SEPTEMBER 2020, ISSUE 2

COMPLEX TRAUMA PERSPECTIVES

ISTSS Complex Trauma Special Interest Group Newsletter

CT SIG CO-CHAIRS' CORNER

Stephen DiDonato, PhD, LPC, NCC, Lori Herod, EdD, & Rebecca Ohler

Greetings complex trauma colleagues,

We wanted to take this opportunity to thank all of the members of the ISTSS Complex Trauma SIG for your contributions to the growth of the SIG. Over the past year, our SIG has made some important progress in accomplishing some of the goals developed at the 2019 ISTSS Annual Meeting. Three projects that our SIG has accomplished this year are the following:

(1) The launch of this newsletter, **Complex Trauma Perspectives** (access the inaugural issue here) - Thank you to Krista Engle and Kelly Pattison for taking on the editorial responsibilities and to all SIG members who are contributors to the editorial team, (*cont.*)

WHAT'S INSIDE THIS ISSUE:

THE COMPLEX TRAUMA SIG SEEKS TO... GALVANIZE SIG MEMBERS AND OTHER ORGANIZATIONS TO PARTICIPATE IN PROJECTS THAT INCREASE A GLOBAL UNDERSTANDING OF COMPLEX TRAUMA [AND] THE SEQUELAE OF THE ASSOCIATED COMPLEX SYMPTOMS.

- CT SIG MISSION STATEMENT 2020

CO-CHAIRS' CORNER (CONT.)

Stephen DiDonato, PhD, LPC, NCC, Lori Herod, & Rebecca Ohler

(2) A **Complex Trauma bibliography** (now available on the CT SIG webpage), and
(3) Co-leading a **Child Trauma Task Force** with the ISTSS Child Trauma SIG and APA Division 56.

Additionally, we have recently revised the CT SIG Mission Statement to better reflect the SIG's current goals and recent activity. This renewed mission statement now appears on the SIG website as follows:

COMPLEX TRAUMA SIG MISSION STATEMENT

The Complex Trauma SIG seeks to bring together diverse perspectives from researchers, clinicians, social and public health providers, advocates, and those with lived experience of complex traumatic stress. Complex traumatic stress is caused by prolonged relational trauma, often during a formative developmental period but also in adulthood, that results in an array of harms to psychological and physical health. We seek to galvanize SIG members and other organizations to participate in projects that increase a global understanding of complex trauma as stressors as well as the sequelae of the associated complex symptoms. We strive to foster advocacy and organize for improvements in research, diagnosis, treatment, services and life outcomes for individuals impacted by complex trauma.

We are always looking for more people to be involved in the SIG. If you are interested in being added to one of the projects on our current wish-list, or have ideas for a project yourself, please contact one of us so that we can support you. We will also be looking for one new co-chair and a new student co-chair soon. The terms for both positions begin January 2021. You may contact Rebecca Ohler (rebecca_ohler@fd.org) or Lori Herod (l.herod@yahoo.ca) directly if you are interested in co-chairing, or look for an announcement on the listserv in the near future.

The **ISTSS Annual Meeting** is coming up soon in November. We are excited to see and hear from everyone in the SIG. We will circulate the SIG meeting time(s) to all our members once they are announced. Thank you for so much energy and good ideas this year and we look forward to continued momentum in the year to come.

Regards,

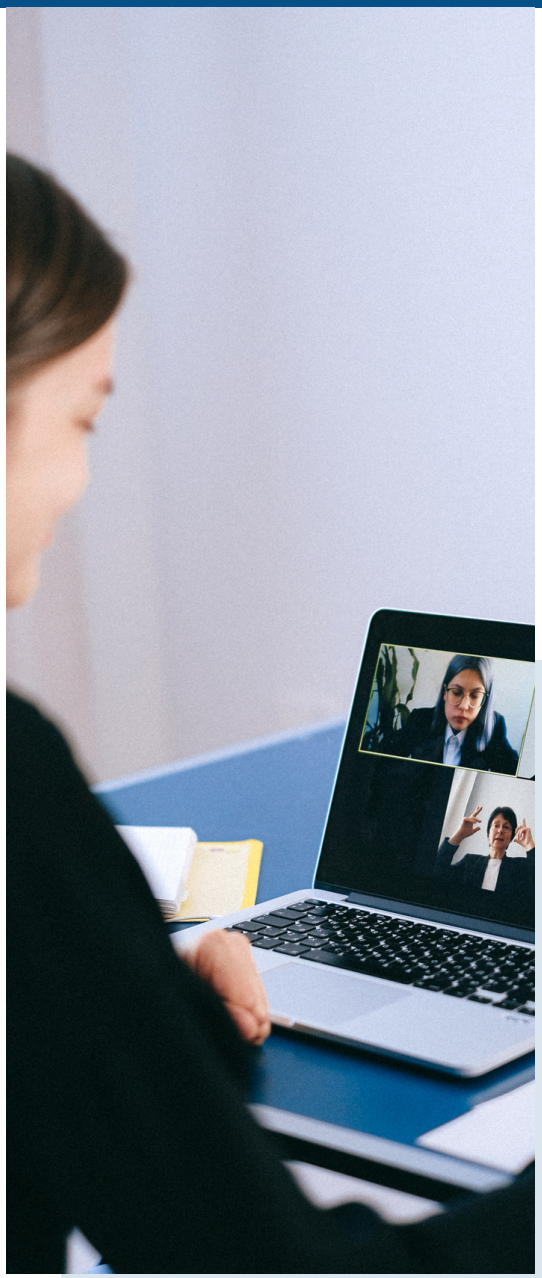
The CT SIG Co-Chairs

Stephen DiDonato, PhD, LPC, NCC
Lori Herod, EdD
Rebecca Ohler

ON THE HORIZON: ISTSS 2020 PRESENTATIONS FEATURING COMPLEX TRAUMA & COMPLEX PTSD

When: November 4th-14th, 2020 (PMIs October 26th-31st)

Where: Virtual



The International Society for Traumatic Stress Studies (ISTSS) 36th Annual Meeting, "Bridging Science and Practice to Reach Underserved Communities: Barriers, Opportunities and Innovations" is just around the corner. Due to the COVID-19 circumstances, the conference will be held virtually this year between November 4th and 14th (Pre-Meeting Institutes will occur between October 26th and 31st). Hopefully the virtual format increases the accessibility and thus the diversity of the conference attendees, making it a wonderful opportunity to hear and exchange ideas and perspectives with professionals from a variety of backgrounds, cultures, and experiences.

We have identified and included below presentations that will feature complex trauma and/or Complex PTSD and may be of interest to CT SIG members. If you are aware of other presentations, especially posters, that may be of interest to SIG members, **please send the title, type of presentation, and date and time of the presentation to CTSIGPerspectives@gmail.com**. We will circulate an updated list of presentations, as well as the Complex Trauma SIG meeting date and time, closer to the start of the conference.

PRESENTATIONS RE: COMPLEX PTSD

WEDNESDAY 10/28

- 10:00 AM - 2:00 PM EST PMI: Assessment of ICD 11 PTSD and Complex PTSD using the International Trauma Interview: A Training Workshop

SATURDAY 11/7

- 10:00 - 11:15 AM EST Symposium: Complex Posttraumatic Stress Disorder—New Treatment-Related Insights and Challenges

WEDNESDAY 11/11

- 10:00 - 11:15 AM EST Panel: Complex PTSD: Global Barriers, Opportunities and Innovations to Reach Underserved Communities (*cont.*)

Register for the ISTSS 36th Annual Meeting at https://istss.org/am20/registration by September 22, 2020 for the lowest rates.

