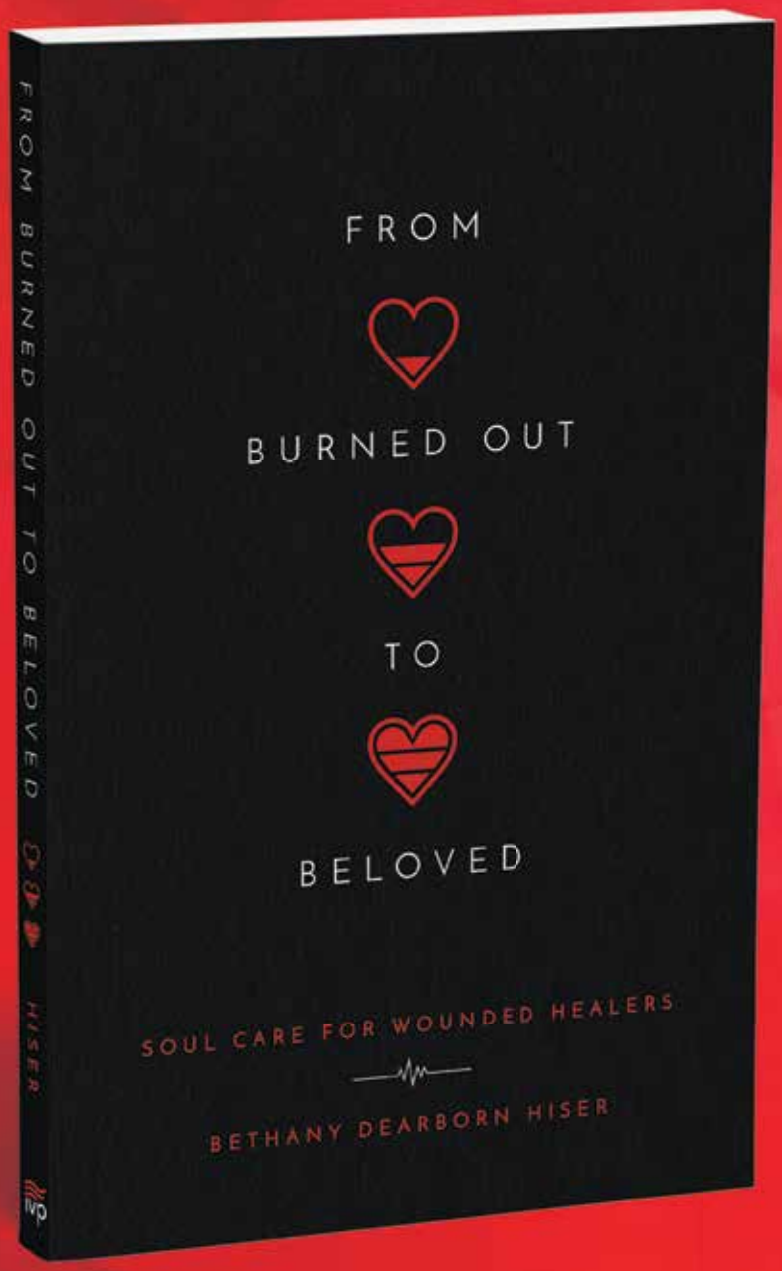

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CHILDHOOD TRAUMA:

DEVELOPMENTALLY APPROPRIATE AND TRAUMA-INFORMED INTERVENTIONS

While much of psychotherapy is prescriptive in nature—whether led by theoretical or technical reasons or perhaps directed by practice standards or managed care—the need to consider developmental factors remains imperative. Unfortunately, this often seems to get lost in working with children, particularly traumatized children.

Consider this. A child engages in their world, terrified because they have been traumatized. Perhaps the adults in their life know about it, perhaps not. Regardless, the child is exhibiting a symptomatic response. The surrounding adults know that professional support is needed. A referral for therapy is made. It is time for a trauma intervention. Many therapists have been trained and are experienced, but most likely with adult clients. However, are children that much different? Yes, incredibly different!

While I would agree with most therapists that the trauma narrative must be expressed and processed—how this is accomplished is where I find myself at odds with some child therapists. Expressing the pain does not need to involve verbalization! In fact, I would argue that compelling this with child trauma clients is often damaging. As an expressive/play therapist, I will use nonverbally-based interventions with most traumatized clients, and always with children! There are basic developmental, psychological, neurological, and scriptural reasons for this perspective.

Children lack the developmental, cognitive, and abstract thinking skills to engage in "adult therapy." Whereas we process verbally with words, children do not have this ability. Even verbally precocious children lack adult cognitive abilities, which can lead child therapists to mistakenly engage exclusively with spoken interactions.

My contentions should, by all means, not discourage us from working therapeutically with children! I believe play therapy is the developmentally appropriate restorative interaction with child trauma clients—actually *all* child clients. Children actually do "talk" in play therapy. However, in their case, *play is the language and toys are the words* (Landreth, 2012). Although my perspective is not to interpret the story but rather to witness their story—a fellow sojourner on the therapeutic journey. This is a goal of mine with trauma clients of any age.

Why Expressive Therapy?

It is important to consider my basic rationale for play and expressive therapies. In Sweeney (1997), Homeyer and Sweeney (2017), and Sweeney and Lowen (2018), several are offered:

- As previously mentioned, play is simply the child's natural medium of communication, as opposed to verbal communication, which is the primary medium of "adult therapy." I would argue it is unfair and dishonoring to expect children to leave their world of expressive play and enter the adult world of verbal communication. After all, empathy involves entering the client's world.

DANIEL SWEENEY

- Expressive therapies inherently have a unique kinesthetic quality. Play and expressive media provide an unparalleled sensory experience, which meets a basic need that I believe all people have for kinesthetic experiences.
- Play and expressive therapies create the necessary therapeutic distance often needed for traumatized clients. While these clients may be unable to express their pain in words, they can find expression through projective media.
- This therapeutic distance then creates a safe environment for abreaction to occur. Traumatized clients need a therapeutic setting to abreact—a place of safety where painful issues can emerge and be relived—thus, a safe place to experience the intense negative emotions that are often attached to traumatic experiences.
- Play and expressive therapies create a place for traumatized clients to experience *control*. I believe that a fundamental result of traumatizing experiences is a loss of control for those in its grip. A crucial goal for these clients must be empowerment, recognizing that the loss of control inherent in trauma and chaos is intrinsically disempowering.
- Expressive and play therapies provide a unique and natural setting for the emergence of therapeutic metaphors. The most powerful metaphors in treatment are generated by clients themselves (as opposed to those orchestrated by therapists), and expressive therapy creates an ideal environment for this to occur.
- Play and expressive therapies are effective interventions for traumatized clients in light of neurobiological issues. Potential neurobiological inhibitions on cognitive processing and verbalization contend for the benefits of expressive intervention.

What about Trauma?

As we attempt to weave together these thoughts on a developmentally appropriate manner to work with traumatized children, I would like to comment on some basic views I have in my work with traumatized clients:

- Trauma is, by nature, intrusive. Therefore, the therapist's interventions should be facilitative and not a recapitulation of this intrusion. The promotion of the child's *self-expression* provides the freedom to explore and grow.
- Trauma *always* occurs within the framework of a system of some kind (most often the family). The trauma may have happened *because* of the family. Regardless, a systemic/family therapy approach must be a crucial element of the therapeutic milieu.
- Treatment must attend to a continuum of issues—including physiological, cognitive, psychological, and spiritual concerns. Trauma involves various levels of impact to any and all of these areas.
- Clinical work in the area of trauma often involves direct encounters with horrifying circumstances. The professional and personal impact on therapists should never be underestimated.
- The focus of treatment should never be the trauma itself, the clinical diagnosis, or even the child's symptomatic response to the trauma. Instead, it should always be the child. If we focus on other elements, we lose sight of the child.
- Trauma treatment takes *time*. It is unrealistic, unreasonable, and unethical to expect that two, five, or 10 years of trauma, neglect, terror, and pain will resolve itself by six or eight sessions by managed care for an hour once a week. We should fight for what the children need.

It is also important to briefly touch upon the neurobiological effects of trauma. Neuroimaging studies with posttraumatic stress disorder (PTSD) clients demonstrates: 1) deactivation of the prefrontal cortex (executive functioning), which interferes with the ability to formulate a measured response to a threat; 2) increased activation of the limbic system; and 3) decreased activation in the Broca's area in the brain, which relates to verbalization (van der Kolk, 2014). To ask the "classic" counseling question—"How does that make you feel?"—makes little sense in light of these neurological realities alone.

Traumatized clients need a soothing intervention. Trauma leaves clients' brains in an alarm state, where alarm reactions trump cortical processing (Perry, 2006; van der Kolk, 2006, 2014). The cortex can be overwhelmed by lower brain regions; thus, expressive interventions, which do not rely on verbal processing and executive functioning, help soothe clients who may have alarm reactions in the therapy process. Perry and Hambrick (as cited in Gaskill & Perry, 2012) emphasize that "… until state regulation or healthy homeostasis is established at the brainstem level, higher brain mediated treatments will be less effective" (p. 40).

van der Kolk (2014) argues that trauma always involves *speechless terror*—that traumatized clients are basically unable to put feelings into words and, thus, left with intense emotions that cannot be fully verbalized. If the children we work with are in this state because of neurobiological realities—or simply because of their development level—we should never force them to verbalize.

Conclusion

When working with traumatized children, my primary goals are: 1) Give *hope* to children/parents; 2) Provide children with a *safe, reparative,* and *relational* experience so development and potential may be realized; and 3) Provide a developmentally appropriate and honoring therapy experience. I believe this is accomplished through play and expressive therapies.

Although I am unable to deliver practical intervention material in such a short article, I encourage readers to consider some of the resources on the reference list provided. More importantly, I always try to remember these two crucial elements: therapeutic relationships are essential on all levels, and being developmentally appropriate is honoring. Neale (1969) wrote, "Consider the play of the child, and the nature of the Kingdom will be revealed. Christ is that fiddler who plays so sweetly that all who hear him begin to dance" (p. 174). For the sake of the children, let's join in the play. ✠

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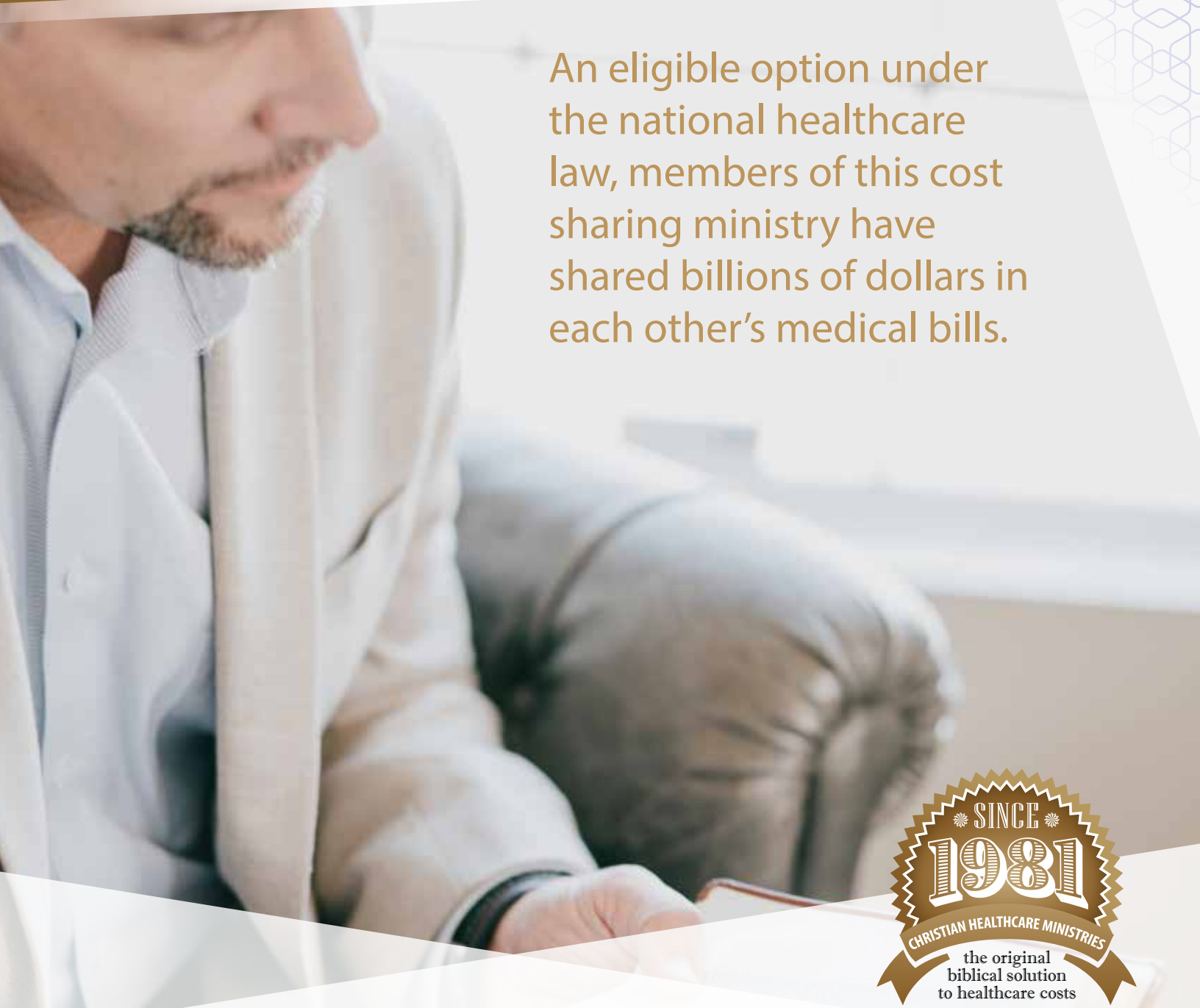

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CHURCH:

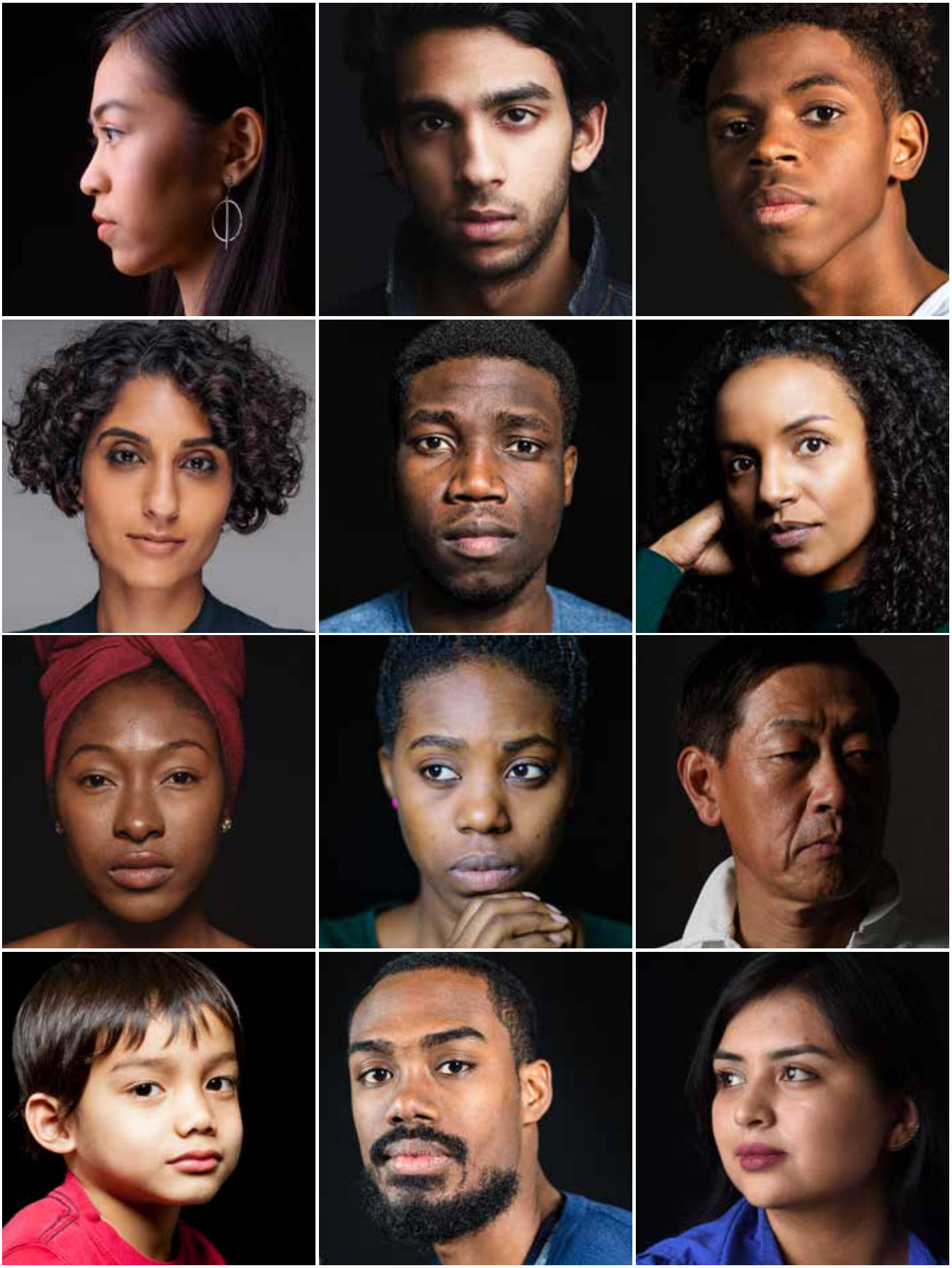
LET'S TALK ABOUT PRO-LIFE & ABORTION

When it comes to the issue of abortion, one would expect the church to have the loudest voice in the pro-life movement. Unfortunately, too many churches feel that speaking about pro-life topics will produce a negative response from their congregation.

