OCTOBER 2021, SPECIAL ISSUE

ISTSS COMPLEX TRAUMA SIG & MORAL INJURY SIG JOINT NEWSLETTER

MI & CT SIG CO-CHAIRS' CORNER

Amanda Khan, PhD, Barton Buechner, PhD & Rebecca Ohler, LMHC

Dear SIG Community,

It is with great pleasure that we present to you the **Special Edition Complex Trauma and Moral Injury SIG Joint Newsletter**. This collaboration is the first of its kind, and we feel particularly proud of the union and synergy of our two groups to bring forth such a special focus on systemic betrayal.

Over the past couple of years one of the topics at the forefront of many minds and hearts has been **intersectionality**, for our clients, in our research, and in many of our lived experiences. The **impact of systems on individuals** is becoming increasingly visible as we see evidenced in the global impact of COVID-19, increasing research into trauma in justice systems, highly publicized police violence disproportionately impacting people of color, rising awareness of Missing and Murdered Indigenous Women, discrimination related trauma and oppression, the health of healthcare workers, rising *(cont.)*

WHAT'S INSIDE THIS ISSUE:

CO-CHAIRS' CORNER

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suicide rates in military personnel, highly publicized sexual assault cases, rising rates of imprisonment and pushes for decriminalizing substances, global environmental crises, and dissatisfaction with the psychiatric diagnostic system. Perhaps now, more than ever before, we might see how **these intersections and the failures of the systems we trust to protect and care for us**, so often play a role in the perpetuation of trauma either through commission or omission.

Many traumatized individuals **struggle to trust others and feel betrayed** by the world around them. These core feelings are **central to both moral injury and complex trauma** as they invite an individual's psyche to call into question their deepest sense of self and relationship to others. The fields of moral injury and complex trauma have both historically lacked recognition and continue to require advocacy and effort towards legitimacy, perhaps another example of the powerful influence of systems of power. However clinical, research and lived experience tell us that **the outcomes for folks experiencing moral injury and complex trauma are palpable, important and require our attention**. Although distinct from one another, the overlaps between moral injury and complex trauma are many in etiology and in this issue, we attempt to tackle this topic head on.

In the first section, you'll find a series of original writings from 6 outstanding authors: **Drs. Joseph Currier and Thanos Karatzias** discuss how systemic betrayal can lead to moral injury and Complex PTSD in military populations and their natural overlap. **Dr. Kristine Burkman** shares her perspective on systemic betrayal in healthcare workers during the pandemic. **Stephen Bradley, LICSW, LMHC** tackles white fragility in therapy with BIPOC clients and how providers can learn to address and stop perpetuating systemic racism. **Sarah Nakonechny** contributes a powerful piece on gaslighting and the connection of this form of abuse with disorganized and disrupted sense of self. **Miranda Galbreath, LPC** shares important perspective from her depth of experience working with older LGBTQ adults in carceral settings. Following the original op-eds, we spotlight an organization, **Out of the Storm**, run by **Dr. Lori Herod**, which provides community and direct support for people with lived experiences of relational trauma and Complex PTSD. Next, we are very proud to spotlight two lived experiences. We have a creative non-fiction (autoethnographic) essay submitted by **Philip Katner** on moral injury followed by an essay **submitted anonymously** sharing the author's experience as a complex trauma survivor psychologist working in, and being harmed by, the mental health system. Finally, we have compiled a bibliography presenting relevant and diverse published works on the topic of systemic betrayal in conjunction with moral injury and complex trauma.

We would like to express our sincere gratitude to our student co-chairs and editorial team of **Aubrie Munson, Morgan McCowan, Amanda Gentz, Kelly Pattison, Krista Engle, and Jason Cruze** for the incredible effort and time put into making this. It was certainly a labor of love and we appreciate the heartfelt driving force behind it.

We hope you enjoy this special edition newsletter on systemic betrayal and its effects on moral injury and complex trauma. We hope this newsletter serves as inspiration for further inquiry, collaboration, and the bridging of worlds and communities.