ON THE HORIZON: ISTSS 2020 PRESENTATIONS FEATURING COMPLEX TRAUMA & COMPLEX PTSD (CONT.)

When: November 4th-14th, 2020 (PMIs October 26th-31st)
Where: Virtual

THURSDAY 11/12

- 10:00 - 11:15 AM EST Panel: Treating Complex Traumatic Stress Disorders: Expert Guidance for Integrated Evidence-based Practice

SATURDAY 11/14

- 10:00 - 11:15 AM EST Symposium: Moving Forward with Complex PTSD: International Advances in Our Understanding of the Complex PTSD Diagnosis and Its Functional Impact on Adults, Children, and Families

OTHER PRESENTATIONS RE: COMPLEX TRAUMA

THURSDAY 11/5

- 2:00 - 3:15 PM EST Panel: What Did You Learn in School Today? Barriers and Opportunities in the Implementation of School-Based Interventions for Diverse Youth Exposed to Trauma

FRIDAY 11/6

- 10:00 - 11:15 AM EST Workshop: Sí se Puede: Prolonged Exposure Psychotherapy with Latinx Survivors of Sexual Assault
- 10:00 - 11:15 AM EST Symposium: Long-Term Consequences of Traumatic Childhood Experiences—Novel Insights and Future Directions
- 5:00 - 6:15 PM EST Symposium: Moving from “Should We?” to “How Can We?”: Implementation of Interventions for Trauma Survivors in the Criminal Justice System

Register for the ISTSS 36th Annual Meeting at https://istss.org/am20/registration by September 22, 2020 for the lowest rates.

MONDAY 11/9

- 10:00 - 11:15 AM EST Panel: Implementing a Centralized Referral System for Childhood Trauma: Bridging the Gap Between Families and Evidence-Based Treatment for Diverse Populations
- 10:00 - 11:15 AM EST Symposium: Personalizing Interventions for Sexual Assault Survivors: Unpacking Barriers to and Moderators of Treatment
- 5:00 - 6:15 PM EST Symposium: Exploring Cyber IPV as a Potential Source of Trauma Exposure and Related Posttraumatic Reactions
- 5:00 - 6:15 PM EST Workshop: Implementing Cognitive Processing Therapy with Patients with Borderline Personality Disorder

WEDNESDAY 11/11

- 10:00 - 11:15 AM EST Symposium: Adaptations to Child Trauma Evidence-Based Treatments in Research and Practice
- 2:00 - 3:15 PM EST Symposium: Current Research on the Nature and Impact of Dissociation

THURSDAY 11/12

- 10:00 - 11:15 AM EST Symposium: Alcohol and Sexual Assault: Innovative Approaches to Increase Reach to Vulnerable and Underserved Populations
- 2:00 - 3:15 PM EST Symposium: Genomic perspectives on the impact of childhood abuse and adversity

FRIDAY 11/13

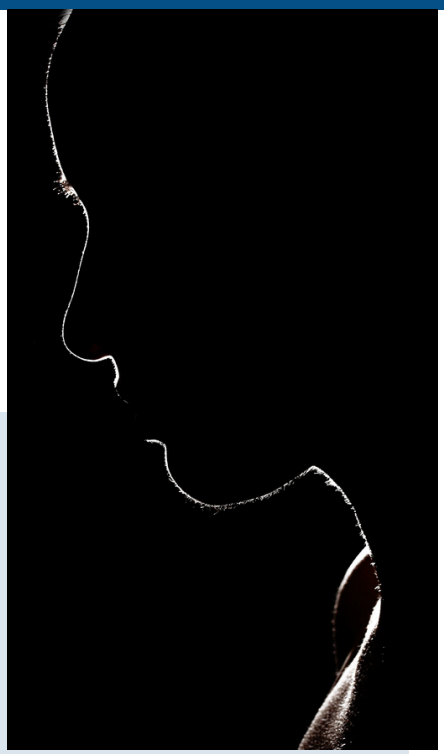
- 5:00 - 6:15 PM EST Panel: Identifying Socio-Emotional Consequences of Adverse Childhood Experiences: A transcultural approach

DATE/TIME TBD

- Poster: Predictors of Treatment Engagement in Veterans with a History of Interpersonal Trauma

RESEARCHERS' CORNER: THE EXISTENTIAL THREAT OF THE COVID-19 PANDEMIC - HOW ARE TRAUMA-EXPOSED PEOPLE ADJUSTING TO THE "NEW NORMAL?"

McKenzie Lockett, MA



The COVID-19 pandemic has brought unprecedented disruption to daily life, challenging many of the social and personal assumptions most people typically held about the world. Heightened awareness of personal vulnerability, increased social isolation, and reduced accessibility to meaningful activities (e.g., going to church, meeting a friend for coffee) has likely increased existential anxiety as people cope with the "new normal." Existential and humanistic perspectives on psychological functioning suggest that grappling with existential concerns – meaning of life, inevitability of death, freedom, and isolation – is a common experience for most people. Reflecting on the purpose and meaning of one's life is often a powerful, motivating force for positive action (Yalom, 1980). However, the persistent perseveration on existential issues, also known as existential anxiety, can lead to a host of mental health problems (Iverach et al., 2014). In particular, the mismanagement of existential anxiety is proposed to play an important role in the onset and maintenance of posttraumatic stress reactions (Pyszczynski & Kesebir, 2011). Emerging research has demonstrated that the pandemic has been associated with higher levels of depression, anxiety, and posttraumatic stress symptoms (Fullanna et al., 2020; Zhang & Ma, 2020). However, there is a paucity of research investigating how people who have a prior history of trauma are affected by the pandemic. This is especially important given the traumatic nature of the pandemic, and prior research showing that previous exposure to trauma is a risk factor for the development of posttraumatic stress disorder (PTSD) (Brunet et al., 2001; Yehuda et al., 2007).

Traumatized individuals may be especially vulnerable to the psychological threat of the virus. People living with posttraumatic stress symptoms often struggle to regulate their emotions or feel confident in their coping abilities (Cloitre et al., 2005; Cunningham et al., 2020). The pandemic is a persistent threat – one that is impossible to avoid when watching television, engaging in social media, reading print news, or even during casual conversations. In general, social media use has been associated with poorer mental health functioning during the pandemic (Gao et al., 2020). Furthermore, people who reported talking and thinking about the pandemic frequently also reported higher levels of psychological distress (Lee, 2020). In a new study conducted by myself and my colleagues (Sander L. Koole and Tom Pyszczynski), we investigated associations of posttraumatic stress symptoms, self-reported existential anxiety, and perceptions of coping self-efficacy in an online sample of US-based adults who reported experiencing at least one potentially-traumatic event in the past. We also asked study participants to rate the extent to which they felt that anxiety and worry associated with the pandemic impaired their ability to function in three major life domains: school/work, socializing with friends and family, and daily tasks. We found that higher levels of posttraumatic stress symptoms from a past traumatic experience were associated with higher (*cont.*)

TRAUMATIZED INDIVIDUALS MAY BE EXPERIENCING DIFFICULTIES IN COPING DUE TO HIGH LEVELS OF EXISTENTIAL ANXIETY, WHICH IS LIKELY HEIGHTENED DUE TO THE PERVASIVE AND UBIQUITOUS NATURE OF THE PANDEMIC.