With such a strong biblical view on the sanctity of life, what is holding pastors back from speaking about pro-life to their congregation?

Many pastors and church leaders see abortion and pro-life topics as "too political" and fear repercussions of bringing politics into church. Some pastors feel that if they speak on these topics, they will be associated with extreme pro-life activism. Inadequacy and fear of not being well-equipped to touch on these subjects holds others back while some believe that they will drive people with abortion in their past out of the church.

HOW CAN WE, AS THOSE WHO STAND FOR THE PRO-LIFE MOVEMENT, EQUIP THE CHURCH TO ADVOCATE FOR THE UNBORN?



Creating Healing Spaces for Those Affected by Race-based Trauma

According to the Federal Bureau of Investigations (FBI) 2019 Hate Crime Statistics Report, data collected by 15,588 law enforcement agencies reported 7,314 hate crimes that involved 8,559 offenses. There were 8,552 victims of single-bias motivated incidents, of which 57.6% were a result of race/ethnicity/ancestry bias, 20.1% religion bias, and 16.7% sexual orientation bias. Of the 6,406 reported known offenders, 52.6% were White, 23.9% were Black or African-American, and the race was unknown in 14.6%. While the United States has made some progress toward improving race relations, racism, discrimination, and race-based traumatic incidents continue to be problematic for people of color (Comas-Díaz, 2016).

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorder's* (*DSM*) definition for trauma is used by practitioners, researchers, and scholars in the mental health field to inform diagnosis, future research, and treatment. The most recent *DSM* (5th edition) expanded its definition of trauma from previous versions; however, it does not include in its criteria the types of stress (e.g., discrimination, racism, poverty) that create similar reactions experienced by those either directly exposed to a life-altering event or who witness an event or a combination of traumatic events (Carter et al., 2020; Carter, 2007).

Racial discrimination is identified in the literature as a form of stress that may lead to traumatic reactions by those who experience a negative, race-based encounter (Carter et al., 2020; Carter, 2007). When a person experiences danger due to an actual or perceived experience of racial discrimination, it can lead to stress referred to in the literature as racial trauma or race-based stress (Comas-Díaz et al., 2019; Carter, 2007). Race-based stress is not limited to a personal experience. Observing a person from another ethnic minority group encounter racial discrimination can also trigger a stress response (Comas-Díaz et al., 2019; Carter 2007). According to clinical psychologists, Sabrina Liu and Sheila Modir (2020), secondary trauma may occur in communities of color following a national crisis event such as September 11, 2001, when innocent Middle Eastern Americans were unfairly treated.

FREDRICA BROOKS-DAVIS

As the incidents of negative race-based encounters rise and people of color report feeling anxious, angry, and/or depressed, creating healing spaces sensitive to the needs of those directly impacted by these encounters is desperately needed.

Every ethnic minority group (EMG) in the United States has a story to tell and experiences to share concerning racism and discrimination. Compared to other EMGs in the United States, African-Americans by far have endured a longer history of racism and discrimination. Conversely, Asian-American and Hispanic immigrants have experienced challenges assimilating into the United States (Chou et al., 2012; Vega & Rumbant, 1991). Additional research is needed to better understand how these groups are subjected to racial discrimination and race-based stress. Understanding these differences will also help inform the best practices for creating healing spaces. Boston University professor, researcher, and clinical psychologist, Stefan Hofmann, and his colleagues, Tina Chou and Anu Asnaani (2012), conducted a study of the three largest communities of color in the United States: African-Americans, Asian-Americans, and Hispanics. The findings suggest that perceived racial discrimination led to an endorsement of major depressive disorder, panic disorder, agoraphobia, panic disorder with agoraphobia, post-traumatic stress disorder, and substance use disorders.

As the incidents of negative race-based encounters rise and people of color report feeling anxious, angry, and/or depressed, creating healing spaces sensitive to the needs of those directly impacted by these encounters is desperately needed. According to the United States Department of Health and Human Services (2001), ethnic minorities tend to seek counseling services at lower rates than whites. Stigma, racism, lack of access to healthcare, unemployment, mistrust of the healthcare system, lack of transportation, and finances have all been identified as barriers to treatment (USDHHS, 2001). Speaking with a clergy member and a trusted elder in the community, religious coping and spirituality continue to be survival strategies used by people of color (Comas-Díaz, 2016; USDHHS, 2001). It is important to note that religion is as diverse as race, which means special attention should be taken when incorporating religion or spirituality in the healing process (Milstein et al., 2010).

As a mental health professional, clergy member, community leader, ministry leader, or teacher, you may or may not currently provide care, minister, or teach individuals affected by race-based trauma. However, as the United States becomes more diverse, there may come a time when you will need to hold space or minister to someone who has experienced race-based trauma. Alternatively, you may feel led to create a healing space via Zoom© for friends or co-workers.

When creating this space, it is important to note it does not have to be limited to a physical location; it may also be a virtual platform (e.g., Zoom, Webex®) or a telephone with a camera (e.g., iPhone® and FaceTime®). Regardless of how the space is created, it is essential to meet face-to-face to ensure privacy. If you feel led to create a safe space for those affected by race-based trauma, consider the following steps before moving forward.

- **Search your heart and purpose.** The facilitator needs to explore why he/she is interested in creating a healing space and be willing to study his/her thoughts

about race and trauma. The goal of having the facilitator explore his/her heart before meeting with the person or group is to learn what areas may need to be healed and what, if any, stereotypes, biases, and prejudices he/she may have toward others. This work is necessary to ensure the facilitator can hold space for those affected by race-based trauma. While providing this resource, the facilitator commits to being an active listener, shows empathy, establishes trust, and respects the individual and his/her experience as it is told.

- **Seek assistance from others.** Consult with colleagues who have a history of providing care to people of color who have experienced race-based trauma. Consider inviting a subject matter expert (SME) to co-facilitate the initial session if you are hosting a group or workshop. Engage in peer supervision.
- **Seek knowledge and understanding.** Learn as much as you can about race-based trauma, race-based traumatic stress, microaggressions, and how racism and discrimination impact people of color on both the micro and macro-levels.
- **Initiate partnerships and/or referrals.** The person who facilitates creating the healing space may not be the one providing the clinical intervention and care. For example, a pastor may want his/her church to be a healing space for community members but is not clinically trained to address the reactions associated with race-based trauma. In this case, the pastor could consult with a culturally-informed mental health professional to host a workshop or clinical group via the church's Zoom account or at the physical location.

The United States has a long history of racism and discrimination; however, the research and clinical interventions to address the traumatic stress people of color often carry after encountering a race-based incident are inadequate. While the inquiry continues to advance in this area, people affected by race-based trauma need a healing space to reduce the pain and pressure they are experiencing at this very moment. The urgency is upon us. If not now, when? And if not us, who?

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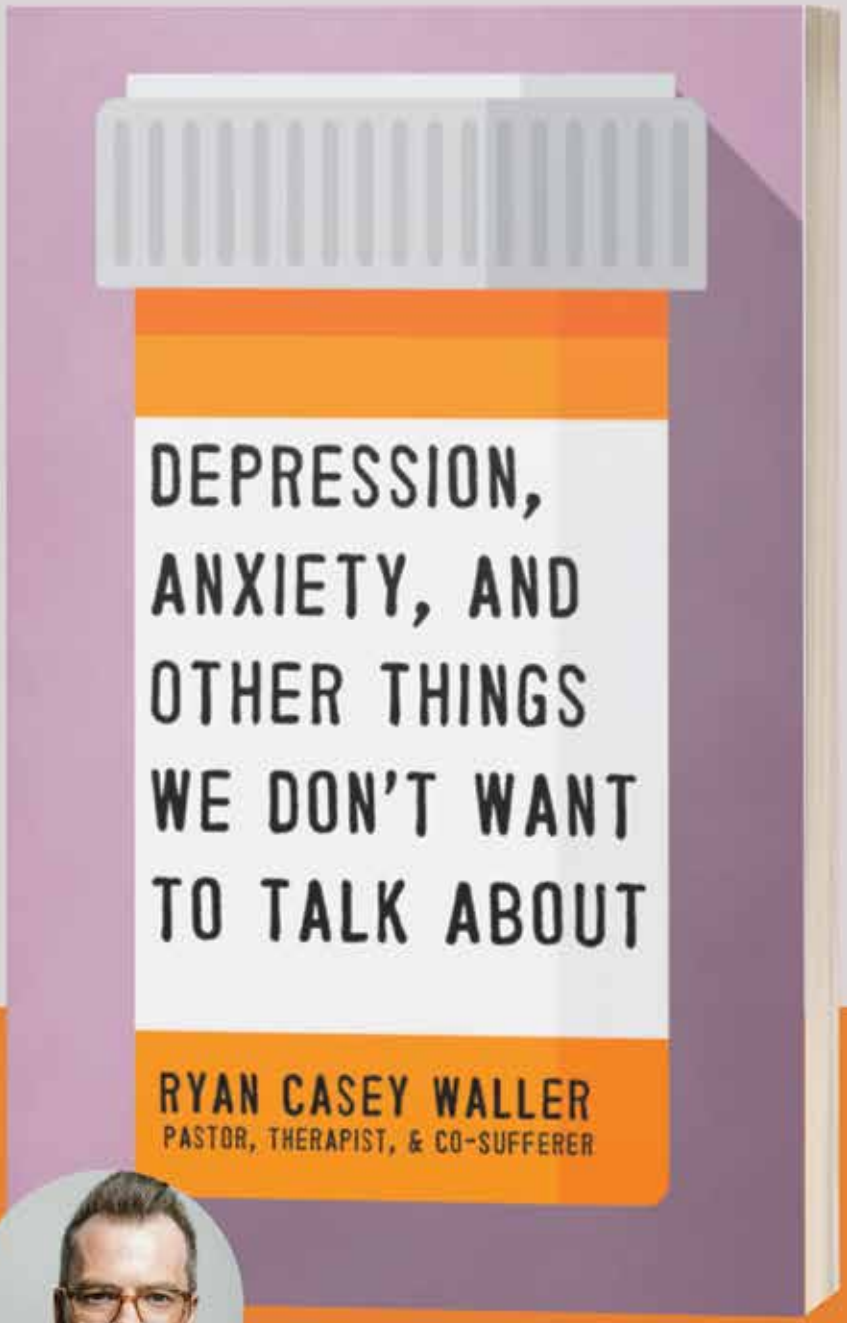

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MORAL INJURY AND TRAUMA TREATMENTS

This article discusses the concept of "moral injury" (MI) in the setting of severe trauma due to experiences in war (killing, seeing others killed, failing to protect innocents), civilian life (rape, robbery, assault, accidents, or other life-threatening or life-changing experiences), or the practice of healthcare (including mental healthcare, particularly during the COVID-19 pandemic when shortcuts to best practices may be taken).

According to psychologist, Brett Litz, "… moral injury involves an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness…" (Litz et al., 2009). *Miasma* is the Greek root of moral injury. This ancient Greek word means moral defilement or pollution, often resulting from unjust killing, but applicable to any transgression of moral values (applies to the perpetrator, victim, or even the observer). As Herakles is quoted in Euripides' classical tragedy written in 416 BC, "What can I do? *Where can I hide* from all this and not be found? What wings would take me high enough? How deep a hole would I have to dig? My *shame* for the evil I have done consumes me… I am soaked in blood-guilt, polluted, *contagious… I am a pollutant*, an offense to gods above" [emphases mine].

Moral injury is a relatively new syndrome in psychology first recognized in war by veterans and active-duty military who were suffering from post-traumatic stress disorder (PTSD). Something seemed responsible for these individuals' poor response to treatment (biological and psychological) and the comorbidity often associated with PTSD (depression, anxiety, substance abuse, relationship problems, and unexplained pain and physical disability). As previously noted, MI may also occur in civilians experiencing severe trauma; first responders, such as police, firefighters, or emergency medical personnel; and healthcare professionals, which may often be a root cause of burnout.

Moral Injury versus PTSD

Because MI is often identified in the setting of PTSD, how are the two syndromes different? Our research team has identified areas of both similarity and overlap (Koenig et al., 2020). The most significant area of overlap with the *DSM-5* criterion symptoms for PTSD is in the negative alterations of cognition and mood (Criterion D) (i.e., symptoms of distorted blame of self or others, guilt, and shame). Unique to MI are the symptoms of moral concern, betrayal, loss of trust, difficulty forgiving, loss of meaning, self-condemnation, religious struggle, and loss of faith/hope. Although no research has been conducted to identify the neuroanatomy (structural or functional brain changes that distinguish PTSD from MI), PTSD involves impairment in prefrontal cortex control of an overactive amygdala in charge of the fight or flight response that is stimulated in "trigger situations."

In contrast, the prefrontal cortex where moral reasoning occurs must be intact for MI to result. This part of the brain appears to be damaged in those with psychopathic personality disorder, a condition where individuals experience no qualms about hurting or seriously injuring others. Psychopaths do not experience MI and, in severe cases, enjoy hurting others. For a person to experience MI, then, they must have a working conscience.

HAROLD G. KOENIG

Diagnosis

Moral injury has both psychological and spiritual dimensions. Widely acknowledged are the psychological symptoms of MI, such as guilt, shame, feeling betrayed, loss of trust, and self-condemnation. However, there is also a spiritual dimension to MI, perhaps the most critical element often ignored by secular mental healthcare professionals. The spiritual dimension involves moral concerns, difficulty forgiving, loss of meaning/purpose, religious struggles, and sometimes loss of religious faith that result from transgressing one's moral values. Indeed, "the wages of sin [moral transgressions or 'missing the mark'] is death" (Romans 6:23), while "… the fruit of the Spirit is love, joy, peace, forbearance, kindness, goodness, faithfulness, gentleness and self-control…" (Galatians 5:22-23), the exact opposite of MI.

Several assessment tools exist for identifying MI, including those that measure morally injurious events (MIEs) *and* moral injury symptoms, as well as those that measure MI symptoms only (Koenig et al., 2019a). Tools that identify both MIEs and MI symptoms in military populations are the nine-item Moral Injury Events Scale and the 19-item Moral Injury Questionnaire-Military Version. Those that identify MI *symptoms only* include the 45-item Moral Injury Symptom Scale-Military Version Long Form (MISS-M-LF) and MISS-M-Short Form (MISS-M-SF), as well as the 17-item Expressions of Moral Injury Scale (EMIS-M) and four-item EMIS-M-SF.

Because one cannot change the fact that MIEs have occurred, we recommend using "symptom only" measures that can be utilized to both identify MI and monitor response to treatment. Furthermore, the instruments that we have developed, the MISS-M-LF (Koenig et al., 2018a) and the MISS-M-SF (Koenig et al., 2018b), are the only scales that include the assessment of religious symptoms of MI (religious struggle and loss of faith). We have also adapted one of those measures, the 10-item MISS-M-SF, for civilians (Koenig et al., 2019b) and healthcare professionals (Mantri et al., 2020). The scale for use in civilians is provided in the included **MISS-C-SF Table below**.

Table. Moral Injury Symptom Scale Civilian Version-Short Form (MISS-C-SF)*

Instructions: Reflecting on a period of severe trauma or stress in your life, please circle <u>the number</u> that most accurately indicates how you are feeling now:

1. I feel betrayed by those who I once trusted.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Mildly disagree		Neutral		Mildly agree			Strongly agree

2. I feel guilt over failing to save someone from being seriously injured or killed.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Mildly disagree		Neutral		Mildly agree			Strongly agree

3. I feel ashamed about what I did or did not do during this time.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Mildly disagree		Neutral		Mildly agree			Strongly agree

4. I am troubled by having acted in ways that violated my own morals or values.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Mildly disagree		Neutral		Mildly agree			Strongly agree

5. Most people are trustworthy.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Disagree		Neutral		Agree			Strongly agree

6. I have a good sense of what makes my life meaningful.

1	2	3	4	5	6	7	8	9	10
Absolutely untrue	Mostly untrue	Somewhat untrue		Can't say true or false		Somewhat true	Mostly true		Absolutely true

7. I have forgiven myself for what happened to me or others during that time.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Disagree		Neutral		Agree			Strongly agree

8. All in all, I am inclined to feel that I am a failure.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Disagree		Neutral		Agree			Strongly agree

9. I wonder what I did for God to punish me.

1	2	3	4	5	6	7	8	9	10
A great deal (very true)			Quite a bit			Somewhat			Not at all (very untrue)

10. *Compared to before* you went through this traumatic experience, has your religious faith since then...

1	2	3	4	5	6	7	8	9	10
Weakened a lot			Weakened a litte			Strengthened a little			Strengthened a lot

11. Do the feelings you indicated above cause you significant distress or impair your ability to function in relationships, at work, or other areas of life important to you? In other words, if you indicated <u>any</u> problems above, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people? (check one of the following):

☐ Not at all ☐ Mild ☐ Moderate ☐ Very much ☐ Extremely

**Reprinted with permission (Koenig et al., 2019). Based on other versions of the MISS-SF, scores of 36 or higher indicate significant levels of moral injury that require clinical attention.*

Treatments for Moral Injury

Several secular and spiritual interventions have been developed for the treatment of MI. Among the secular interventions that address the psychological symptoms of MI are Adaptive Disclosure Therapy (Litz et al., 2017), Acceptance and Commitment Therapy (Nieuwsman et al., 2015), and Cognitive Processing Therapy (CPT) (Resick et al., 2017). These treatments, however, do not typically address the spiritual or religious aspects of MI.

Given the spiritual nature of many of the core symptoms of MI (loss of meaning, moral concerns, difficulty forgiving, religious struggles, loss of faith/hope), we believe that this syndrome's treatment requires an intervention that seeks to produce a *spiritual transformation* in the individual. There are now two spiritual interventions that are available for the treatment of MI—Building Spiritual Strengths (BSS) intervention (Harris et al., 2011) and Spiritually-Integrated Cognitive Processing Therapy (SICPT) (Pearce et al., 2018). Originally developed to treat PTSD, BSS also addresses MI aspects and may be administered by chaplains under a licensed psychologist's supervision.

Specifically developed to address MI in the setting of trauma, SICPT, however, can only be administered by state-licensed counselors. It is a manual-based structured psychotherapeutic intervention administered in 12, 50-minute, in-person, individual sessions delivered over six weeks at two sessions per week. This practice is considered a spiritual/religiously-integrated intervention that uses a standard CPT framework. The goal of reducing MI is to decrease trauma symptoms and comorbid conditions (e.g., depression, anxiety, substance abuse, relationship problems). There is a more generic spiritual version of SICPT, as well as religion-specific adaptations of SICPT for Christians and other faith traditions.

Additionally, a Structured Pastoral Care for Moral Injury (SPCMI) treatment that has been developed for chaplains and clergy, specifically targeting Christian clients and those from other religious faith traditions—Jewish, Muslim, Hindu, and Buddhist—based on their core sacred scriptures—the Torah and Talmud, Qur'an and Hadith, Bhagavad Gita, and Dhammapada, respectively (Ames et al., 2020). Involving 12, 50-minute sessions delivered at two sessions per week for six weeks, SPCMI targets each of the 10 core symptoms of MI: guilt, shame, moral concerns, feelings of betrayal, loss of meaning/purpose, loss of trust, difficulty forgiving, self-condemnation, religious struggles, and loss of faith. Although designed originally for chaplains, this pastoral care intervention may also be administered by licensed counselors. Both the SICPT and SPCMI interventions are based on the philosophy described in a book provided with these interventions (Koenig, 2016).

All of the previously described interventions (secular and spiritual) were designed to treat veterans or active-duty military with MI in the setting of PTSD. However, they could be easily adapted by counselors for use among civilians with MI in the setting of trauma. We are currently examining the efficacy of SICPT and SPCMI in veterans, compared to standard secular CPT, in a randomized controlled trial being conducted at the greater Los Angeles Veterans Administration Healthcare System.

Conclusions

Moral injury is a new syndrome, yet thousands of years old, which has been identified among those experiencing severe trauma, particularly individuals with PTSD from combat experiences during war. It has now also been identified in civilians experiencing severe trauma and healthcare professionals. Often unrecognized and untreated, MI may be one reason individuals with PTSD are so resistant to treatment. In this article, MI has been defined, and ways to identify it have been provided.

Finally, several treatments are now available—both secular and spiritual—that may be utilized to treat this condition, with the hope that trauma symptoms and associated disorders will also improve. A screening measure is now available for civilians to identify MI, and spiritual and religion-specific treatments have been developed to treat veterans and active-duty military with PTSD—interventions that could easily be adapted by Christian counselors to treat patients with a history of severe trauma and MI symptoms. ✠

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THE PATH FORWARD:

PERSONAL REFLECTIONS ON HEALING AND RECOVERY FROM TRAUMA

My alcoholic father and depressed mother created seven children. My younger brother and I spent our days and nights in anticipation of the drunken violence that accompanied our dad's homecoming. Individual identity and rights were surrendered in the system designed by my mother to enable our survival. I was the provider of financial resources, and every morning at 3:00 a.m. I reported to my job at the bakery. Esteemed psychologist and trauma expert, Dr. Diane Langberg, describes very well what trauma victims encounter, "Human beings who experience trauma feel alone, helpless, humiliated, and hopeless" (2017). This statement is exactly how my brother and I felt regularly.

Professor, counselor, and scholar, Dr. Heather Gingrich, suggests that recovery from the experience of trauma occurs in three phases. The phases include "achieving a sense of safety and stability, trauma processing, and consolidation and resolution" (2013). Reflecting on trauma literature, counseling victims, and my personal experience have all led me to the conviction that, minimally, moving through these three phases of recovery to healing requires that:

- **We receive with gratitude the benefits derived from grace-based relationships.** The book of Ecclesiastes (NKJV) declares, "Two are better than one…" (4:9) and "… woe to him who is alone when he falls, For he has no one to help him up" (4:10) and "… a threefold cord is not quickly broken" (4:12). Men and women are created in God's image, who has existed from eternity past in the trinity's relational matrix. In the words of Dr. Daniel Siegel, clinical professor of psychiatry at the UCLA School of Medicine, to be human is to be "hardwired for relationships" (2012). My journey out of trauma was possible because an amazing group of people over a long period "graced" me with the gifts of support, hope, and love. In Ephesians 4:29, Paul describes grace as listening well, identifying what is needed, and then flowing with love and support into the vacuum that has been created by the need.

Grace communicates to trauma victims the message that they can face together what they cannot face alone. In that messaging, hope rises and provides a sense of safety for the first time. Without that sense of security and stability, processing the trauma necessary for recovery cannot begin. Grace first appeared for me in the form of a guidance counselor who found me a job with reasonable hours, and then a coworker invited me to church. It continued with a pastor who patiently lived out God's love for me, a wife who loves me in every way possible, my adult children, fellow professionals in the mental health field, and scores of friends.

- **We exhibit the courage and readiness to process our trauma.** My annual wellness checkup was always accompanied by heightened anxiety and white coat hypertension, but I did not live in a doctor's office. Typically, I managed my life quite well. In college and grad school, I felt the need to perform with excellence and was always anxious about grades. It was not until I was 34, in a busy pastorate, when I experienced a virus that sapped my strength and left me shattered physically and emotionally that I realized something was still broken inside. At that time, I did not know I needed to better understand the thoughts and emotions I was having and their connection to my childhood immersion in trauma. In my role as a pastor, I was a man apart, and it took me a long time to develop the vulnerability and transparency required for processing my experience with trauma.

I never considered seeing a counselor for help with processing my experience, nor did any of the people around me make the recommendation. The power of shame from feeling weak, flawed, or simply not good enough kept me isolated and cut off from the resources that could have helped me better understand my thoughts and feelings. Fortunately, I later found myself in relationships with people who manifested grace so powerfully that I was convinced I could open up to them and process my brokenness. I was ready to move beyond my fear that confessing my inner brokenness to them would diminish me in their eyes. I know now that hiding the brokenness and isolating from the help found in healing relationships are prominent features in Satan's plan for trauma victims.

RON HAWKINS

We practice this attention to truth because we understand that in doing so, we are reducing the power of the negative neural connections and supporting the wiring of new, life-enhancing neural connections.

• **We understand the negative effects of trauma on the brain and recognize that those influences can be changed.** Brain science has revolutionized how we understand the damage trauma has on the development of the brain. In the language of neuroscientists, "what fired together in the days of our trauma has wired together" (Siegel, 2012) the neural pathways of our brains and profoundly influences our subsequent thoughts, emotions, behaviors, and relational styles. The resolution of trauma requires the conviction to have significant power to change the relationships that have been the source of suffering and the neural pathways formed in response to the trauma. Commenting on that power, Tim Jennings, board-certified psychiatrist, states, "… we have the power, by use of the will, to choose what neural circuits receive continued use in our brains. Over time neural circuitry changes as certain circuits slowly degrade and others strengthen" (2012). When supported over time by grace relationships and attention to specific processes, this power of choice produces changes in our brains that impact how we behave, achieve relationships, and manage our thoughts and emotions.

• **We take responsibility for a disciplined engagement with the processes leading to the creation of new neural pathways in the brain.** Processing my thoughts and feelings with those I trusted enhanced my understanding of the damage done by my experience with trauma. The consistent support experienced in these relationships, combined with time in Scripture and literature on trauma, provided me with valuable resources to enter the resolution and consolidation phase in my recovery. At the same time, my understanding of God's relationship to my suffering and its value for maturing me as a person and Christ-follower grew immeasurably. At that point, the challenge before me was to understand and commit to the processes that would allow for the consolidation of my progress to reverse the patterns I had nurtured due to my trauma experience.

The Apostle Paul admonishes Christ-followers to renew their minds for the purpose of achieving the transformation of their character (Romans 12:2). Paul insists that renewal is the outcome of using our brains to focus our attention on the things that are true, pure, and of good report (Philippians 4:8). Thus, Paul counsels young Timothy to give keen attention to the Word of God because, in Scripture, he would find the truth that will set him free from the grip of his fear (2 Timothy 2:15). Paul established a process for the promotion of mental health. With their notion of "neuroplasticity" (the brain's neural network's ability to change via growth and reorganization), neuroscientists have explained the science that supports this process.

Building on brain science insights, Dr. Curt Thompson, psychiatrist, speaker, and author, states that "attention is the key to the ignition of the mind" (2010). In line with Paul's counsel on mind renewal, Dr. Thompson insists that this goal is only achievable when we discipline ourselves to "pay attention to what we are paying attention to" (2010). Recovery from trauma requires that we consistently focus our brains' attention on that which contributes to the reversal of our trauma. We practice this attention to truth because we understand that in doing so, we are reducing the power of the negative neural connections and supporting the wiring of new, life-enhancing neural connections. Ultimately, the reversal of the effects of trauma depends on our disciplined awareness of what we are paying attention to and our readiness to live that commitment out with transparency in a circle of grace-based relationships for encouragement and accountability. ✠

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PREPARING THE CHURCH TO HELP:

Training Congregants to Assist those in Crisis, Trauma, and Recovery

I was leaving a restaurant when I received a call about a serious accident in our community. The caller ended with, "Come quick!" I was a counselor educator at North Carolina Central University and had recently begun serving as a pastor at Tippett's Chapel, a rural church. When I arrived, what I saw was surreal. The fire chief walked me to a grieving couple whose daughter had been killed. I spoke with them, prayed with them, and encouraged them to go home, where I met with them later. At the end of the evening, I remembered seeing several people from our church who knew the couple at the accident scene. In many ways, they could have helped the couple more effectively.

What do they need to know?

What does the average congregant need to know to help people through crisis and trauma? Most importantly is to embrace his or her call to be an ambassador of Christ (2 Corinthians 5:20) to those who do not know Him… and a burden bearer (Galatians 6:2) for those who do. When a tragic event takes place, they ask, "What can I do to help?" A shift from bystander to participant will take place when they become other-centered.

Next, we want to empower congregants by helping them identify and utilize the tools they have as Christians. God is at work within every Christian (Philippians 2:13), preparing them to help others. We want to shift away from the idea that only an expert can help. Often, the average person can assist in ways an expert cannot since they are a part of the community and have a rapport with the individual in need.

What do they need to do?

Observe: Just like Joseph observed the baker and the butler in prison (Genesis 40:6-7), we want our congregants to observe those in their neighborhoods, workplaces, schools, and even the Church. In an emergency, we want them to look for those in need and consider ways to help. Observe, but never gawk. If congregants are trying to assist someone at an accident scene, it might help to position their backs toward the action and face the person they are assisting. Later, we want them to observe the coping strategies that should be used following a crisis. For example—have they isolated themselves from others or engaged in negative, or even dangerous, coping activities?

Attend: Train congregants to "attend," much like the friends of Job did immediately after the deaths of his children (Job 2:11-13). Concentrate on the power of presence, which is easier said than done. For example, after a house fire in our community on a cold night, some of our congregants attended to the family while the firefighters worked. The family had a difficult time leaving their home behind, so people stayed with them despite the elements. Another way of attending is to stay involved with someone after a loss. For example, a widow might withdraw from friends, saying she does not wish to be a "third wheel." When we insist that those recovering from trauma join us for meals or trips (attend to them), they often improve.

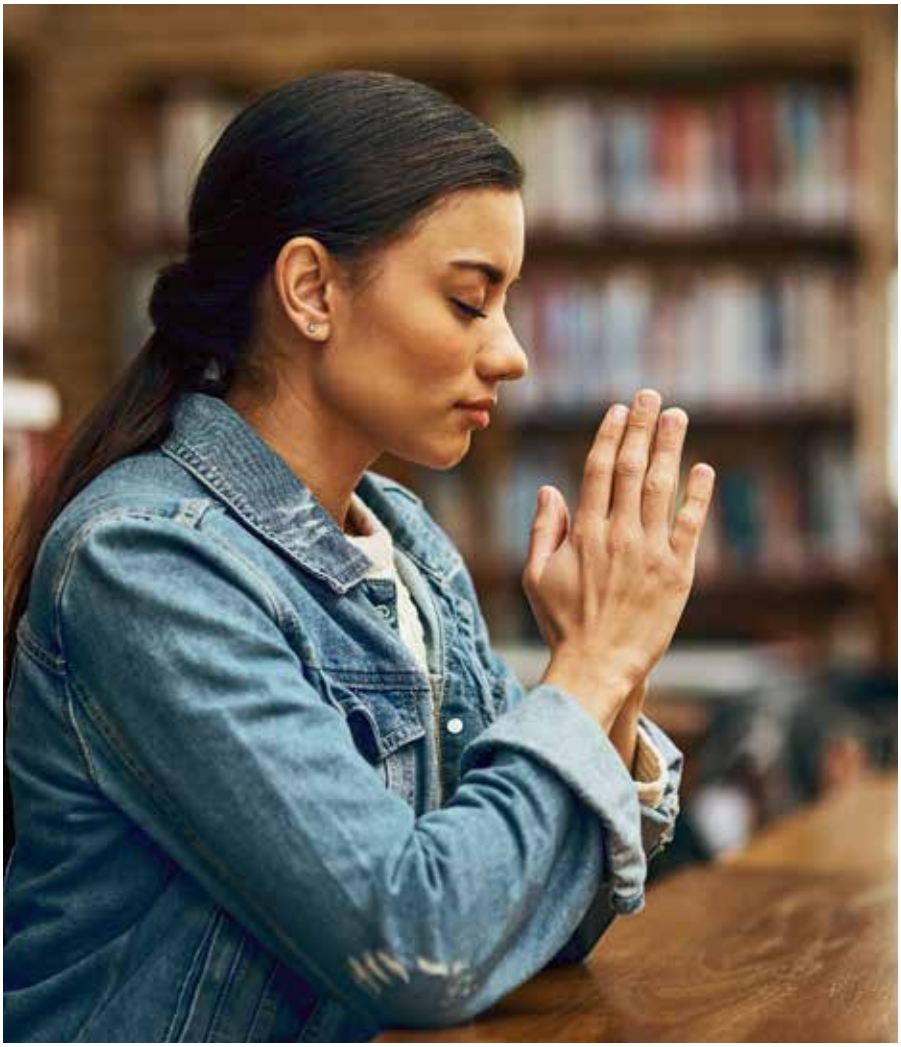
Listen: Like Job's friends, when we listen to people rather than correct them or try to "fix" them, healing occurs (Job 4:7-8). We get into trouble when we quote passages like Romans 8:28 out of context. We are also less likely to harm (Proverbs 10:19) and more likely to help when we listen (James 1:19). If we listen, we will hear guilt, doubt, and blame, which open opportunities for better helping later. For now, just being able to unburden themselves to someone they know will help those traumatized.