- LOCKETT

RESEARCHERS' CORNER (CONT.)

McKenzie Lockett, MA

functional impairment due to the pandemic. Furthermore, this association was mediated by self-reported existential anxiety. This finding suggests that previously traumatized individuals may be feeling particularly impacted by the pandemic and that this is, in part, due to concerns about death, meaning of life, and loss of social connection. We also found that posttraumatic stress symptoms, functional impairment due to the pandemic, and existential anxiety were all associated with lower levels of coping self-efficacy. This is important as traumatized individuals already experience low levels of coping self-efficacy, which in turn is an important factor in posttraumatic recovery (Benight & Bandura, 2004). More importantly, we found the effect of posttraumatic stress symptoms on coping self-efficacy was partially accounted for by existential anxiety as well. These results suggest that traumatized individuals may be experiencing difficulties in coping due to high levels of existential anxiety, which is likely heightened due to the pervasive and ubiquitous nature of the pandemic.

Our findings are some of the first to connect existential anxiety with posttraumatic stress symptoms and COVID-19-related functioning. These results provide insight for psychotherapists and trauma researchers alike. Clinicians who observe that their clients with a history of trauma are struggling to cope during the pandemic may consider assessing for existential anxiety and addressing existential concerns. The pandemic has made it especially difficult to do many of the things many people find meaningful (e.g., meeting up with friends, going to church, visiting museums and movie theaters, going to the gym). Helping clients find new pathways toward meaningfulness may quell existential anxiety and improve coping during the pandemic. Furthermore, researchers can consider the role of existential anxiety in trauma, particularly in understanding the potentially traumatizing effects of the pandemic. Existentially oriented theories of PTSD have often highlighted the role of implicit assumptions in psychological functioning. Shattered Assumptions Theory (Janoff-Bulman, 1992), for example, has argued that traumatic events can be so harmful because they challenge the implicitly held beliefs that one is a good person in a meaningful world. As trauma researchers continue to study the effects of the pandemic on psychological functioning, understanding the extent to which existential anxiety accounts for these effects can provide helpful insights. Future research may help in clarifying how to manage existential anxiety during such unprecedented and precipitous times, particularly for traumatized individuals who may be especially prone to experiencing existential anxiety.

MCKENZIE LOCKETT, MA

McKenzie Lockett, MA, is a doctoral student in Clinical Psychology at the University of Colorado at Colorado Springs and the Vrije Universiteit Amsterdam. McKenzie's research endeavors focus on the social and emotional outcomes of trauma exposure. In particular, McKenzie often applies social psychological theories, including Terror Management Theory and Objectification Theory, to understanding how trauma exposure relates to social and motivational processes that are typically only studied in nonclinical samples.

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CLINICIANS' CORNER I: ATTENDING TO THE SOCIAL FABRIC - TREATMENT OF RACIAL TRAUMA

Karen Zilberstein, MSW

When Judith Herman (1992) described complex post-traumatic stress disorder (CPTSD) as a syndrome affecting survivors of chronic and repeated trauma, she drew upon a body of literature documenting the reactions of victims who were unable to flee from their perpetrators: prisoners, hostages, religious cult members, battered women, and abused children. When Felitti et. al (1998) conducted their Adverse Childhood Experiences Study (ACEs) and found correlations between early traumatic experiences and later physical and psychological health, they concentrated their questions on exposure to abuse, neglect, and hardship in the family and sexual abuse outside of it. At the time of those landmark investigations, few studies existed that linked racism with inescapable victimization or traumatic stress. Since then, The Black Lives Matter Movement and a growing body of research has highlighted the detrimental emotional, psychological, and physical effects of racism and the importance of reshaping treatments to address them.

Like other types of traumas, harmful racist encounters can involve single or distinct events or chronic and repetitive experiences. Experiences or threats of physical violence, saturated cultural messages of inferiority, contending with discriminatory laws, policies, and practices, or vicariously experiencing the contemporaneous or historical trauma of one's people (i.e., through slavery, war, murder, genocide, colonialism, forced dislocations, and other *(cont.)*

THE BLACK LIVES MATTER MOVEMENT... HAS HIGHLIGHTED THE DETRIMENTAL EMOTIONAL, PSYCHOLOGICAL, AND PHYSICAL EFFECTS OF RACISM AND THE IMPORTANCE OF RESHAPING TREATMENTS TO ADDRESS THEM.

- ZILBERSTEIN

CLINICIANS' CORNER I (CONT.)

Karen Zilberstein, MSW

oppressions) inflicts singular and cumulative wear and tear. Microaggressions, which Sue et al. (2007) describe as "unconsciously delivered ... subtle snubs or dismissive looks, gestures, and tones. ...[that] impair performance ... by sapping the psychic and spiritual energy of recipients and by creating inequities" (p. 273) are also commonly directed at marginalized populations (Bryant-Davis & Ocampo, 2005, Sue et al., 2007). As with other types of adversities, experiencing microaggressions, racial violence, or discrimination serve as risk factors for poorer physical health, anxiety, depression, stress, anger, low self-esteem, substance abuse, family violence, and suicidality (Carter, 2007; Haskell & Randall, 2009; Lanier, Sommers, Fletcher, Sutton & Roberts, 2017). When overt and covert experiences of racism are frequent, severe, and/or perpetrated by trusted members of society such as law enforcement officials, teachers, and judges, symptoms of CPTSD can result.

One of the ways chronic adversity and traumatic stress affect physical and psychological functioning is by priming the body's stress response system to become hypervigilant and reactive to traumatic triggers. Distress signals cause a release of hormones and a cascade of physiological changes that enable a person to respond quickly to threats. In the short run, a highly activated stress response increases the probability of survival. In the long run, recurrent surges of hormones can create chronic emotional and physiological dysregulation. The demands of responding to persistent and pervasive oppression sensitizes the body and mind in a similar manner. As Bryant-Davis & Ocampo (2005) note, "when an experience of overt racism occurs or even an experience of ambiguous racism (Did that just happen? Did that happen because I'm Latina, Black, or Indigenous?), the experience simply jumps out of the social fabric that already encapsulates us, and we are primed for a traumatic response" (p. 575).

As with any trauma, the impact of an event or series of experiences is never linear, but varies according to numerous, uncountable factors. Idiosyncratic responses depend upon genetics, a person's physical condition, level of development, severity and chronicity of the traumas, the social and community context and response before and after the event, and the quality of relationships and life events before and after the trauma (Carter, 2007). Since racial trauma occurs in an environmental context, sociocultural protective factors are important to nurture. Racial-cultural group membership and strong family and community relationships can be especially helpful in providing buffering and enhancing coping (Carter, 2007: French; Haskell & Randall, 2009).

Addressing racial trauma in treatment requires, first and foremost, investigating its presence. General trauma questionnaires do not specifically ask about racial experiences, rendering supplemental assessments important. Without a clinician broaching the topic through questions or other means, clients may not feel comfortable divulging traumatic aspects of their racial experiences, particularly when the counselor belongs to the dominant culture. In order to ensure clients of different backgrounds are treated

comprehensively and effectively, psychotherapists should also reflect on their own identities and implicit biases, as well as those encased in psychological theories, so that their work is not prejudiced or constrained by cultural beliefs (Sue et al., 2007).