Act: We want our congregants to prepare to act. When Jesus described those who served Him (and others in His name), He referred to their actions (Matthew 25:35-36). The Good Samaritan was commended for helping the wounded traveler (Luke 10:34-37). Help congregants identify needs in various crises (e.g., cleaning the home or mowing the lawn after a loved one has died). Everyone offers, "Please let me know if I can do anything to help." A father whose daughter died in an accident told me, "People say that as they back out the door." Helpful congregants look for a need and meet it. Once people see a person's willingness to help, they are more likely to open up about other needs.

Respond: Prayer steadies the helper during a crisis and invites God into the situation. Asking, "Would you like for me to pray with you?" is an invitation rarely rejected. Research indicates the first coping strategy people utilize after trauma is prayer.[1] Praying aloud is helpful because we are modeling for listeners how to pray. Praying for the person by name is also comforting. Encourage congregants to offer reading Scripture like Psalm 46 and prepare them with additional passages to share throughout recovery. As they walk with others on this journey, they will listen to them, read a pertinent passage to them, and pray.

Remember: Being present with someone in a trauma creates a bond like no other. Educate congregants about the ebb and flow of the grieving process and how to help the person who experiences doubt. Eventually, they will have the opportunity to address doubts and guilt, though they may need to point the individual to a pastor or professional helper. Provide referral information so they have a place to direct those needing more assistance. Often, referral to an expert is received better from a friend. As the recovery continues, make contact during holidays, the birthday of the loved one lost, the anniversary of the event, and other significant times.

EDWARD E. MOODY, JR.



How do we train them?

After the accident at the beginning of my ministry, we began using Bible studies to train our congregation. The material eventually became my book, *First Aid for Emotional Hurts.*[2] It seemed beneficial to consider the tools and techniques of helpers in the Bible. The Church will never handle these situations perfectly, but we can prepare our churches to help people through the worst day of their lives by working together. When our people are Christ's ambassadors and burden bearers, Jesus shows up (Matthew 18:20).

EDWARD E. MOODY, JR., PH.D., *currently serves as the Executive Secretary of the National Association of Free Will Baptists (NAFWB). For more than 25 years, he engaged in the training of professional counselors, primarily at North Carolina Central University, where he was a Professor of Counselor Education and Associate Dean of the School of Education. He also served as pastor at Tippett's Chapel in Clayton, North Carolina, for almost two decades. Dr. Moody is a licensed clinical mental health counselor supervisor, as well as a licensed health services provider-psychological associate in North Carolina. The Licensed Professional Counselors Association of North Carolina honored him as their Counselor of the Year in 2016.*

Endnotes

1 Murphy, S.A., Johnson, L.C., Lohan, J., and Tapper, V.J. (2002). Bereaved parents' use of individual, family, and community resources 4 to 60 months after a child's violent death. *Family & Community Health, 25* (1), 71-82.

2 Moody, E. (2018). *First aid for emotional hurts: Helping people through difficult times-revised.* Nashville: Randall House Publications.

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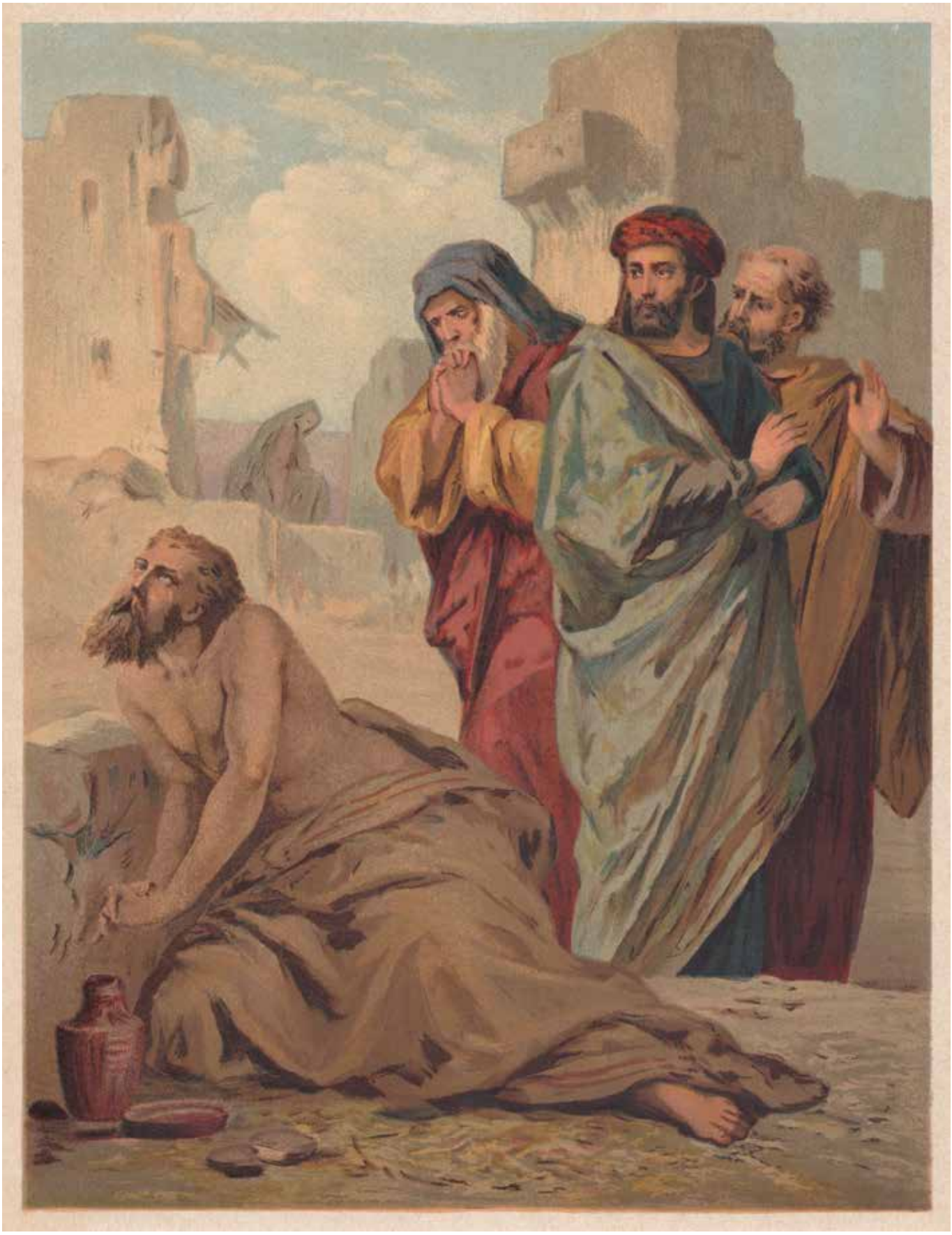

The Life of Job:

MULTIPLE LOSSES AND RECOVERY

Grief is a universal human experience. Everyone experiences loss and, therefore, grief. However, there is relatively little understanding of "how" one should go about grieving. I have spent a lot of time in recent years writing and teaching about grief. I have also spent many hours counseling and coaching people on how to grieve effectively. One of the factors I believe complicates the grief process is that people are often suffering multiple losses.

Generally, people will be most impacted by the death of a loved one. If that death results from a traumatic event, processing the grief can be more challenging. I often work with people whose loved ones die because of a sudden event such as a violent attack, shooting, or natural disaster.

While it is rare, many people today lose multiple family members during a disaster or accident. This type of loss was also the case in the biblical story of Job, as all his children died when the home they were in collapsed because of a natural disaster. Likewise, the current COVID-19 pandemic has taken multiple lives in the same family, church, or community. It is vital for people grieving multiple tragic deaths to also understand that they may be experiencing the impact of trauma. I recommend that professionals address the issues of trauma first because traumatic stress can paralyze the grief process. When death is sudden and traumatic, brain function may be altered in those grieving due to the trauma. The neurobiological changes may impair a healthy grief process, so it is critical to help people work through trauma issues to grieve effectively. Trauma makes us avoid remembering, and healthy grief requires remembering.

The Bible teaches us a great deal about grieving multiple losses, especially in the story of Job. People often mistakenly view grief only as the emotion experienced when a loved one dies. However, grief is a normal reaction to all types of loss, not just death. One of the essential keys to facilitating grieving is helping people recognize their losses and articulate their pain. People are generally aware of their primary losses. Most often, a primary loss is the death of a loved one. It can also be a loss that represents a significant change in life, such as divorce, job loss, or a significant health crisis. However, in almost every situation where someone faces a primary loss, there are also secondary losses. These secondary losses may have a lesser impact but still add to the overall burden of grief. For example, if someone faces the death of a spouse, likely that death may also create financial losses. Grieving widows/widowers are now without their spouses' income and may have to sell their homes and move as a result, which may also mean a loss of relationships with neighbors and friends. They may have to change churches. Grieving spouses may have to give up hobbies and activities they no longer have time to engage in because they must now function as a single parent.

JENNIFER ELLERS

Although it is normal for sufferers to ask "why," we should not feel the need to answer those questions or even try. What they need is for us to sit with them in silence while they ask questions.

One of the first steps in supporting those grieving multiple losses is to help them unpack the losses they have experienced. Let me review the most common categories of loss people experience other than death.

Material Loss/Financial Loss. Many people see grief over material or financial losses as shallow, although that thinking misses the essence of what people are genuinely grieving. For the loss of "things," I do not believe the objects are what people are actually grieving, but instead, they are mourning the memories, relationships, or feelings symbolized by those things. I have learned from working with disaster survivors that the most important items they search for when sifting through a destroyed home's rubble are photographs. Photos have no cash value and cannot be insured, but they strike at the heart of our material losses with the memories of people we love and days past.

When you stand with those whose homes have been devastated by tornados, hurricanes, floods, and fires, they do not mourn their appliances, expensive electronics, or high-end furniture. Instead, they tell stories of holidays and special anniversaries spent in their homes. They speak of loved ones no longer with them, beautiful memories around their dining room tables, and the hash marks on the door frames marking the growth of their children and grandchildren. With financial loss, people grieve the end of their dreams—dreams for a child's education or wedding, a home where extended family can gather, or an enjoyable retirement. Those are the losses they are truly grieving, so it is important to help them recognize this and not be ashamed of their sadness.

Relationship Loss. One of the most common causes of grief is the loss of a relationship that is not a result of death but due to a breach or break. Divorce is the most common and can be devastating for all involved, not just marital partners. Children and extended family members also experience a significant loss with the end of a marriage. Friends may even find themselves having to choose who to keep and who to let go. Of course, there are arguments, betrayals, breakups, and church splits that also cause painful estrangement in meaningful connections. Favorable events like getting a new job or moving to a new town can even create separation that leads to loss.

Functional Loss. This type of loss is when our bodies or minds—through illness, injury, or aging—do not function the way they once did. It can be as simple as not being able to see or hear as well. I notice many people resist purchasing reading glasses or flatly refusing to get hearing aids even when necessary. Then there are the more dramatic functional losses that occur suddenly because of a stroke, injury, or cancer diagnosis. When people suddenly can no longer do what gave them pleasure or brought a sense of accomplishment, the grief can be substantial. While some may be grateful to be alive, we must remember that their gratitude is also paired with grief.

Role Loss. We all find a sense of purpose and self-worth through the many roles we play in our lives. Whether it be a personal role such as husband, wife, father, mother, son or daughter or a professional role such as pastor, counselor, teacher, doctor, lawyer, etc., we may not realize how much this position means until it is gone. Role loss has many circumstances, but two of the most common are the loss of a professional role resulting from retirement and the loss of a personal role when parents are left with an "empty nest" once their children grow up and leave home. People must recognize their feelings as part of a normal grief response and then get assistance with discovering who they are in their new roles.

Systemic Loss. While we understand grief as an individual experience, many people do not realize it is also a collective experience. Any system, such as a family, church, company, community, or even a nation, that experiences a collective loss will also have collective or systemic grief. The loss and ensuing grief will impact the individual as well as the whole and how it functions. I have found that if people in a system cannot grieve together, it can tear them apart, which is why marriages become so vulnerable following the death of a child. Helpers need to address both systemic and individual loss and take steps to enhance a system's ability to grieve together.

Intrapsychic Loss. This is the clinical term for "the death of a dream." It is the loss of someone or something that a person never really had… the loss of what was hoped for and expected… the loss of a vision or plan for the future. Intrapsychic loss is also one of the most challenging types to grieve because most people are not aware that they can grieve or are griev-

ing. The pain of infertility can cause the loss of one's dream of carrying and giving birth to a child. An untimely injury can cost an athlete a gold medal or a career in the sport he or she loves. Intrapsychic loss can also be an unfulfilled dream for a loved one, a business, or a relationship, causing us to grieve once we realize that dream will never come true. Allowing people to voice those dreams and the pain of losing them can aid in their recovery—and with God's help, they can build new dreams.

We can learn some valuable lessons from Job and those who tried to help him. Job's friends came to be with him and sat in silence for some time, which was very helpful. It was not until they opened their mouths and tried to figure out why Job was suffering that they made a mess of things. Although it is normal for sufferers to ask "why," we should not feel the need to answer those questions or even try. What they need is for us to sit with them in silence while they ask questions.

It was okay for Job to cry out to God in his pain. He never blamed God or turned his back on Him. Not everyone, even committed Christians, will be able to have the faith of Job. I have sat with many who have been angry with God and some who even temporarily turned their backs on Him. However, those who recover almost always find their way back to God by allowing Him to offer them comfort. Like Job, many find that if they trust God, He will be faithful in mending their broken hearts and blessing them in ways in which they never dreamed.

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NOT EASILY BROKEN:

Trauma Bonds and the Road to Healing

"He will not crush the weakest reed or put out a flickering candle. Finally, he will cause justice to be victorious."
– Matthew 12:20 (NLT)

In recent years, the mental health community has focused on understanding a phenomenon known as *trauma bonds*. The interest in these bonds is mostly due to our efforts to better understand and treat interpersonal violence victims, such as domestic violence and human trafficking. Although it was challenging to find sufficient information on trauma bonds until recently, the term was first used in the late 1980s by addiction therapy expert, Dr. Patrick Carnes, to describe how abuse, fear, and excitement (typically connected to sexual attraction) can lead to a destructive attachment.[1]

A trauma bond is a powerful emotional connection between an abuser and victim developed and strengthened by repeated traumatic events. These bonds are an adaptive response to extreme distress and tend to occur when all other coping attempts have been exhausted. Therefore, they are a type of defense mechanism with strong connections to attachment theory and learned helplessness. A trauma bond can be understood as an exploitive attachment wrapped with confusion and topped off with trauma and despair.

SHANNON WOLF

Trauma bonds develop when cycles of intense love are followed by abuse that produces an almost unbreakable attachment.[2] Bonding begins when an abuser identifies and meets a victim's needs while professing love for that person. Those recognized needs are exploited in order to gain control of the targeted victim. Common vulnerabilities include security, family, being desirable, and belonging. This process is sometimes referred to as "love-bombing" due to the intense and continuous pursuit of the victim.

The next stage begins with the abuser—confident of the attachment—finding fault with the victim and then threatening to withdraw affection. The victim is repeatedly devalued, and gaslighting (psychological manipulation) is introduced that causes the target to doubt his or her judgment, perception, and even memory. Then, the victim works to please the abuser to restore the relationship. Abusers will alternate their responses with either cruelty or affection. The randomness of these extremes creates a powerful dynamic for bonding to develop. The abuser's cycle includes a combination of reward and punishment and appreciation and degradation, all of which promotes the development of trauma bonds. Thus, the stronger the attachment to the abuser, the more control rendered over the victim, creating an obsession with pleasing the abuser. Paradoxically, victims often experience a deeper bond with their abusers than with those who treat them well.

"He will cover you with his pinions, and under his wings you will find refuge; his faithfulness is a shield and buckler. You will not fear the terror of the night, nor the arrow that flies by day, nor the pestilence that stalks in darkness, nor the destruction that wastes at noonday."
– Psalm 91:4-6, ESV

Abusers create a never-ending series of exploitive hoops for victims to jump through to earn their affection.[3] These hoops escalate the victim's need for security in the relationship, and once the emotional pain becomes intolerable, the abuser offers affection, thereby becoming the savior. The greater the pain, cruelty, or trauma, the deeper the bond. The

abuser is the source of the victim's pain and yet the only one who can relieve that pain.[4]

Understanding the bonding formation's spiraling nature makes it clear why victims simply do not leave the relationship. Grasping this rationale also offers a much-needed explanation to those who continue to struggle with unrelenting attachment even after surviving such a relationship. Perhaps one of the most troubling and lasting effects of trauma bonding is the victim's connection of abuse with love. To a certain degree, the victim cannot fully feel love without some level of abuse. Even after the bond is broken with an abuser, victims often continue to seek out toxic and abusive relationships. Healthy relationships seem to pale in comparison to the powerful emotions connected with a trauma bond.

Signs of Trauma Bonds

What are the indicators that someone may be trapped in a trauma bond? Here are the top five warning signs:

1. The thought of leaving may cause panic so intense that nothing will keep the victim from reconnecting with the abuser. Unfortunately, victims often mistake these strong feelings for love.

2. When friends and family hear or see what is happening, they often react by encouraging the victim to leave the relationship. Should victims continue to have contact with family members, they cover up the abuse or defend the abuser's actions.

It is not always possible to witness the abuse leading to traumatic bonding or identify the signs that indicate such a dangerous bond exists. However, all indicators involve elements of the exploitation of trust and power.

3. Too often, abusers isolate their victims from anyone who questions their behavior. Keeping their victims from those who would contradict abusive messages is necessary to keep them under control.

4. Victims doubt their memory, perception, and judgment about the abuse and have difficulty making simple decisions.

5. Victims commonly blame themselves for the state of the relationship and may deny help even when it is offered.

It is not always possible to witness the abuse leading to traumatic bonding or identify the signs that indicate such a dangerous bond exists. However, all indicators involve elements of the exploitation of trust and power. The signals, then, include variations of the inability to detach from exploitive relationships, misplaced loyalty, and destructive denial.

Breaking the Bonds

While abuse can have distinct patterns and processes, every person's experience is unique. There is no one-size-fits-all remedy. Because trauma bonds are complicated to overcome, those helping to bring healing must use wisdom and patience. The following are some general recommendations on how to foster this process.

- **Invite the Lord into the healing process.** A great place to start is praying for the victim. It is very likely to find the victim confused, so gently challenge any damaging beliefs with a biblical perspective. Strive to model God's unconditional love and offer assurance of His comfort and mercy.
- **Education.** The better a person understands trauma bonds and the tactics used by abusers to manipulate and control, the less power these bonds will have on victims.
- **Focus on reality.** One way to accomplish this is to keep a journal of all interactions, being careful to write down just the facts. Another excellent exercise is to have victims write their relationship stories as if they happened to someone else—including the good times and the bad.

"But this I call to mind, and therefore I have hope: The steadfast love of the Lord never ceases; his mercies never come to an end; they are new every morning; great is your faithfulness."
– Lamentations 3:21-23, ESV

Being subjected to traumatic bonding from an intimate partner creates profound, lifelong wounds. Even though overcoming this complex issue is daunting, there is hope. Christian counselors have a unique ability to speak words of healing into the lives of these individuals, breaking the damaging bonds and setting them free on the road to recovery. ✠

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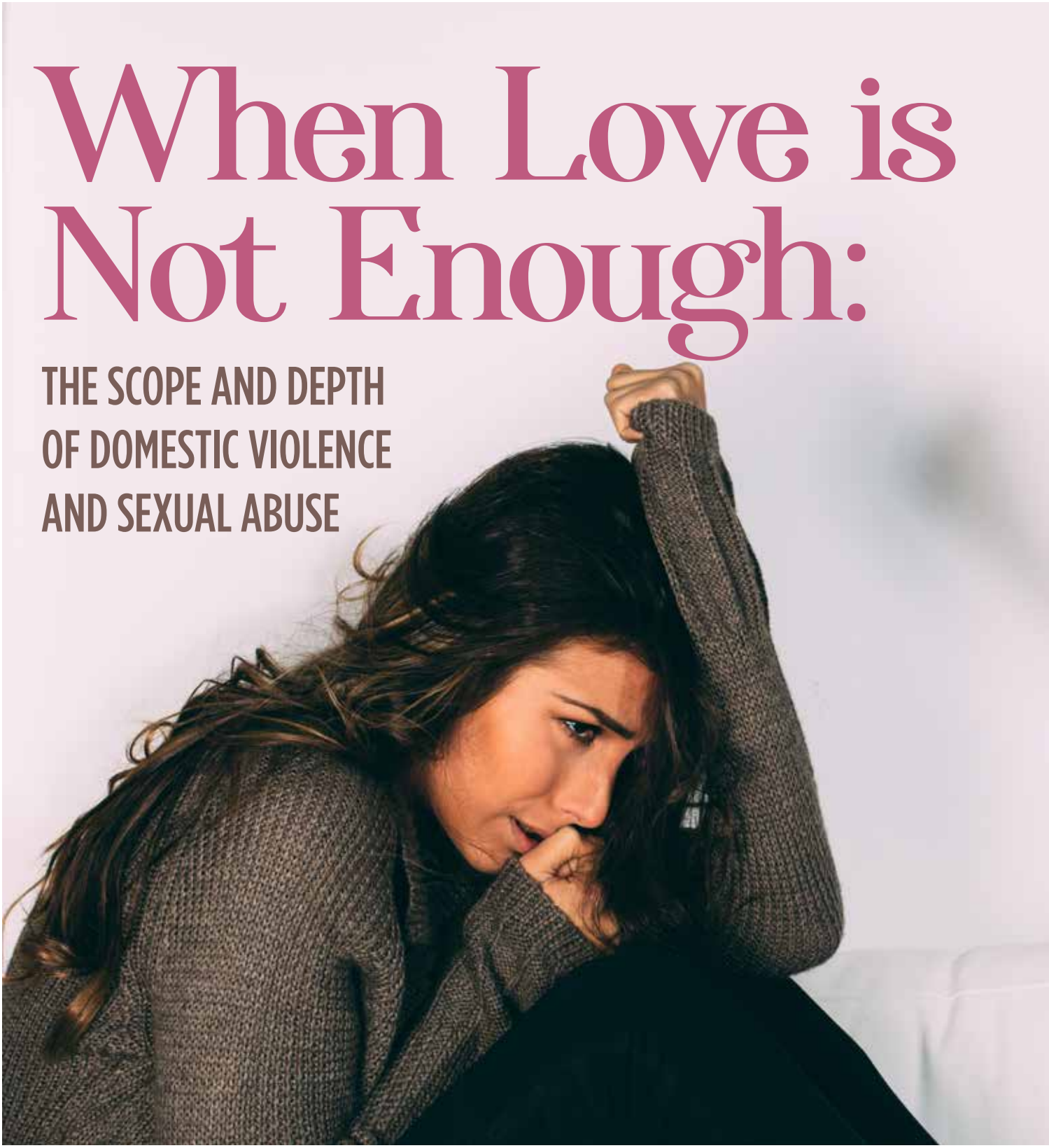
When Love is Not Enough:

THE SCOPE AND DEPTH OF DOMESTIC VIOLENCE AND SEXUAL ABUSE



According to the United States Department of Justice (DOJ), "the term *domestic violence* includes felony or misdemeanor crimes of violence committed by a current or former spouse or intimate partner of the victim, by a person with whom the victim shares a child in common, by a person who is cohabitating with or has cohabitated with the victim as a spouse or intimate partner, by a person similarly situated to a spouse of the victim under the domestic or family violence laws of the jurisdiction receiving grant monies, or by any other person against an adult or youth victim who is protected from that person's acts under the domestic or family violence laws of the jurisdiction."[1]

The Centers for Disease Control and Prevention (CDC) says, "Intimate partner violence (IPV) is a serious, preventable public health problem that affects millions of Americans."[2] Intimate partner violence or domestic violence, depending on the state, "describes physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy."[3]

The Interconnection of Sexual Assault and Intimate Partner Violence

Often, domestic violence offenders who are *physically* abusive toward their intimate partners will also become *sexually* abusive. Both physically and sexually abused victims are at a greater risk of being injured or killed than those experiencing one form of abuse only. Abusers attack people regardless of their gender, age, ethnic nature, or social environment. Those who are at the greatest danger of intimate partner rape are women who are disabled, pregnant or trying to abandon their perpetrators.[4]

The National Coalition Against Domestic Violence (NCADV) published the following disturbing national statistics:[5]

- One in five women will be raped in her lifetime.
- Nearly one in two women and one in five men reported being victimized by a sexually violent predator (other than rape) at some point in their lives.
- Intimate partners use sexual assault and rape to intimidate, control, and debase victims/survivors.
- Intimate partners who commit sexual assault are more likely to cause physical harm than a stranger or friend.
- The proportion of women who are sexually assaulted by intimate partners during their relationships is between 14-25%.
- The number of women in abusive relationships who are sexually assaulted is between 40-45%.
- More than half of women raped by an intimate partner were also sexually assaulted *multiple times* by the same person.

BARRY LORD

- Women sexually abused by an intimate partner are at a greater risk for intimate partner homicides than non-sexually abused females.
- Women sexually abused by an intimate partner experience severe and long-term physical and psychological health problems comparable to other rape victims.
- Women sexually abused by an intimate partner experience higher depression and anxiety rates than those who were either raped by a non-intimate partner or physically, but not sexually, abused by an intimate partner.

Rape in Marriage

Additional statistics reported by the NCADV reveal alarming details regarding marital rape:[6]

- Eighteen percent of female victims who were raped by their spouses say their children witnessed the crime.
- At some point during their marriages, between 10-14% of married women will be raped.
- Only 36% of *all* rape victims ever file a police report, and that percentage is even lower for *married* women reporting spousal rape.
- State laws exclusively exempted spousal rape from their general rape laws until 1976; however, that same year, Nebraska became the first state to pass a law recognizing nonconsensual intercourse with a spouse as rape.
- All 50 states had at least partially or entirely revoked their spousal rape exemptions by 1993.
- Even today, some states legally consider spousal rape a lesser crime than non-spousal rape and continue to have *some form* of marital rape exclusions.

Making a Difference in Your Community

Do you want to take a stand against domestic violence and sexual abuse in your community? The NCADV suggests the following six ways to help make a difference.[7]

1. "Encourage primary care physicians and OB/GYNs in your community to screen women for signs of physical and sexual violence and ask if they are in violent or abusive relationships during regular checkups." Some states require that physicians become mandated reporters if they reasonably suspect domestic violence. Other states require all people to be mandated reporters of suspected domestic violence.

2. "Demand state legislators update rape laws to include marital rape rather than considering [it] a different crime."

3. "Work with local schools, religious youth groups, and other youth-oriented programs to teach about healthy sexuality and healthy relationships."

4. "Ask local schools and universities to address the issue of sexual violence in their classrooms and through victim assistance programs."

5. "Ask your Members of Congress to support funding for direct surveys and programs created in the Violence Against Women Act (VAWA)."

6. "Volunteer at your local rape crisis center or state sexual assault coalition."

By working together, we can offer help and hope to the many women who suffer from domestic violence and sexual abuse and positively influence their lives. ✠

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Additional Resource

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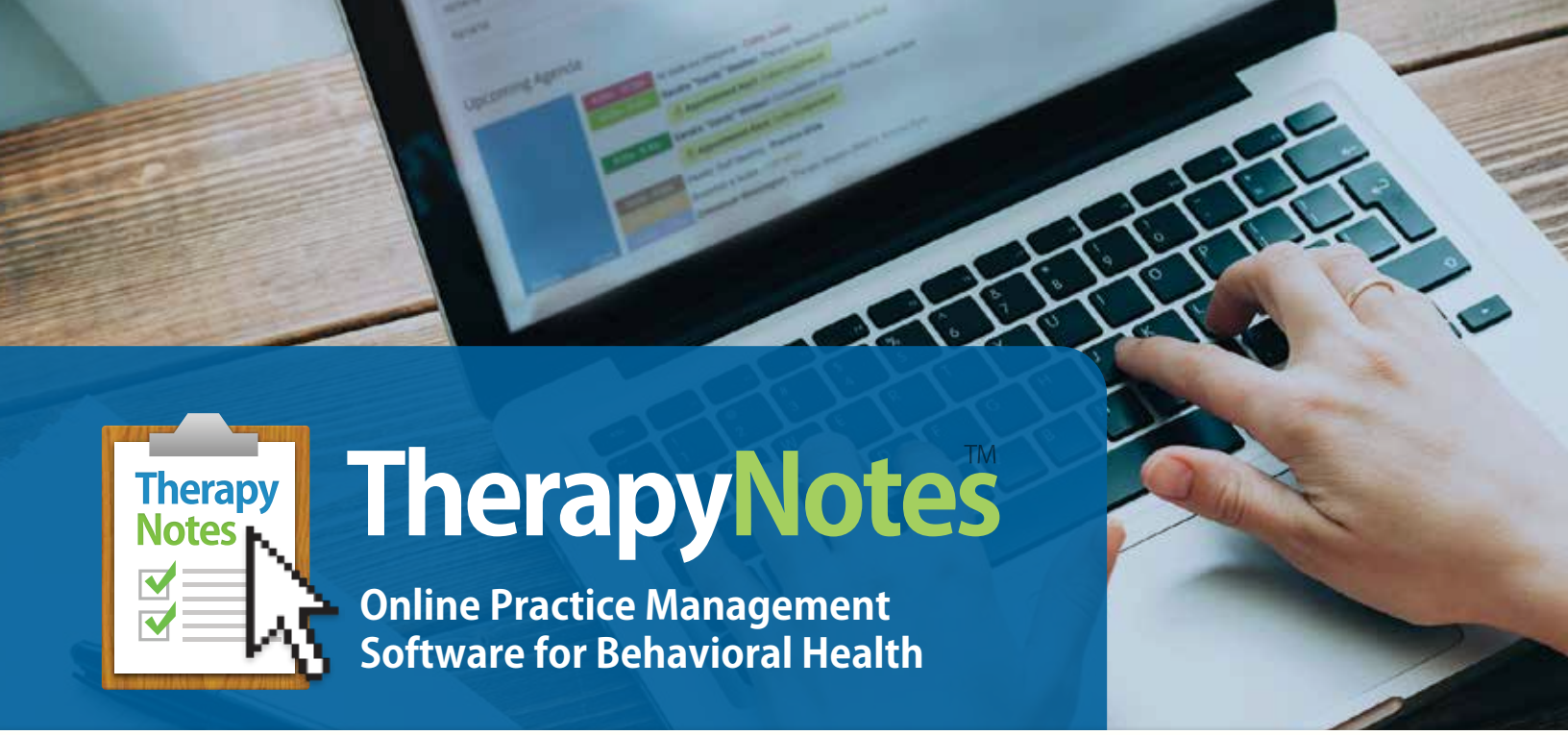

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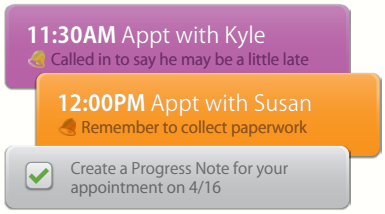

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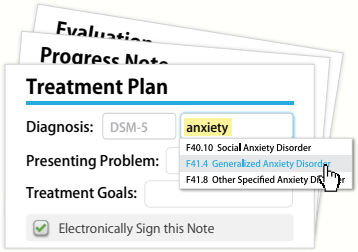

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Helping Each Other Cross the Finish Line

I was the alternate for the Oswego High School Panthers cross country team in the early 90s. That meant I had to be ready at a moment's notice in case one of the top seven was sick or injured. Most Saturdays in the fall, I was a cheerleader more than a runner.

The starter's gun prompted cheers from the sidelines. After the boys disappeared into the woods, I made my way to the finish line. I loved running the last one hundred yards alongside my fatigued teammates, encouraging them to finish strong. I like to think my cheers shaved a few seconds off their times. When they collapsed after crossing the line, I offered water and high fives. Cross country is definitely a *team* sport.