Culturally competent care includes consideration of how different people experience and express stress reactions, appraise events, and utilize indigenous methods of coping (Bryant-Davis, 2019; Carter, 2007; Kirmayer, Dandeneau, Marshall, Phillips & Williamson, 2011). Western treatments tend to base interventions on cognitive and individual interventions, but for many cultures healing occurs in spiritual and communal realms (Bryant-Davis, 2019; Kirmayer et al., 2011). Practices that reconnect traumatized individuals and groups to their culture, strengthen community support, aid with racial identity development, and *(cont.)*

CLINICIANS' CORNER I (CONT.)

Karen Zilberstein, MSW

include a focus on resistance and collective struggle can be particularly beneficial (French et al., 2020; Haskell & Randall, 2009).

Since individual, family, community, cultural, and sociopolitical factors impact illness and health, treatments for racial trauma must cast a wide enough lens to understand and address the pernicious and healing properties of each. Attention especially needs to be given to what aspects of the family, community, and sociopolitical environment can be leveraged to establish safety and reduce racist incidents. Unless culture, identity, and sociocultural problems are acknowledged, psychotherapy with survivors of racial trauma risks replicating the microaggressions, invalidations, and structural inequities clients face outside of the consulting room and lessens the likelihood of successful treatments.

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KAREN ZILBERSTEIN, MSW

Karen is a psychotherapist and Clinical Director for A Home Within who specializes in the treatment of youth who have experienced trauma and foster care. She is a former adjunct professor at Smith College School for Social Work and an author of books, blogs, and journal articles. Her recent narrative nonfiction book, *Parenting Under Pressure: Struggling to Raise Children in an Unequal America*, won two Next Generation Indie book awards.

SURVIVORS' CORNER: DISMANTLING RACISM WITH COMPLEX PTSD

Elizabeth Perry, ECE, M Ed, RPC-C

To say the least, we are experiencing a lot of changes in our society these days. Prior to the arrival of COVID 19, many were already working towards a more just, equitable, respectful, diverse society. With the murder of George Floyd, these efforts have ramped up.

Many of us are facing the transformation of our long held worldviews. Even if we're completely in agreement with the need to dismantle the racism with which we have all been infused as a result of living in a society created by and for white people, it will potentially be very destabilizing to deconstruct and rebuild our worldviews, our beliefs, our prior knowledge, our perceptions of trust in our systems, our relationships with our fellow humans of similar or different origins, and our very identities.

As survivors of Adverse Childhood Experiences (ACEs) who live with CPTSD, we can be especially challenged by the tenuous ground we already live on, which is now shifting cataclysmically around and inside us.

I'll share here some of the challenges I have been facing and the strategies I have implemented in the hope that others may understand how difficult this time can be for some of us. I also hope to let others living with CPTSD know that they are not alone on this journey, nor are they without resources. We truly are in it together, and we can support each other as we navigate the transition from one imperfect human civilization to a better one.

I've empathized with the underdog my whole life; being invisible has been part of my personal life experience. So it's been even more identity shattering to discover that my lifelong efforts to see and treat all people as equals have been uninformed and therefore insufficient to influence societal change. I'm still missing the insight into the lived reality of Black, Indigenous people of the global majority and awareness of the advantages I have simply because I have white skin.

All this lens cleaning, although humbly welcome, requires particular care and dosing for those of us who live with the effects of (*cont.)*

AS WE DEVELOP OUR NEW RACIALLY CONSCIOUS IDENTITIES, ... WE WILL FIND WAYS TO MAKE THE DIFFERENCE WE CAN, OFFERING OUR WISDOM GAINED FROM OUR EXPERIENCE OF TRANSFORMING OUR OWN WORLDVIEWS, TO ASSIST OTHERS AND CREATE A WORLD THAT IS SAFE, WELCOMING, AND SUPPORTIVE FOR ALL HUMANITY.

- PERRY

SURVIVORS' CORNER (CONT.)

Elizabeth Perry, ECE, M Ed, RPC-C

CPTSD, so we don't lose our connection with ourselves and the level of stability we have achieved thus far through our recovery. We have to be careful not to lose our connection with reality as our worldviews are incrementally but persistently challenged by the burgeoning voices of those who have been largely silenced sharing their diverse perspectives that contradict our white worldviews.

For many of us who are survivors of childhood relational trauma and Adverse Childhood Experiences, our worldviews were shaped by our threatening experiences. Through recovery, we learn to clarify that worldview, abandon many of our prior held beliefs, and construct a new lens for looking at ourselves, others and the world at large, with new levels of understanding gained hopefully through support from professionals and peers.

Having already experienced the process of constructing a new worldview, we may actually adapt and incorporate new perspectives into our living framework more easily than other people who have not experienced major world view shifts as a result of relational betrayal or life threatening trauma. We can have confidence in our own ability to participate in the consciousness-shifting process because we've done it before and we survived and thrived (to whatever extent that has been able to occur). We can also model that confidence and provide reassurance to others who haven't yet had to completely reconstruct their worldview. Many of us survivors have developed skills and adeptness with letting go of the old and embracing the new with grace and willingness.

We especially understand what it's like to live in danger, to be pariahs, to have to watch our backs all the time, to be hypervigilant about who we trust, and to develop creative ways to at the very least survive. We are also viscerally invested in creating an inclusive, just, equitable, safe, compassionate society. We too have a longing for a civilization where all children have their needs met, where families are given the support they need to meet their children's needs, where everyone is valued and their contributions welcomed, included and celebrated, and no one is abused, exploited, rejected, oppressed, isolated, or blocked from accessing full participation in society, including holding and influencing power.

As much as our experiences with having our worldviews shattered can benefit us and others as we collaborate to dismantle anti-black and anti-indigenous racism and white supremacy, the destabilization of our own constructed identities can also be a trigger that sends us back into patterns of rage, dissociation, depression, anxiety, isolation, giving up, re-embodying a victim consciousness, defensiveness, and expanded mistrust in the system and others.

That's why it's so important to understand our own CPTSD symptoms and to be able to recognize when they're flaring up. We need to be able to catch ourselves when we're losing our connection with our calm and getting caught up in the feelings, the injustice of it all, and the passion to make the changes NOW!

We need to pace ourselves - not because we're fragile white people who can't tolerate conversations about race. But because we're sometimes fragile humans, because we've survived some of the worst of what humanity can do to each other, and we need to take care of *(cont.)*

SURVIVORS' CORNER (CONT.)

Elizabeth Perry, ECE, M Ed, RPC-C

ourselves so we're around to fight another day. It is only then that we can contribute meaningfully and have the resources to do so. One caution we need to be alert for is to ensure we get our support needs met through our own avenues, so when we're participating in anti-racist work we're fully available to contribute to the fight, and not seeking support from other activists as we all fight against the bigger foe.

The fight against anti-Black racism has been underway for 400 years. As much as its dismantling is past due, we need to be able to sustain our efforts for the long haul. Those of us with CPTSD are usually fighting on many fronts concurrently. Supporting our Black and Indigenous siblings at this time, although absolutely essential, is not the only war we are waging. We're still recovering from our own horrific experiences that caused our CPTSD. As we've been recovering by establishing new identities, even these new perceptions of ourselves are also being revealed as problematic. Having constantly shifting identities further destabilizes our ability to navigate safely and confidently through this world.