In 2 Timothy 4:6-8, the Apostle Paul writes, "For I am already being poured out like a drink offering, and the time for my departure is near. I have fought the good fight, I have finished the race, I have kept the faith. Now there is in store for me the crown of righteousness, which the Lord, the righteous Judge, will award to me on that day—and not only to me, but also to all who have longed for his appearing."

Paul is not talking about leaving a city. His race on earth is ending, and he is longing to be face-to-face with Jesus. This departure caused tension for Paul. In Philippians 1:23-24, he said, "I am torn between the two: I desire to depart and be with Christ, which is better by far; but it is more necessary for you that I remain in the body." He longed for heaven but knew his race on earth was not complete. He had more to do.

Finishing strong and receiving the crown was his goal. Paul wanted that for you, too. He says in 1 Corinthians 9:24-25, "Do you not know that in a race all the runners run, but only one gets the prize? Run in such a way as to get the prize. Everyone who competes in the games goes into strict training. They do it to get a crown that will not last, but we do it to get a crown that will last forever." We run this race until we draw our last breath. We run for the crown.

You are not done when the kids leave home or you retire. The finish line is at the end of this life's journey. Until that day, run. When the race is hard and you are winded, run. When you hit the wall, keep running until the finish line is in sight.

One aspect of Paul's race that inspires me is the fact that he did not run alone. He did not fight the good fight by himself. Paul was surrounded by others who loved and cared for him as he poured into their lives. In Colossians 4, we read a list of teammates that surrounded Paul. Tychicus, Onesimus, Aristarchus, Mark, Jesus, who is called Justus, Epaphras, Luke, and Demas are all mentioned in verses 7-14. Paul uses words like "dear brother," "faithful minister," "fellow servant in the Lord," and "co-workers for the kingdom of God" to describe these men. In verse 11, he says, "… they have proved a comfort to me." This sentiment was a result of Paul's team supporting him while he was imprisoned in Rome.

Just like Paul, you do not need to run your race alone. No one expects you to "fight the good fight" by yourself. Now, more than ever, we need a good support team. Who is on your team? Who is cheering you on today? I encourage you to take a moment and write down the names of the friends and family members who you know are with you to the end… or until they cross the finish line. Give them a call and check in on them… be an encouragement.

I asked a medical doctor recently,

"If the COVID-19 pandemic was a marathon, what mile are we on?" He said, "Somewhere between mile 16 and 20, and that is when most runners hit the wall." This is my first pandemic. In the early months, I watched as family, friends, church members, community leaders, and I grew frustrated with the restrictions, shutdown, and uncertainty of it all. Now, fatigue has set in. We hit the wall, and our physical, emotional, mental, and relational wellness is paying the price. Some experts describe the pandemic as "collective trauma" for our nation, and I see it every day.

If you have hit the wall, now is the time to reach out for help. In Galatians 6:2, Paul exhorts the Church to, "Carry each other's burdens, and in this way you will fulfill the law of Christ." We all have individual loads we must carry on our own, but sometimes in life the load becomes too heavy for one person. When this happens, we need someone else to walk alongside us and help. That does not mean we drop our share; we just need a little assistance. Caring for one another and carrying each other's burdens is when the Church is at its best.

Some of the most inspirational moments in sports history are when runners help each other across the finish line. We see the best in athletes when they stop near the end of a race to help a weary or injured runner. Possibly the most memorable assist came during the 1992 Summer Olympics in Barcelona, Spain. British sprinter, Derek Redmond, was favored to medal in the 400 meters until a torn hamstring took him out in the semi-finals. That did not stop him from finishing the race after his father ran down to help him cross the finish line. If you watch the video, you cannot help but choke up as Derek wraps his arm around his dad and places his head on his shoulder. This illustration is a beautiful picture of the Church and our call to help each other finish the race.

I pray you "… run with perseverance the race marked out for us" (Hebrews 12:1). Run and help others finish strong. Lean on others to help you cross your finish line.

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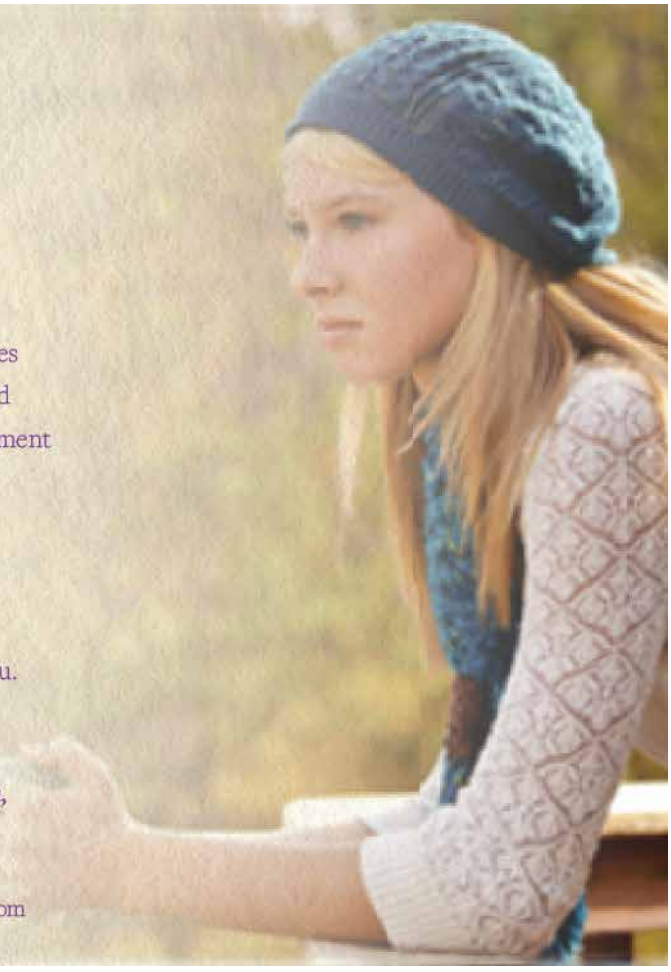

« DIANE LANGBERG, PH.D.

Listening to God's Voice to Silence Trauma

The burden of Habakkuk… "How long, O Lord, will I call for help, And you will not hear? I cry out to You, 'Violence!' Yet You do not save. Why do you make me see iniquity… destruction and violence are before me… justice is never upheld" (1:2-4, NASB 1995). Does this resonate with you? It is the cry of nearly 90,000 Boy Scouts abused and discarded to preserve an organization "for training boys." It is the cry of those crushed by sexual abuse, rape, and domestic violence. It is the cry of millions crushed by racism. Precious humans handknit by God in their mother's wombs and given dignity and purpose cry out "violence." Beings created in the image of our God and for whom His blood was shed say, "Justice is never upheld."

In Habakkuk's day, in order to deal with His people, God had to respond from the outside. His people, who were called by His name, did not respond with justice, care, and safety. When God's people fail to respond to the cries of the traumatized but also create and cover-up trauma, He will use other means to ensure little ones are protected, truth is exposed, and refuge is provided. It is a grievous failure of those who claim to be the people of God when they not only fail to be a sanctuary but also create the need for one.

Some years ago, I stated that "trauma is the mission field of the 21st century." I still believe that is true. However, now I also know that the voices of the traumatized are prophetic—the voice of our weeping God calling us to Christlikeness. The vulnerable, the oppressed, and the battered and abused are the call of God. However, we ignore it at our peril and seem to have lost our way.

We emphasize Christian ministry, numbers, gifting, and fame, easily confusing externals as a measure of success with God. We forget that holiness and integrity are the paths to God's work.

Nurturing a life with Christ from the inside is one that develops into manifestation and actions *from within.* Often our love and obedience to Jesus Christ are sacrificed to the work. The system of the Church has become a substitute for God Himself. And for the sake of that system, we ignore, silence, and discard the trampled and traumatized. Do we not hear the anguished and indignant voice of our God saying, "What have you done? The voice of your brother's blood is crying to Me from the ground" (Genesis 4:10, NASB 1995). When Abel could no longer cry out, our God cried out for him. We are not only silencing victims of trauma and abuse when we ignore their suffering; we are also silencing our God.

Trauma silences. The Word made flesh returns voice and calls that speak truth. Exploitation and oppression destroy relationships; however, the God who came and lived among us restores them with dignity. Trauma crushes power in victims and feeds the powerful. Spiritually, the effects of abuse are profound. The resulting distorted image of God, coupled with a distorted image of self, creates many barriers to experiencing His love and grace. The blood of our brothers and sisters is crying out to God. We desecrate the name of our Lord and bring great damage to His well-loved creatures when we fail to bend down, listen, tend to, carry, and honor God's image-bearers.

One of the characteristics of caring for the traumatized is the repetitious nature of the work. A Bible verse does not remedy the effects of violence in someone's life. I am not sure where we got the idea that quoting a verse should make a person's struggle go away. Human beings are slow to change, partly because evil and its impact are more terrible and profound than we understand. Are the Scriptures important to healing? Absolutely. However, it takes time before Scripture's truths can work their way down into a mind that has

been devastated by the evil of abuse. *And those Scriptures first need to be incarnated by you and me. Those words need to be made flesh.* Jesus demonstrated in the flesh what a human being is to be like who bears God's image. He pursued the vulnerable, protected the little ones, and poured out compassion on the least of these. Any dismissal of abuse, any baptizing of evil, any cover-up or denial is *nothing like Him*. Any discarding of the least of these or trampling of the vulnerable is an assault on God Himself—no matter the spiritual words used as an excuse.

You see, this Jesus had a passion for redeeming. For those who have been abused and are suffering from its debilitating aftereffects, listen hard. There is hope for you—hope for healing and transformation. I know; I come to you from the frontlines and have seen it happen countless times. It takes courage, hard work, and there is no quick fix. Such redemption was Jesus' master passion. This God came to seek and redeem what has been lost. What have you lost? Your voice? The truth, drowned out by lies? Your life and its vibrancy, its strength, its giftedness? Your hope? Not the hope that everything here will be fine… it clearly is not. It is the hope within that waits because God has said He is making all things new… and that includes you, every last one of you.

Devastation is, bit by bit, redeemable. I know. I have had a front-row seat to God's redemptive power for 47 years—and for the record, one of the people He has done redemptive work in is me. My work with victims has revealed to me who God is. Through my school and my teachers, I have come to see our God more clearly. So evil can be transformed in the life in which it occurred. That work is also redemptive in the one who walks alongside. *Evil is then twice crushed.* May the Church of Jesus Christ repent of her pursuit of human externals and bend down, listen, and walk alongside trauma, abuse, racism, hatred, and a blind eye as did her Lord. In doing so, we will bring joy to the heart of the Father. ✠

DIANE LANGBERG, PH.D., is globally recognized for her 47 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 *Redeeming Power: Understanding Authority and Abuse in the Church*.

« GARY W. MOON, PH.D.

Finding Serenity in Today's Traumatic Culture of Anger and Contempt: Part I

Did you think you would live to see a year like 2020? As I type these words, the global pandemic has resulted in more than 50 million cases and 1.3 million deaths. The tiny village of a few hundred in which I grew up has experienced death, directly and indirectly, related to the pandemic—on a COVID unit and from suicide by a community pillar who was desperate to escape his profound loneliness.

Simultaneous to the COVID trauma, our world seems to be teetering on the brink of what could be an economic, if not actual, Armageddon. We have seen things on the nightly news (aka polarized and politicized shouting heads) that would have seemed too unbelievable to have been included in the scary end-time movies that frightened me into many youth camp versions of salvation.

And if these horrors were not producing enough stress, there is another factor. It appears that some of the laws of social psychology (which l like to describe as the prolonged elaboration of the obvious) have been suspended. Isn't this precisely the time when the superordinate goal of needing others for survival is supposed to come into focus? Lord have mercy.

Speaking of divine intervention, it seems very significant that Jesus chose to live in an even more traumatic time than our present… and He had a lot of relevant advice. Jesus' opening lines to the main body of His most famous sermon (see Matthew 5:20) proclaim that the very best of the human personality exists much deeper than the surface level realm of right behavior. A person can be dead right and still far from righteous. The least in His kingdom, He underscores, is better than the best of the world order. Certainly, this cannot be accomplished by trying harder than the Pharisees. It can only happen when a heart heals and begins to gush living water.

And then, what does Jesus point to first as symptoms of a sick heart? Anger and contempt. But wait a minute… is this not the same Jesus who cleared a temple with a whip and cursed a fig tree? And didn't the Apostle Paul say, "… be angry and sin not?" Maybe we need to take a closer look at sin, anger, and the pathway that produces virtue instead of vice.

What is Sin?

The Hebrew word commonly used for sin, *hata*, has its origins in archery. Its translation into the Greek language of Jesus' day was "hamartia" or "to miss the mark." It would call to a first-century hearer's mind an archer missing the bullseye at the center of a target, even if the surrounding target was hit.

Jesus was making it clear. The center of the target is righteousness. And the best known "archers" of that time, the Pharisees, were missing that mark. They were hitting the target area (right behaviors) but consistently missing the center. And they were not signing up for His archery lessons.

So, what is the center… what is righteousness? The early Church got Jesus' point. The target is salvation or the healing or *sozo* of the human heart, so it is progressively becoming one with the heart of God. The target is living in union with God, so His love flows in and back out through thoughts, feelings, behaviors, and social relations.

What is Anger?

According to the frustration-aggression hypothesis developed by a group of Yale psychologists that included John Dollard and Neal Miller, anger and aggression result from the frustration or blocking of a desired goal. Give even an angelic-looking child a Tootsie Roll® Pop, and if his or her goal becomes getting to the chocolate center but some cruel researcher snatches it away before that goal is achieved, anger is likely to follow.

Psychology and spiritual formation are on the same page. Well-known American writer and philosopher, Dallas Willard, reminds us that the word "anger" comes from a Latin term for being put in a bind or pinched. The primary sense is that anger results from a violation of our will.[1] We are angry when we feel that our will has been set aside or stepped over. Willard further suggests a strong relationship between anger and love in that love can be seen as a fulfillment and expansion of the will. Love is willing and acting on what is good for another. Anger, on the other hand, results from restricting the will.

Anger is not in and of itself wrong. It is a healthy sign that we have a will and desires. We want to do, create, and enjoy. What becomes important, however, is to use our anger as a warning signal. Anger brings essential information as to the identity of our deepest goals and how we have come to believe our pathways to achieving these goals have been blocked. And if anger's presence is persistent, we can learn how we have become stuck in downward cycles of unforgiveness, self-justification, and pride.

For the most part, and to the embarrassment of the group, becoming incensed was almost entirely over selfish and unworthy concerns.

The Church's Approach to Anger

Professor, researcher, and author, Rebecca Konyndyk DeYoung, wrote the influential book, *Glittering Vices: A New Look at the Seven Deadly Sins and their Remedies*. She wrote it because she wanted to take sin seriously and learn from centuries of Christian reflection on vice and virtue pathways.

Why did she focus on the seven vices of envy, vainglory, sloth, avarice, gluttony, lust, and anger? "Not," she says, "because they are the worst sins or even the most harmful." And not even because of the overlap with the Enneagram personality model. She singled out these seven sins for the same reason as philosopher and theologian, Thomas Aquinas… because they concern areas of life that we think promise us happiness. Each promise, however, is a false pathway to happiness that leads only to temporary joy and long-term isolation.[2]

With our focus here being on the vice of anger, it is significant to note that according to DeYoung, church history has offered two different polarities concerning how to handle our anger. Aquinas represents the argument that anger is a natural human response that needs to be guided by reason. Anger can be part of a virtuous life; however, Christian monk and theologian, John Cassian, represents wisdom of the desert—the more ascetic approach and view that human anger regularly reveals disorder within, the roots of which should be dug up and put away.[3]

Perhaps the best answer is one that draws from both of these traditions within the Church. First, anger is to be viewed as a normal human response to a frustrated goal, a signal. However, it should be carefully questioned to better reveal if it is rooted in something as holy as an instinctive response to injustice or as hellish as a passion focused on a self-centered object or desire. The latter possibility can reveal an anger that is disproportionate to the frustration experienced and a hindrance to prayer and surrender to the will of God.

What is Your Anger Guarding?

We will close out part one of this reflection by referencing Rebecca DeYoung's fascinating experiment with her college class and a story from desert spirituality. She conducted an experiment in which she and her students began to journal about the times when they became angry. While the expectation was discovering a great deal of righteous indignation about injustice in the world, their notes revealed a surprising truth. For the most part, and to the embarrassment of the group, becoming incensed was almost entirely over selfish and unworthy concerns.

This discovery led her to ask a critical question from Evagrius Ponticus, a Christian monk and ascetic. It is a question which is, I believe, the beginning point for the journey of finding serenity in a culture of anger and contempt. What is our anger guarding? The answers will likely point us to the presence of one, or all, of the seven deadly vices.