As we work to transform our society in long overdue ways, we must be conscientious about our own contributions, for our own self-care, and for the good of the movement. The last thing wanted by anyone who seriously desires to live in a better civilization is to be further victimized by attracting more relational trauma, or by inadvertently causing harm to others.

Contrary to the powerlessness which caused our CPTSD, we do have the right, the responsibility, and the permission to take care of and protect ourselves first. We can also choose carefully and strategically where and how we direct our efforts to dismantle racism and all other forms of oppression throughout our society. As we develop our new racially conscious identities, continue to recover from our own trauma, and gain experience and insight into our capacity to contribute, we will find ways to make the difference we can, offering our wisdom gained from our experience of transforming our own worldviews, to assist others and create a world that is safe, welcoming, and supportive for all humanity.

Our trauma is not personal. It's purposeful. Using what we learned from it to help dismantle racism can definitely help with making our trauma meaningful.

People I have found helpful in understanding my own racial blind spots: Resmaa Menakem, Robin DiAngelo, Pam Palmater.

ELIZABETH PERRY, ECE, M ED, RPC-C

At 42, Elizabeth realized she had been in a spirituality cult for the previous 16 years. During her journey of recovery, she discovered the Adverse Childhood Experiences research which helped her understand the one question that preoccupied her, "Why Me?" She came to understand the historical, intergenerational, and social factors that contributed to her childhood neglect and isolation, her need for a sense of belonging, her susceptibility to escape into faith addiction, and her ability to be wholly self-sacrificing including giving up her infant son for adoption to protect him from her mother's prejudice.

Elizabeth now dedicates her life to learning about and educating others on all things Trauma, ACEs, PTSD, CPTSD, Coercive Control, Cults, Spiritual Abuse, and Adoption. She is keenly interested in inspiring a just humanity and works every day to understand her own white culture and privilege and to dismantle white supremacy, anti-black and anti-indigenous racism, and all forms of hateful and hurtful human practice.

Elizabeth contributes her 1st Voice lived expertise through her writing, webinars, workshops, counselling, peer support, and consulting. Elizabeth is the founder of #ACEs Canada and operates Interpersonal Insights.

Follow her on Twitter and Facebook @ACEsCanada2020 @eperryinsights

JUSTICE & ADVOCACY CORNER: COMPLEX TRAUMA, MARGINALIZATION, AND THE US CRIMINAL JUSTICE SYSTEM

Rebecca Ohler

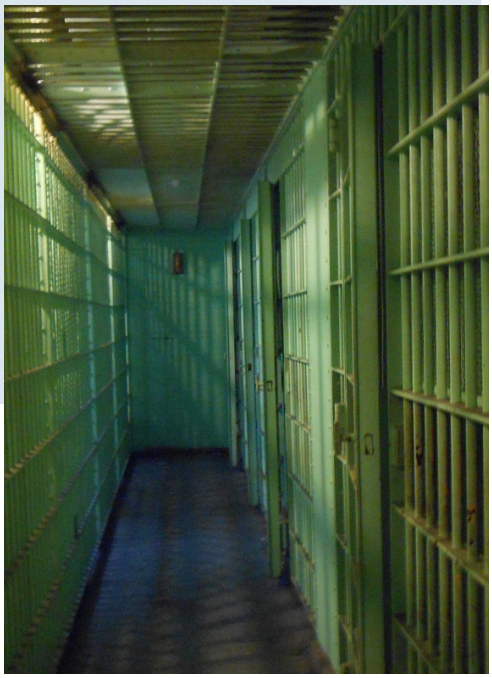
Trauma professionals have a valuable role at the intersection of marginalization and the US Criminal Justice System. It is well established that the incarceration rate in the United States is higher than anywhere else in the world and common sentiment that many of our residents who would benefit from support and mental health treatment instead find themselves in correctional settings with even further limited access to care. While there are some excellent judges, lawyers and trauma-informed systems entering onto the scene, our system as a whole remains plagued by inequality. Vestiges of slavery, segregation and antiquated ideas about the inherent criminality and savagery of Black and Indigenous people in this country remain strong in the institutions of criminal justice (Alexander, 2015; Haney, 2020). It is perhaps not surprising then that individuals belonging to marginalized groups by race, social class, religion and sexuality come into contact with this justice system at a highly disproportionate rate. I propose that trauma professionals have the opportunity to impede stigmatization and further marginalization of these individuals through critical thinking and care whether working in justice or community settings.

I have worked for several years in a grey area between the worlds of trauma professional and criminal justice advocate, which has given me an intimate purview into the lives and histories of offenders over time. As a mitigation specialist, I conduct intensive and exhaustive biopsychosocial history assessments to be used in sentencing proceedings in state and federal courts. My cumulative work-product often seeks to answer the question of who someone is and how they got to be where they are, including a close analysis of their mental health and functioning over the life course. While every individual I have worked with is different, there are two things that have stood out starkly as common threads. One is the presence of monumental developmental trauma that is usually pervasive through a multigenerational family history and is complex in nature. The other is the consistent marginalization of my clients because of their socioeconomic class, race, religion and sexuality.

The two threads appear highly associated from a lay perspective. My clients typically have prolonged, repetitive trauma with the ensuing multifaceted symptomology associated with complex PTSD. As it may occur generally in any population, the multilayered and interpersonal symptoms of the individuals with whom I work have been largely misunderstood. Many are survivors of ongoing childhood abuse that they both directly experienced and witnessed perpetrated against family members. Many suffer from the ongoing distress associated with racism and/or genocide. Many suffer from extraordinary emotional abuse and neglect where secure loving attachment figures and basic necessities such as food and physical safety were out of reach. When they come into contact with the justice system, mental health practitioners are charged with evaluating them both in court and in correctional settings. However, these evaluations frequently miss the impact of post-traumatic stress, minimize it, ignore it, or dismiss formative traumatic experiences as merely coincidental to the individual's current symptoms and behavior. Many offenders in the justice system are dehumanized and described as monsters of varying degree. Affective (*cont.*)

[E]VALUATIONS FREQUENTLY MISS THE IMPACT OF POST-TRAUMATIC STRESS, MINIMIZE IT, IGNORE IT, OR DISMISS FORMATIVE TRAUMATIC EXPERIENCES AS MERELY COINCIDENTAL TO THE INDIVIDUAL'S CURRENT SYMPTOMS AND BEHAVIOR.

- OHLER



JUSTICE & ADVOCACY CORNER (CONT.)

Rebecca Ohler

changes and dissociative coping skills are often deemed to be character flaws and evidence of an unfeeling, or uncaring, coldhearted individual. Indigenous and Black Americans may be labeled as paranoid or antisocial when they have a very reasonable fear and distrust of law enforcement based on their lived experiences and the lived experiences of their family and community members.