Is my anger guarding my desire for food, pleasure, wealth, security, the esteem of others, avoidance, power, control, etc.? And, if so, what do these frustrating goals and the fierceness with which I guard them have to say about the state of my life of trust and friendship with God?

As spiritual teachers from Jesus to François Fénelon remind us, we find humility and the open palms of willingness or letting go at the heart of spirituality. "One day when Abba John the Dwarf was sitting in front of the church, the brethren were consulting him about their thoughts. One of the old men who saw it became a prey to jealousy and said to him, 'John, your vessel is full of poison.' Abba John said to him, 'That is very true, Abba; and you have said that when you only see the outside, but if you were able to see the inside, too, what would you say then?'"[4]

We will pick up our discussion in the next issue of *CCT*. But for now, let's ponder the questions: What is my anger guarding? And does my level of anger at this time point me to any disordered attachments, fear, or pride in my heart that need to be healed? ✠

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« MICHAEL R. LYLES, M.D.

Ketamine: An Answer or a Bridge?

The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study, a large-scale clinical trial funded by the National Institutes of Health (NIH), demonstrated that about a third of adult patients with Major Depressive Disorder (MDD) did not respond to oral treatment with two antidepressants.[1] Many have speculated that this is due to physicians' focus on antidepressant therapies that interact with monoamines such as serotonin, norepinephrine, or dopamine. As a result, there has been a great deal of interest in treatments that focus on other systems. Dr. Carlos Zarate, Jr., and his associates at the National Institute of Mental Health (NIMH) called attention to intravenous (IV) infusions of ketamine in 2006.[2] In this study, ketamine helped patients who had been significantly depressed and non-responsive to other treatments after one intravenous infusion. This result triggered a series of investigations into the system with which ketamine is involved—glutamate.

Ketamine is a longstanding drug that was approved as an anesthesia medication in 1970. It was preferred in surgical procedures due to its failure to suppress respirations during surgery and allow for less opiate pain medication after surgery. It also garnered a reputation as a drug of abuse at "rave parties" under the street name "special K" at high dosages. The Zarate study suggested that a single low dose infusion significantly improved mood in adult patients with treatment-resistant MDD for varying periods of time. This thread of research led to the proliferation of ketamine infusion clinics for patients with treatment-resistant MDD. The reports of people getting well, for short periods, after one infusion triggered unrealistic expectations about intravenous ketamine infusions driven by the immense suffering of treatment-resistant patients. The research on intravenous ketamine is thin in depth[3] and has not been approved by the United States Food and Drug Administration (FDA) or covered by insurance. Each treatment can cost approximately $400-500.

Ketamine is given intravenously due to the drug's low bioavailability if given orally (17-25% of the IV route) or sublingually (30-40% of the IV route). The usual dosage is 0.5-1 mg/kg intravenously given twice per week for two weeks and then every other week or once per month thereafter, based on clinical response. Many centers provide six infusions and then assess for clinical response. Patients are maintained on antidepressants while having the infusions. The literature response rate is 65-70%, but some of those studies had flawed methodologies.[4] Patients who have failed electroconvulsive therapy (ECT) tend to have

The Zarate study suggested that a single low dose infusion significantly improved mood in adult patients with treatment-resistant MDD for varying periods of time.

lower response rates (45-50%). Side effects peak within 40 minutes of infusion and cease 40 minutes after. Common side effects include nausea, perceptual disturbances, dissociation, anxiety, headache, and dysphoria. It is not known whether having more infusions convey a cumulative and/or sustained benefit. Patients are usually excluded from this treatment if they have an active substance use disorder, psychosis, or do not have an escort to transport them after treatment.

Ketamine is a "racemic mixture" consisting of two mirror-image isomers, S-ketamine and R-ketamine, in a 50/50 mixture. Sometimes racemic mixture drugs can be improved by separating the two isomers if one has an advantage. R-ketamine has not shown efficacy in treating depression. The S-ketamine isomer, esketamine, has been approved for use as an adjunct to an antidepressant in treatment-resistant adult patients with MDD under the trade name of Spravato.®[5] It is also FDA approved for the acute treatment of suicidal ideation in adult patients with MDD. Given intranasally in treatment facilities certified under the "Risk Evaluation and Mitigation Strategy," administering this drug requires treatment setting, physician, and dispensing pharmacy certification.

Patients are enrolled in a registry and monitored for two hours after each session. It is given twice per week for four weeks and then once per week for four weeks. Subsequently, it is individualized based on the clinical response of patients. At this time, there is no extensive data as to how long treatment should occur with esketamine. After receiving the nasal spray, patients are required to remain at the treatment site for two hours for observation and cannot drive for the rest of the day. Side effects may include abnormal taste/smell, dizziness, and sleepiness.

Both ketamine and esketamine work as modulators of a receptor that is involved with the glutamate system. Glutamate systems are very abundant in the brain and extremely excitatory to neuronal development. Glutaminergic systems are theoretically felt to stimulate neuroplasticity through the stimulation of a variety of brain-derived neurotropic factors. These factors function as a sort of fertilizer for neuronal synapses. Ketamine is a non-competitive antagonist (blocker) on the glutamate receptor, N-Methyl-D aspartate (NMDA). Ketamine acts as a modulator regulating the activity of glutamate systems through the NMDA receptor, keeping them in an optimal range. There are several other theories for the antidepressant effects of ketamine isomers, as the glutamate system is very complex and interacts with glial cells (non-neuronal cells in the central/peripheral nervous system that do not produce electrical impulses) and a host of other neurotransmitter systems.

In summary, ketamine and its isomers do appear to be the answer for some adult patients with MDD who have failed at least two trials of oral antidepressants at proper dosages.[6] For others, it may not be the desired result because of lack of efficacy or side effects. However, it does challenge our thinking to move outside the box of serotonin, norepinephrine, and dopamine options and consider other mechanisms of action. In that way, it certainly serves as a bridge to consider glutamate and additional systems for future research and development for depression and other disorders.[7]

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« JEANNEANE MAXON, J.D., ESQ.

Recognizing Post-abortion Trauma in the 21st Century: The Current Problem, Part I

One of the most important issues in the 2020 United States presidential election centered around the future of legalized abortion in the United States. Would a Biden presidency reverse the numerous pro-life gains seen under the Trump administration? Would the nomination of Amy Coney Barrett to the Supreme Court lead to the reversal of *Roe v. Wade*?[1] All too often lost in the political discussion are the thousands upon thousands of women who have suffered trauma as a result of abortion, an issue vitally important to Christian counselors. This article is divided into two parts. In part one, we seek to understand the current problem as it relates to counseling post-abortive women. In part two, we will look at the potential future of this issue and your role.

The Current State of Abortion in the United States

Since the U.S. Supreme Court legalized abortion in 1973, more than 60 million abortions have occurred in the United States.[2] An estimated 25% of women will have an abortion by age 45.[3] The U.S. joins only six other countries in the world today that allow elective abortion after 20 weeks: China, North Korea, Vietnam, Canada, Singapore, and the Netherlands.[4]

Recognition of Post-abortion Trauma as a Mental Illness

The third edition of the *Diagnostic and Statistical Manual* (*DSM*) recognized Post-abortion Syndrome (PAS) as a "suggested variant of Post-traumatic Stress Disorder (PTSD)." Also,

"abortion was one of the traumatic events listed in *DSM-111-R*, 60." In the *DSM-IV*, abortion was removed from its list of possible predictors for PTSD.[5] Despite clear evidence to the contrary, neither the American Psychiatric Association nor the American Psychological Association recognize PAS. Likewise, abortion is not mentioned in the Code of Ethics for the American Counseling Association (ACA).

The American Association of Christian Counselors, however, rightly acknowledges the adverse consequences of abortion and instructs counselors to "… *consider and inform clients of potential adverse consequences (emotional and psychological consequences including any increased risk of depression, anxiety and suicidal ideation), as well as alternative means to abortion, recognizing the client will ultimately be responsible for the decision that is made.*"[6]

Post-abortion Syndrome is also becoming increasingly recognized by experts. *Psychology Today* magazine recently published an article by Suzanne Babbel, MFT, Ph.D., which acknowledges that "… any event that causes trauma can indeed result in PTSD, and abortion is no exception." Dr. Babbel further lists the following possible symptoms of PAS: guilt, anxiety, numbness, depression, flashbacks, and suicidal thoughts.[7] In a 2013 article published by *Counseling Today*, Trudy M. Johnson, MFT, noted that "… very few venues exist in our culture where women have permission to grieve an abortion loss. It has been 40 years since abortion was legalized… [and] most mental health professionals are not informed or equipped to serve an extensive population that is confused by and disenfranchised with their abortion grief."[8]

Dr. Babbel and Ms. Johnson are joined by Dr. Christiane Northrup, author of *Women's Bodies, Women's Wisdom* (2010), who stated, "[M]any women have written to me expressing their gratitude that I have addressed this issue [of processing abortion grief]. And they have written about how their willingness to tell the truth about their abortion experience has healed them."[9]

Even the U.S. Supreme Court has recognized the emotional and mental harms of abortion on women in its majority opinion in *Gonzales v. Carhart*: "It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound… [when she learns the details of the abortion procedure]."[10]

Evidence Supporting Post-abortion Syndrome[11]

The conclusions of the previously-noted experts are supported by numerous studies revealing significant emotional and psychological problems. Between 1995 and 2009, more than 100 studies showed a correlation between abortion and subsequent mental health issues.[12] For women who chose to abort, compared to women who carried their first pregnancies to term, the studies found that post-abortive women:

- Have a 65% greater likelihood to score in the "high-risk" range for clinical depression.[13]
- Are three times more likely to commit suicide.[14]
- Suffer an increased risk for depression and anxiety.[15]
- Suffer an increased risk for eating and sleeping disorders.[16]

As author and pro-life convert, Frederica Mathewes-Green, so aptly stated, "No one wants an abortion as she wants an ice-cream cone or a Porsche. She wants an abortion as an animal, caught in a trap, wanting to gnaw off its own leg."[17] In part two, we will explore how the need to recognize PAS will become increasingly important, and your critical role in helping post-abortive women.

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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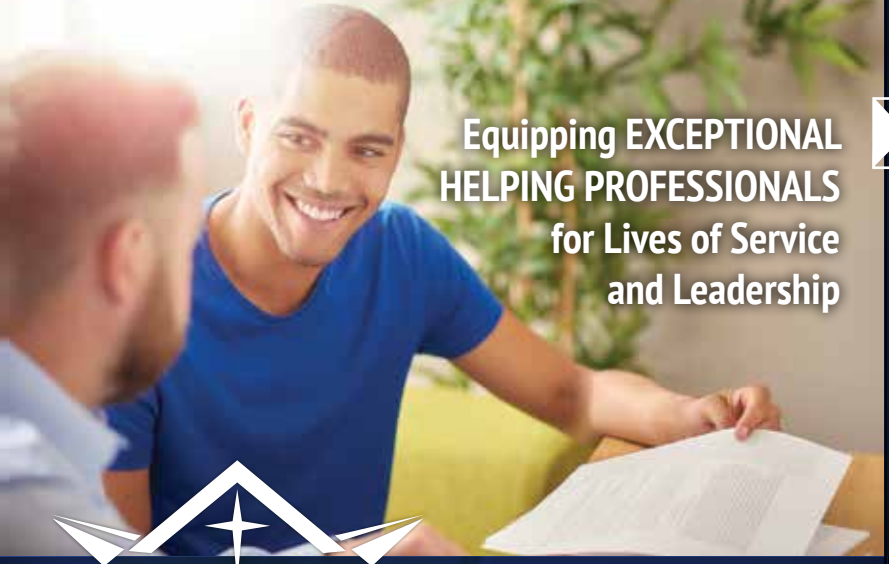

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« GREGORY L. JANTZ, PH.D.

Redefining Trauma with Hope

Trauma: a deeply distressing or disturbing experience creating an emotional shock consisting of physical trauma, psychological trauma, or both.

Even before the shockwaves of the global pandemic and economic lockdown, trauma was all-too-present in the lives of many. According to the National Center for Post-traumatic Stress Disorder (PTSD), "Going through trauma is not rare. About six of every 10 men (60%) and five of every 10 women (50%) experience at least one trauma in their lives. Women are more likely to experience sexual assault and child sexual abuse. Men are more likely to experience accidents, physical assault, combat, disaster, or to witness death or injury."[1] A good portion of my work as a therapist has centered around recovery from the effects of personal trauma. As a therapist, I know how to help people understand their trauma, come to terms with it, and begin the healing journey.

Outside of the counseling setting, understanding how and when to help becomes less clear. Some people may desire to hide the effects of trauma and pretend everything is "fine." There can be shame involved with admitting to the debilitating results of trauma. What can I do, as a leader, to help those around me cope with trauma? The role of a leader does not always (nor should it) lead me into the role of therapist or counselor. If I am not acting as a therapist or counselor, what can I give to the traumatized individuals I lead? How can I respect the boundaries in my leadership role while still providing help to those in need?

Reject Personalizing the Trauma

Leaders, by nature, place themselves at the forefront of many decisions and situations. When dealing with a traumatized individual, I believe this tendency needs to be muted. In trauma, the *what* may be experienced by many, but the *how* is highly personal. As a leader, my function is not to place a value judgment on whether the degree of trauma is legitimate nor attempt to "fix" the other person. Again, leaders are not therapists. Instead, my role, as I see it, is to listen so I can understand. Once I can understand, my capacity to find ways to support that person increases.

Nurture a Relationship of Hope

One of my functions, as a leader, is to point the way to the future. At work, home, in the community, or the Church, I have the responsibility to project and articulate an outcome beyond what is currently visible and provide others with a vision of hope. To me, the future and hope are inexorably linked. This belief is why the theme verse for my counseling center is Jeremiah 29:11: "'*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.*'"[2]

Trauma takes hope, with its optimistic vision of the future, and shakes it to the core—the more severe the trauma, the greater the aftershock. When trauma compounds trauma, repetition can create a destructive resonance that breaks hope apart. For a person who begins with hope, trauma can severely undercut that belief. For a person with little hope to start, experiencing trauma acts to validate a bleak future of I-told-you-so.

As a Christian, my faith firmly establishes that hope exists outside of circumstance, beautifully articulated in Hebrews 11:1. My faith, then, becomes the foundation for the hope I can share with those whose vision is clouded by trauma. As a leader, my job is to nurture a relationship of hope, articulating with confidence my belief in the resiliency of the individual and my trust in God's future.

Embrace Your Leadership Role

Over the years, I have influenced many people through my role as a therapist. If I were to go over my 35 plus years of professional records, I could probably come up with a finite number. However, I do not think I could calculate the number of people I have, hopefully, influenced in the various leadership positions in my lifetime. Leaders do not always realize the profound effect they have on those around them. If you doubt that, think back to a teacher or coach or neighbor or family member who "led" you by words, actions, or example. You probably never really said anything, but their influence was profound—and sometimes it was profound because it occurred amid trauma.

When the world is shaking and shifting, when those I am leading are in danger of losing their balance, I want to be the stable, dependable ground they can run to for help. I want to be the type of leader others trust to provide clarity, optimism, and hope. As a result, I need to have resources and reinforcements in place to strengthen myself so I can, in turn, strengthen others. After all, there is no trauma exclusion clause for leaders.

Dealing with trauma is not something you can schedule on your calendar when you have a free afternoon. The adage, "when it rains, it pours," sometimes seems tailor-made for trauma.

Counting the Cost of Hope

One last thought—those we lead in our workplaces, churches, communities, and homes can be subject to trauma at the most inconvenient times. Dealing with trauma is not something you can schedule on your calendar when you have a free afternoon. The adage, "when it rains, it pours," sometimes seems tailor-made for trauma.

With the weight of multiple responsibilities, leaders must find the compassion, understanding, and empathy needed to address the effects of trauma, even when it seems overwhelming. As one author put it, "Demonstrating true empathy can be a costly discipline. It requires us to sacrifice time and convenience, to alter our personal schedules and reorganize our priorities. It even requires the humility to hold back our best advice so that we can come alongside those in need and invite them into healing."[3] Such are the sacrificial demands—and rewards—of servant-leadership. ✠

GREGORY JANTZ, PH.D., is the founder of The Center • A Place of HOPE (www.aplaceofhope.com), a healthcare facility in Edmonds, Washington, which emphasizes whole-person care, addressing the emotional, relational, physical, and spiritual aspects of recovery. He is the author of multiple books and is a sought-after speaker in person, on television, and radio (www.drgregoryjantz.com).