The world has witnessed the validity of this fear in the recent video-taped police killing of George Floyd, and many before him such as Tamir Rice, Alton Sterling, Breonna Taylor, Philando Castile and Eric Garner. We have seen it in the photos of Emmett Till and the hangings and violent deaths of countless Indigenous Americans. Traumatized individuals may be unable to imagine close caring relationships without betrayal and harm (Courtois and Ford, 2009). In justice settings, they are frequently labeled as resistant or uncooperative when they display both a deep mistrust of others and an associated self-loathing. This mischaracterizes the expected emotional fallout from complex trauma and also invalidates what is likely to be an accurate perception. Many individuals in the justice system are correct to identify relationships with forensic evaluators and correctional health providers as ones with potential for betrayal and harm. The alliance of these mental health professionals is complicated and lies, at least in part, with the court or the correctional facility rather than the client. It is important for mental health professionals to understand the history of the justice system as a punisher and the differentiation needed between extensive, valid barriers to trust typically present in justice-involved individuals and opposition or noncompliance with treatment.

I have also seen a great deal of misdiagnosis or under-diagnosis largely related to inaccurate or inadequate information. Often, evaluations at the court level leave out precious information regarding the history of a client, or focus very heavily on the crime that was committed as the behavioral basis for a clinical assessment. This frequently occurs at the expense of considering the full spectrum of an individual's life and functioning. Often, when a history is incomplete, evidence of the traumatic events or ongoing and pervasive interpersonal trauma from which an individual continues to suffer are not uncovered. These problems are present in the non-justice world of mental health also, where the exclusion of a DSM CPTSD diagnosis has left many clinicians poorly equipped to recognize the fallout from trauma that is distal or complicated (Hopper, et al. 2019). The consequences for marginalized individuals in the criminal justice setting are dire, resulting in both loss of liberty and life.

I often also see a long history of bias leading up to an individual's incarceration that must be viewed through a critical lens. For example, poor people and people of color have often experienced multiple instances of institutional bias previously in social services, medical and other mental health settings, which is reflected in their historical records. When relied upon at face value in future evaluations, they may present subjective and biased accounts of an individual's prior history (Goddu, 2018).

To prevent further marginalization we must take the time and care to properly contextualize and evaluate prior history. Likewise, thoughtfulness in regards to language and assessments carries significant importance for clients who have a high likelihood of (*cont*.)

JUSTICE & ADVOCACY CORNER (CONT.)

Rebecca Ohler

REBECCA OHLER

Rebecca is a mitigation professional and counseling intern with an emphasis in traumatic stress and biopsychosocial history assessment. While born and raised in rural Oregon, she has also worked across the deep south and midwest in the capital defense community. Her clinical work has been rooted in relational-cultural and emotionally-focused therapy and she has presented nationally on mitigation and mental health in the justice system. She is passionate about advocacy as well as complex and intergenerational trauma. She currently serves as co-chair of the ISTSS Complex Trauma SIG and is employed by the Federal Public Defender for the District of Oregon.

institutional contact in their future. It is important to be accurate and truthful, but also to not characterize clients in ways that can be used to dehumanize them in the future or that minimize the reality of their lives and ongoing trauma exposure. Words like 'maladaptive' or even 'histrionic' can have entirely different connotations from clinically similar language such as 'ineffective' or 'dysregulated'. Likewise, personality assessments and associated screenings which may seem harmless clinically are sometimes viewed as vehicles for dehumanization and the philosophy that criminality and savagery are inherent characteristics in justice contexts.

Because many individuals of color have a disproportionate rate and severity of contact with law enforcement, we must also properly contextualize these prior experiences. For example, I had a Black client many years ago who had been diagnosed with a conduct disorder and characterized by court-appointed evaluators to have a long criminal history showing pervasive lawlessness and future dangerousness. But upon closer examination I discovered that his juvenile record, which constituted his entire prior criminal history, had been greatly mischaracterized without examination of the underlying offenses. He was incarcerated at a young age for theft, but in the details I saw that the offense constituted stealing a piece of candy from a grocery store. He was jailed when his grandmother made him apologize to the white store manager. I pocketed a piece of candy as a child myself, but as a white woman, my consequences were much less grave.

As professionals, we have to be careful about taking what law enforcement agents say about someone at face value and integrating it into our own assessments and judgements without critical consideration of entrenched systemic biases and how they show up for our clients. Complex trauma professionals have a valuable role to play at the intersection of marginalization and the justice system that calls for a discerning, compassionate and unbiased lens. This is true when working at the court level, the correctional level or clinically with individuals belonging to marginalized groups. Clinicians and researchers who understand complex trauma are uniquely situated to give a rich context to the experiences of individuals who will likely be, or already are, in contact with the justice system. While we cannot prevent police brutality or single-handedly take down institutional racism in the United States, we can certainly do our part to bring a lens of humanity to the individuals we work with. An awareness of systemic biases, complex symptomology and thoughtfulness in language and assessment are valuable steps in the reduction of stigmatization and equitable treatment of those who experience discrimination.

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CLINICIANS' CORNER II: THE IMPACT OF COVID AND RACIAL TRAUMA - CARING FOR THE CAREGIVERS

Betty Everett, PhD

In early February 2020, Americans began to be diagnosed with the CORONAVIRUS. As the disease progressed, along with the issues related to it (e.g losses and new ways of doing things, quarantine and physical distancing, working from home, lack of childcare, and threats of death or illness) our worlds began to change. As mental health providers and first line responders, we were faced with decisions about how to care for our families, our patients, and ourselves.

Early in the pandemic, Panchal et al. (2020) found that 45% of adults reported their mental health had been negatively impacted by worry and stress over the virus. There was increasing concern about suicide because of increased isolation, loneliness, and disconnection. School closures introduced new stressors, including children unable to receive school lunches. Disparities in death rates among lower socioeconomic populations and minorities facing increased risk of exposure due to their work in food service and other industries, brought to light the long history of historical and racial traumas. Those of us working with clients who suffer with Complex PTSD know how difficult a routine day can be for those struggling with trauma's after-effects, and how disruptive additional stresses are to their functioning and mental health. This led to increased demands on mental health providers including the need to adapt to telemedicine platforms quickly. We began providing services for patients who were more distressed and we were coping with an increased demand for services. Zoom fatigue became a real issue in our lives as we altered our way of working. In addition to the lack of information obtained in person, we were faced with dealing with technical difficulties. Can the patient use the technology? Do they have the technology? What do we do when the equipment does not work? All these factors have negatively impacted the functioning of our patients as well as adding high stress for us. There were more stressors for the patients, and more stressors for us as providers.

EARLY IN THE PANDEMIC,... 45% OF ADULTS REPORTED THEIR MENTAL HEALTH HAD BEEN NEGATIVELY IMPACTED BY WORRY AND STRESS OVER THE VIRUS.

- EVERETT

I personally prefer in- person sessions. I miss all the information I get from being in the room with someone. Another loss.

Trauma informed practitioners are aware of the importance of attending to secondary trauma, of the need to care for the caregivers. Front line workers who provide mental health services have had tremendous stressors as they meet increasing professional demands, move to telemedicine platforms, and continue to see patients at increased risk for suicide, self-harm, and severe exacerbations of mental illness. A dear friend of mine, who works in an end of life facility, recounts a colleague's heart wrenching conversation. "Am I safe to go home?" s/he asked, "I've potentially been exposed. What if I give this to my child?" These kinds of decisions are a strain on us and go beyond secondary trauma to a primary concern for the health and wellbeing of those we love.

In the midst of my Zoom fatigue, while I witness the heart wrenching new traumas my clients face on top of their (*cont.*)

CLINICIANS' CORNER II (CONT.)