Endnotes

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« FERNANDO GARZON, PSY.D.

Natural Disasters, Coping and the Frequency of Future Trauma in College Students, and Spiritual Distress Among PTSD Veterans

In this Research Digest, we examine the role of faith in coping with natural disasters. We also look at how different coping strategies may predict the frequency of future traumas in college students. Finally, we consider how veterans' beliefs on why a good God could allow the evil they experienced might influence their spiritual distress and PTSD symptoms.

Natural Disasters

Davis, E.B., Kimball, C.N., Aten, J.D., Andrews, B., Van Tongeren, D.R., Hook, J.N., Davis, D.E., Granqvist, P., and Park, C.L. (2019). Religious meaning making and attachment in a disaster context: A longitudinal qualitative study of flood survivors. *The Journal of Positive Psychology, 14*(5), 659-671.

Natural disasters challenge our coping resources. Davis and colleagues investigated the role of faith as a meaning making framework to overcome such catastrophes and developed a grounded theory of the meaning making process. Some of their findings will be reported in this brief review. The researchers conducted in-depth interviews at one-month and six-months following the 2016 Louisiana flood utilizing an adapted variation of the Religious Attachment Interview. Thirty-six highly religious flood survivors (20 women and 16 men averaging 43-years-of-age) participated. Twenty-three of these participants had their homes or businesses flooded, and 14 were impacted indirectly through their communities being flooded. Twenty-three were white, 11 black, one Latina, and one Asian. There were 23 Protestants, nine Catholics, two Mormons, one Jewish, and one was unaffiliated.

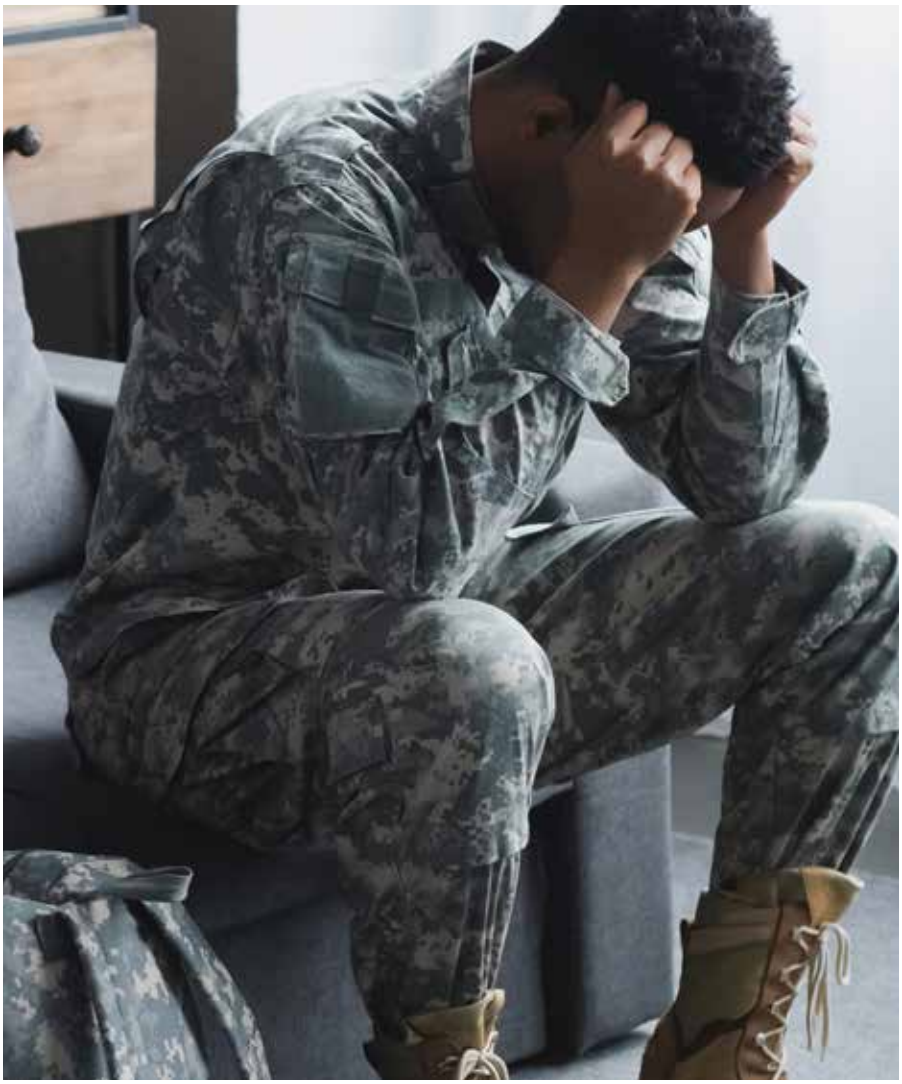
The researchers found that the vast majority of these highly religious disaster survivors exhibited spiritual resilience and strength in the disaster's aftermath. As psychological resilience has been noted to be the most typical psychological response to disasters, "… spiritual resilience may be the most typical [religious/spiritual] response to disasters" (p. 668). Anger at God or other forms of negative religious coping were quite rare in this sample, both at four-weeks and six-months post-disaster. Most participants conveyed views and experiences of God as present, benevolent, and powerful. Many believed that God did not cause the catastrophe but allowed it, that He remained providentially in control and had higher purposes for the suffering. The participants reported that they had grown closer and stronger in their relationships with God. Davis and colleagues acknowledged more studies with different designs are necessary to ascertain whether such reports demonstrate verifiable post-traumatic growth. For Christian clinicians, the study reminds us of the power of faith as a coping resource in natural disasters. While some people experience spiritual struggles in the aftermath of such catastrophes (and often end up in our offices), many find faith a valuable source of meaning making in dealing with the experience.

Coping and the Frequency of Future Trauma in College Students

Jenzer, T., Meisel, S.N., Blayney, J.A., Colder, C.R., and Read, J.P. (2020). Reciprocal processes in trauma and coping: Bidirectional effects over a four-year period. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(2), 207-218.

Even though 50-90% of people in the United States experience some form of trauma yearly, many do not develop post-traumatic stress disorder or trauma-related conditions but instead experience post-traumatic growth. Jenzer and colleagues examined how avoidant, approach, and support-seeking coping strategies predict the frequency of traumatic experiences in a four-year longitudinal study of 1,002 college freshmen. Approach and avoidance strategies focus on whether people move toward or away from stress-related experiences and emotions when coping with difficulties. Support-seeking strategies relate to how much the individual pursues relational support to cope. The participants were young (18-years-old on average at the start) and predominantly white (73%). Retention rates were good (93-99% for each year of the study).

The researchers applied multivariate Latent Curve Modeling with Structured Residuals to examine cross-lagged associations between coping strategies and trauma. Over time, coping styles influenced the frequency of future traumas that participants reported yearly. When social support seeking or approach coping



was higher than anticipated, a lower number of future trauma experiences were reported. "These findings point to the potentially protective role of these coping styles in preventing new trauma and may help explain why individuals appear to have different risks for experiencing trauma" (p. 215).

The investigators noted that clinicians working with populations at high risk for trauma should consider including coping skills training where clients could learn to proactively deal with stressors (approach strategies) and intentionally seek out others for assistance (support strategies) as a central component in treatment. "This may be more important than trying to decrease avoidance strategies, which did not have an impact on future trauma in our sample" (p. 215). Further studies are needed in this area. The findings are limited but intriguing.

Spiritual Distress Among PTSD Veterans

Harris, J.I., Usset, T., and Cheng, Z.H. (2018). Theodicy and spiritual distress among veterans managing posttraumatic stress. *Spirituality in Clinical Practice, 5*(4), 240-250.

Harris and colleagues conducted the first study examining the relationship between theodicy (theological explanations for why a good God allows evil), spiritual distress, and post-traumatic stress disorder (PTSD) in veterans. Would specific theodicy beliefs predict spiritual distress and PTSD symptoms? The researchers recruited 214 predominantly male veterans (n = 165) from two VA centers in the Midwest. The sample contained a wide variety of Christian denominational backgrounds, a small percentage of other religions (less than 1% in each category), and agnostics (3%). Each participant completed various tests that were then analyzed using factor analysis and hierarchical multiple regression analysis.

When the researchers examined data on the theodicy beliefs, one belief emerged as a significant predictor of spiritual distress and PTSD symptoms—retribution theodicy. In retribution theodicy, veterans believe that God is actively punishing them with traumas and symptoms because of their sins. While the nature of this cross-sectional study limits the ability to make causal statements related to this finding, the result is essential. Christian mental health professionals are in a unique position in helping veterans who believe their sins are the cause of their traumas and suffering. God's grace and forgiveness could be powerful antidotes for such distress. Future research may bear this out scientifically. ✠

FERNANDO GARZON, PSY.D., is a professor at Regent University in the School of Psychology and Counseling. His research interests focus on investigating spiritual interventions in therapy, multicultural issues, and evaluating psychologist/counselor education practices in spirituality. Dr. Garzon's professional experiences include private practice as a clinical psychologist, being an associate pastor for a Latino church, and doing pastoral care ministry.

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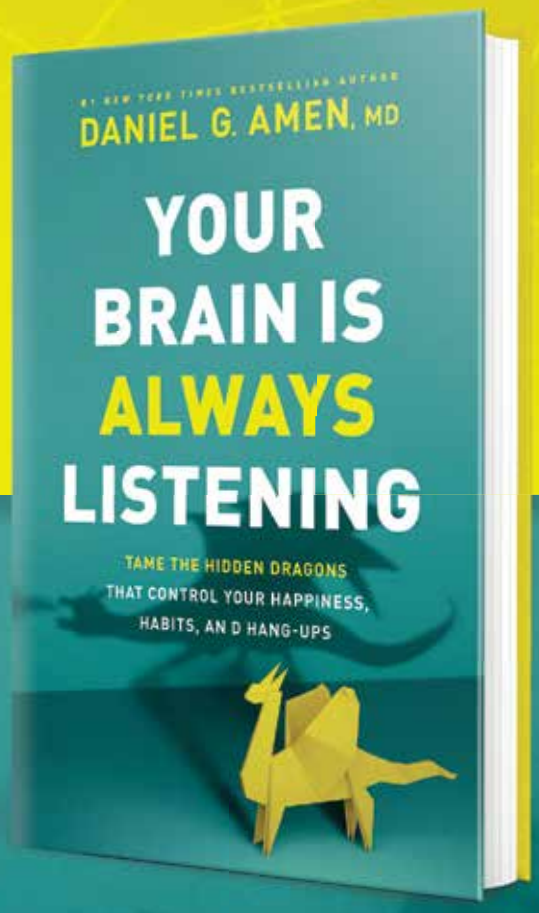

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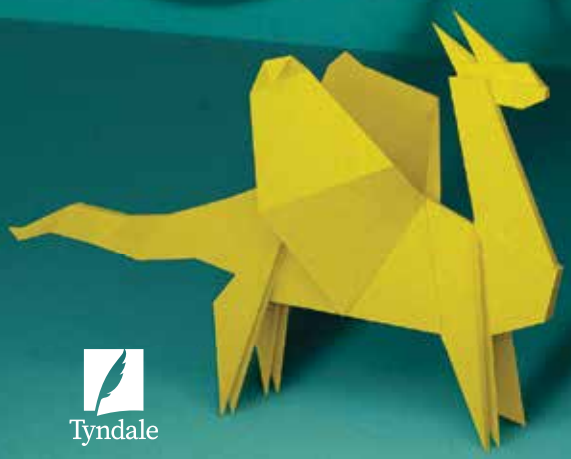

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DANIEL G. AMEN, MD, is a physician, a double board–certified psychiatrist, the founder of Amen Clinics, a 12-time *New York Times* bestselling author, and the recipient of the John Maxwell Transformational Leadership Award for 2019. Dr. Amen has written, produced, and hosted 15 popular public television shows about the brain that have aired more than 120,000 times across North America.

Answer the following questions from this issue of Christian Counseling Today by marking the appropriate circle. Once completed, you may send in this entire page or a photocopy with your payment to the address below. Please do not send cash. The quiz is open-book and you will need a minimum score of 70% to receive a letter of completion.

Childhood Trauma: Developmentally Appropriate…
– Daniel Sweeney

1. Play and expressive therapies heal trauma by
   - O a. creating the necessary therapeutic distance to express pain
   - O b. creating a safe environment for abreaction to occur
   - O c. creating a place for traumatized clients to experience control
   - O d. all of the above

Creating Healing Spaces for Those Affected by Race-based Trauma – Fredrica Brooks-Davis

2. Racial discrimination is identified in the literature as a form of
   - O a. rejection that leads to a profound sense of loss
   - O b. stress that may lead to traumatic reactions
   - O c. trauma that invariably creates affective disorders
   - O d. anxiety that leads to an identity crisis in victims

When Love is Not Enough: The Scope and Depth of Domestic Violence… – Barry Lord

3. Which of the following is **NOT** true regarding spousal rape?
   - O a. In some states it is considered a lesser crime than non-spousal rape
   - O b. At some point in their marriages, 25-30% of women will be raped
   - O c. Eighteen percent of female victims raped by spouses say their children witnessed the abuse
   - O d. Less than 36% of married women report spousal rape

Redefining Trauma with Hope – Gregory L. Jantz

4. According to Jantz, leaders in general
   - O a. should try their best to be counselors to others in trauma
   - O b. should try to evaluate if the degree of trauma is legitimate
   - O c. should try to provide a vision of hope
   - O d. none of the above

Listening to God's Voice to Silence Trauma – Diane Langberg

5. To remedy the effects of violence and trauma in someone's life,
   - O a. quote appropriate Scripture verses to bring healing
   - O b. the truths of Scripture must first be incarnated in us
   - O c. we should explain that suffering is part of the call for Christians
   - O d. keep up to date with the latest in trauma therapy techniques

Moral Injury and Trauma Treatments – Harold G. Koenig

6. For people to experience MI, they must
   - O a. have a psychopathic type of personality
   - O b. have a working conscience
   - O c. have transgressed their own moral values
   - O d. both b and c

Not Easily Broken: Trauma Bonds and the Road to Healing
– Shannon Wolf

7. Which of the following is true of a trauma bond?
   - O a. the greater the pain, the deeper the bond
   - O b. the abuser is the source of pain and the only one who can relieve it
   - O c. eventually the victim cannot fully feel love without some level of abuse
   - O d. all of the above

Preparing the Church to Help: Training Congregants to Assist…
– Edward E. Moody, Jr.

8. Which of the following is **NOT** considered by the author as helpful?
   - O a. observe and consider ways to help those in crisis
   - O b. listen well to help others in trouble unburden themselves
   - O c. respond to others in need by praying for them out loud
   - O d. quoting verses like Romans 8:28

The Path Forward: Personal Reflections on Healing…
– Ron Hawkins

9. In healing personal trauma, we take responsibility for
   - O a. creating new neural pathways by a disciplined engagement in the process
   - O b. putting the past in the past and not dwelling on it
   - O c. redirecting thoughts in a more positive, adaptive direction
   - O d. avoiding situations that trigger the trauma response

Understanding Complex Trauma and the Path…
– Heather Davediuk Gingrich

10. The goal of phase II work is
    - O a. providing safety within the therapeutic relationship
    - O b. restoring relationships with others and society
    - O c. processing the trauma frame-by-frame
    - O d. learning coping skills and grounding techniques

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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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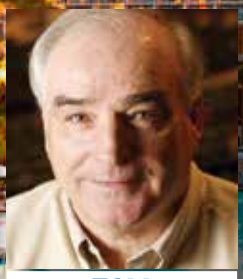
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OUR THERAPY STARTS AT 8 WEEKS OLD.

Capstone Treatment Center is a residential therapy center for young men ages 14 to 25 struggling with addictions, behavioral and attitude issues, co-occurring disorders, trauma, family conflict, and struggles with relinquishment and adoption. Every resident receives a Labrador retriever puppy upon admittance. Canine Companion Therapy is a unique and special part of our approach, forming an irreplaceable relationship with unconditional love and acceptance. After graduation, the Labrador serves as a recovery companion and constant reminder of the Capstone experience.

LET US BE YOUR PARTNERS IN HEALING. Residents receive highly personalized attention thanks to our 1-to-2 therapist/resident ratio – and all of our therapists either hold PhDs or master's degrees, specializing in sexual addiction, trauma, and attachment issues. They'll help your son identify, address, and heal the root cause behind his struggles so he can begin to restore relationships and build his future.

Healing the Past.
Embracing the Present.
Redeeming the Future.

CAPSTONE
PROFESSIONAL EXCELLENCE | CHRIST-CENTERED

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