Betty Everett, PhD

lifetime of traumas, I have to remind myself of the skills I teach to those with whom I work. How can I regulate my Autonomic Nervous System to be fully present and aware, to think and feel and focus on each person's needs as my heart races or I feel myself shutting down? How can I get the information to know what is happening in their bodies? Remember to breathe! Just be aware. Finally, but very importantly, I need to remember to make time to show compassion for others and myself.

As a clinician and a supervisor of clinicians, I am aware of the energy required to address the increased needs of patients and to keep balance for ourselves in our mental health community. Coretta Scott King (LA Times, 2000) said, "The greatness of a community is most accurately measured by the compassionate actions of its members…. all one needs is a heart of grace and a soul generated by love." Thank you all for your hearts of grace, your souls of love, and your compassion for yourself and those in need of mental health services with Complex PTSD.

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BETTY EVERETT, PHD

Dr. Betty Everett, Ph.D., is a clinical psychologist and director of the University of Arkansas for Medical Sciences' Center for Trauma Prevention, Recovery and Innovation. Besides having administrative and program development experience, she has close to 40 years of experience working with traumatic stress disorders in children, adolescents and adults and geriatric populations. Her experience ranges from in the moment critical incidence intervention to acute stress disorders to post-traumatic stress disorder to complex PTSD with significant associated features and comorbid mental and physical health problems. Everett is a professor in the UAMS Department of Psychiatry and sees patients in the Psychiatric Research Institute's Walker Family Clinic.

SOCIAL & TRANSCULTURAL CORNER:
WHEN SURVIVORS BECOME CHAPLAINS - SPIRITUAL CARE AND CHRONIC DISSOCIATION

Rev. Jeny Running Brook Covill

You, me, and everyone else experience dissociation as part of our daily lives. In other words, dissociation is a normal, God-given coping mechanism. If you've walked out of the house wondering if you turned off the coffee pot or if you've driven somewhere and questioned if the light you went through five minutes earlier was green, you've experienced dissociation. These are common, everyday occurrences. However, for the survivor of chronic childhood trauma, dissociation is a complicated matrix of self-preservation that can become problematic over time (Fisher, 2017, p. 19; Maynes & Feinauer, 1994, pp. 165, 167). In my case, it has kept me sane and alive for several decades. It has also caused frustrating issues in my adulthood, both personally and professionally.

How have I championed these challenges in the context of Christian faith and pastoral ministry? The short, simple answer is: One day at a time and by the power of the Holy Spirit. By itself, that statement can be empowering to a person of Christian faith. Alternatively, it can be perceived as completely useless, insensitive Christianese to someone who does not understand or identify with Christian beliefs. To complicate matters further, a survivor may have a variety of conflicting opinions about God and Christian values (Cataldo, 2013, p. 792). Therefore, there really isn't a simple mantra for the Christian survivor.

The reality is that successful healing is often a grueling, confusing, complicated process that may challenge the survivor's sense of Christian tradition and doctrine, as well as their personal faith, convictions, and perseverance. Additionally, the survivor's dissociative behaviors and beliefs may similarly challenge the members of their church or their pastoral leadership. More specifically, if a spiritual care provider does not understand complex trauma or dissociation, they may further traumatize a survivor who is seeking their help (Covill, 2019, pp. 5-7). Unfortunately, due to the latter, I had to seek help from outside of the institutional church while intentionally leaning on and surrendering to God.

In the beginning of my conscious healing journey, I believed that my childhood was great; that I had no remarkable story of God's divine intervention saving me from a life of crime, addiction, and despair; and that I didn't have any significant emotional or mental injuries. When I started experiencing flashbacks and panic attacks, I had no idea what they were or why I was experiencing them. A few months later, I found myself reacting to some stressful situations in ways that seemed in conflict with my faith-based convictions. Some of my relationships became strained and the stress was taking a toll on me.

In seeking guidance from my church leadership, it was suggested that my physical, emotional and mental experiences were demonic. It was recommended that I read the Bible and pray more, in addition to refraining from any activities that may be causing these issues. This advice did not seem unusual or inappropriate to me at the time. It is common Christian advice and often expected in times of suffering and conflict. I believe in prayer, fasting, reading the Bible, etc. I also believe that emotional, mental, and spiritual health has a supernatural component. Furthermore, practicing these faith-based activities is biblical and theologically sound.

Unfortunately, this plan wasn't resolving my issues. I began to question myself, my sincerity of faith, my salvation, and my role in ministry. I became even more confused (*cont.*)

SOCIAL & TRANSCULTURAL CORNER (CONT.)

Rev. Jeny Running Brook Covill

and anxious. It was at this point that some good-intentioned church members began to give unsolicited advice that hinted at condemnation and judgement (cf. Job1-42 New Revised Standard Version). My church was no longer a safe place in the context of my mental health.

Conversely, I had a couple of close Christian friends who suggested that the experiences I was having may be related to childhood trauma and they recommended I see a psychotherapist. I began therapy in 2001 with a local Licensed Clinical Professional Counselor specializing in ego state therapy using the Internal Family Systems model, as well as Eye Movement Desensitization and Reprocessing (cf. Sullivan, 2020, p. 1). According to my therapist, I was treated for severe codependency and delayed onset of post-traumatic stress disorder. I believe this was based on our identifying numerous dissociative tendencies, as well as significant narratives recovered through therapy. Considering the degree of dissociation I was experiencing, we determined that I am somewhere in the middle section of the dissociation "continuum" (Vermilyea, 2013, p. 10).

While I was receiving therapy, I continued to pursue my faith and calling in faith-based ministry, independent of the church I was attending. I was facilitating an international prayer ministry; hosting a radio program; traveling to Peru and Israel on short missions trips; organizing Native American Christian conferences; co-pastoring a talking-circle style home church; and then later became a hospital chaplain. In addition, I went back to college and earned a Christian ministry degree that included taking several theology courses that enriched my faith. Over the years, I learned the tremendous value of balancing religion and psychology, as well as grace and acceptance. This has been especially useful in providing spiritual care to others. Unfortunately, not all Christian organizations have the same philosophy about the value of psychology and psychotherapy (Munson & Munson, 2014). Not only are there conflicts within the universal Christian church over theology, traditions, and rituals, but also in contemporary daily life, applications of biblical principles and addressing mental, emotional and spiritual issues. More specifically, it seems that while the healthcare industry is working towards providing better, trauma-informed care, some church communities appear to be indifferent with the relevance of it all beyond basic pastoral counseling of biblical principles (cf. Munson & Munson, 2014).

Meanwhile, a significant percentage of churchgoers (including leadership), are navigating their Christian (*cont.*)

[S]PIRITUAL CARE PROVIDERS, UNAWARE OF COMPLEX TRAUMA AND DISSOCIATION, RISK INAPPROPRIATELY COUNSELING SURVIVORS BY APPLYING BIBLICAL PRINCIPLES AND MISCONDUCT PROCEDURES OUT OF CONTEXT (COVILL, 2019, PP. 5-7). FOR THIS REASON, IT IS IMPERATIVE THAT CLERGY/CHAPLAINS BECOME INFORMED OF COMPLEX TRAUMA...

- COVILL

SOCIAL & TRANSCULTURAL CORNER (CONT.)

Rev. Jeny Running Brook Covill

faith through the lens of dissociative experiences (Covill, 2017, pp. 3-5). These traumatic stress reactions may include a sudden onset of confusion, “anxiety,” “dizziness,” “a sense of being frozen,” or uncharacteristic irritability (Maynes & Feinauer, 1994, p. 167; Dissociative Experiences Scale - II., n.d.). Other signs and symptoms may include seemingly abrupt changes in one’s beliefs, faith, behaviors, emotions, countenance, confidence, vocabulary, or tone of voice (Covill, 2020). In some cases, the survivor may experience mental “fog” and “switching” between feelings, thoughts, and behaviors that may seem conflicting or out of the ordinary (Maynes & Feinauer, 1994, p. 167; Dissociative Experiences Scale – II., n.d.). Depending on the severity of symptoms, they may be “maladaptive,” creating conflicts in the survivor’s personal, professional, and congregational life (Covill, 2020; cf. Dowd, 2014, p. 3; Vermilyea, 2013, p. 10).

For example, there are three meaningful biblical principles that come to mind: To be single-minded; to live a life above reproach; and to serve the One and Only God (cf. Matt 6:19-24, John 1:1-14, John 3:16, James 1:6-8, 1 Tim 3:1-3, Rom 8:4-6). This may become problematic for the survivor of chronic childhood abuse whose coping mechanisms include various degrees of detachment from and hatred of self (Fisher, 2017, p.19). More severe forms of detachment may cause a survivor to feel or act as though they are double-minded, falling short of moral or ethical expectations, or that they have embraced contradicting attitudes toward God (Covill, 2017, p. 7; Fisher, 2017, p. 19; Cataldo, 2013, p. 792).

Without healthy acceptance, support and guidance, a survivor could potentially fall into hopeless, repeating cycles of punitive correction and repentance producing even greater self-hatred, guilt and shame (cf. Allard, 2020; Fisher, 2017, p. 19). Furthermore, spiritual care providers, unaware of complex trauma and dissociation, risk inappropriately counseling survivors by applying biblical principles and misconduct procedures out of context (Covill, 2019, pp. 5-7). For this reason, it is imperative that clergy/chaplains become informed of complex trauma, including the cause, prevalence, and associated symptoms of “problematic” coping mechanisms (Covill, 2020; Covill, 2017, p. 8; Covill, 2019, pp. 5-7; cf. Dowd, 2014, p. 3; Vermilyea, 2013, p. 10). Additionally, in my opinion, ministers ought to refrain from counseling survivors beyond basic daily life applications of biblical principles and make referrals to appropriate mental health professionals (Covill, 2019, pp. 5-7).

For the survivor, identifying safe people and supportive environments may be more difficult than for the pastor or chaplain making a referral. First, it is understood that many survivors may not be aware of their dissociative tendencies or the long-term effects of childhood trauma. Second, they may not have the self-esteem or healthy boundaries to seek appropriate help from within the church. More specifically, they may not have the experience, confidence or tools to advocate for themselves when confronted with misapplied Scripture, whether it is self-imposed or from authority figures. Certainly, these points affirm the importance of spiritual care providers becoming trauma-informed, sensitive and inclusive.

To me, the ideal safe place for worship and fellowship is a place where the pastor quotes the apostle Paul, who reflects on inner conflict (cf. Rom 7:15-25). Then they teach a contemporary life lesson as if Paul had been a complex trauma survivor, struggling with dissociation. Paul says,

> “I do not understand my own actions. For I do not do what I want to do, but I do the very thing I hate… I can will what is right, but I cannot do it. For I do not do the good I want, but the evil I do not want is what I do” (Rom. 7:15-19).

First, the message of the pastor would remind everyone who is present, whether integrated or dissociated, that God’s undeserved favor, given out of pure love, is “new every morning" and that His compassion, acceptance and forgiveness is all that anyone needs to navigate through the difficulties of overcoming childhood trauma (Lam. 3:22-23; 2 Cor. 12:9). Second, the message would be presented in such a way that those who are hearing about God for the first time, could feel safe, affirmed, accepted and included (Lam. 3:23). Ideally, this could increase congregational awareness, while creating a healing environment for survivors (Covill, 2017, pp. 7-8; cf. Cataldo, 2013, p. 803). (*cont.*)

SOCIAL & TRANSCULTURAL CORNER (CONT.)

Rev. Jeny Covill

This article is the opinion of Rev. Jeny Running Brook Covill and is not written on behalf of North Valley Hospital.

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REV. JENY RUNNING BROOK COVILL

Jeny Covill is an ordained minister with Indigenous Messengers International and works as a hospital chaplain at North Valley Hospital in Whitefish, Montana. She is a member of three clergy groups in Flathead County, as well as the Montana Spiritual Care Association. Jeny has been involved in cross-cultural ministry for over 20 years advocating for Native American cultural identity and expressions in the Christian church. She co-pastors a talking circle style church and formerly hosted the Across Turtle Island radio show on two Montana stations. In 2010, Jeny was nominated for the Aboriginal Peoples Choice Music Award for Best Aboriginal Music Radio Program. In 2011, Jeny received the Spirit Wind Records Silver Arrow Award for Outstanding Contribution to Native American Radio. In 2019, Jeny completed her degree of Bachelor of Science Ministry & Leadership, Cum Laude, through Oklahoma Wesleyan University. Jeny is Cherokee descent, as well as English, Irish, Scottish, and German. Her Cherokee name is Usdigeyvqua Gayvhi which roughly translates 'Running Brook'. Her passion, in addition to advocating for American Indian culture and identity, is end-of-life spiritual care and raising awareness for adult survivors of childhood trauma. Jeny writes and speaks about complex trauma as a survivor.

EDITORS' CORNER: CONCLUDING COMMENTS

Kelly Pattison, MA, LMHC & Krista Engle, MA

In our second issue of Complex Trauma Perspectives, we wanted to take **a deeper look at the complex trauma associated with the COVID-19 pandemic and the systemic racism experienced by BIPOC**. While there is much resiliency and strength in our communities, there is also a deep need for systemic change. We must join together in the fight against white supremacist structures so that the weight is not solely carried by BIPOC. Our contributors in this article have highlighted the need for change at both systemic and personal levels. Care for ourselves is intertwined with care for our communities; no one can truly be well in a system built on a foundation of racism and inequality. We hope that this second issue of the newsletter highlights ways in which we can move forward together in care for ourselves and one another, as we dream of and move toward a future that is truly rooted in equality, dignity, and love for all.

In this spirit of community, we are also excited to introduce our **new editing team members**, who have worked so hard to bring this issue together:

RESEARCHERS CORNER
Barbara Shaya
Mitchell Waters
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Miranda Galbreath
Elizabeth Lehinger

As always, please feel free to send any feedback, questions, potential contributions, or desire to be involved in the production of the next edition of Complex Trauma Perspectives to CTSIGPerspectives@gmail.com.

Thank you to everyone who has supported us and contributed to this edition of the newsletter, and we look forward to our third issue, which will likely be published in December 2020!

Sincerely,

The *Complex Trauma Perspectives* Editors
Kelly & Krista

Contact us at CTSIGPerspectives@gmail.com with questions, feedback, contributions, or interest in helping with the production of future issues of *Complex Trauma Perspectives*.

KELLY PATTISON, MA, LMHC

KRISTA ENGLE, MA