Sincerely,

Amanda Khan, Bart Buechner & Rebecca Ohler
Moral Injury SIG and Complex Trauma SIG Chairs

A BRIEF DISCUSSION OF THE NATURAL OVERLAP BETWEEN MORAL INJURY & COMPLEX PTSD

Joseph M. Currier, PhD & Thanos Karatzias, PhD

We are grateful for this opportunity to contribute to this conjoint newsletter between the Complex PTSD and Moral Injury SIGs. Beyond the ever-growing discussion and debate about the association between moral injury and DSM-5 PTSD, the recent formalization of a complex PTSD (CPTSD) in ICD-11 provides an opportunity to consider the natural overlap with moral injury. Historically, morality concerns in psychological practice and research were neglected or were not given adequate attention. However, particularly in the repeated and interpersonally-mediated events that might lead to CPTSD, there are always unavoidable moral issues that could drive distress and problems in our patients' relationships and functioning. Due in part to the work of Jonathan Haidt (2012) and other moral psychology researchers, we know that morality is about more than just "right" and "wrong"; rather, in all of our complexities and differences, systems of moral beliefs and values represent the glue that holds human relationships and communities together. By not attending to moral reactions to traumatic events for which another person was culpable, we are omitting a core aspect of our patients' identities and lives. Hence, whether focusing on a micro- or macro-level, the concept of moral injury may allow us to honor moral aspects of recovery that could help our traumatized patients and communities more fully heal in the aftermath of acts of trauma and violence that human beings too often do to each other.

This discussion about the intersection between CPTSD and moral injury is also quite timely. The COVID-19 pandemic revealed inadequacies of political, healthcare, and economic systems across the world. Viewed alongside sharpened awareness of long-present realities of systemic racism, sexism, and other social injustices, many people are feeling alienated and betrayed by institutions that should protect and promote their well-being. It is therefore not surprising that interest in the moral injury concept has proliferated in parallel to approval of criteria for a CPTSD diagnosis for ICD-11. Initially, the moral injury concept was almost exclusively applied to understanding emotional, relational, and spiritual consequences of war-related traumas. However, as appreciation for systemic betrayal has increased in mental health professions, moral injury has been increasingly applied to conceptualizing trauma-related issues of healthcare professionals, first responders, refugees, prisoners, and juvenile offenders as well. In keeping with high-stakes situations that often characterize war-time service, these groups may experience profound inner pain by what they did and/or were not able to do in situations that held a possibility of death or serious injury to themselves and/or others. Further, when institutions fail to act in ways that prevent harm to an individual, create environments that systematically cause harm, or respond in a manner that worsens harm, a betrayal or other-directed moral injury can emerge. Moral injury has been described as a strong cognitive and emotional response that follows events that can violate a person's moral code. This can ultimately lead to a lower sense of self, and a disrupted sense of self is one of the core symptoms of CPTSD. Ultimately then, moral injury and CPTSD would overlap.

Led by Profs. Thanos Karatzias & Dominic Murphy, these *(cont.)*

MORAL INJURY & COMPLEX PTSD

Joseph M. Currier, PhD & Thanos Karatzias, PhD

possibilities (cont.) were recently supported in a study with military veterans who had sought mental health treatment in the United Kingdom in the past year. When compared to veterans with or without PTSD, those who satisfied the criteria for CPTSD reported a higher magnitude of exposures to betrayal events *before* (e.g., child abuse) and *during* (e.g., physical and sexual assault) their military service that were not related with combat (Murphy et al., 2021). Building on these findings, we found these veterans with probable CPTSD also typically reported worse outcomes associated with betrayal- and perpetration-based moral injury (Currier et al., 2021). Further, results of a latent profile analysis (LPA) revealed strong overlap between moral injury and all symptoms of CPTSD. Namely, rather than distinct profiles emerging for morally injured veterans with and without symptoms of PTSD and/or disturbances in self-organization (DSO), problems related to moral injury appeared to universally occur in the presence of the full CPTSD syndrome (Currier et al., 2021). Hence, in the same way that researchers and clinicians are attempting to clarify the association between moral injury and DSM-5 PTSD, these studies highlight the inherent overlap between moral injury and CPTSD related to traumatic events that might occur in the context of systemic betrayal.

Theoretically-speaking, there are two general models for understanding the overlap between moral injury and CPTSD. First, similar to comorbidity patterns for other mental health conditions that guide clinical practice, moral injury could partly overlap with CPTSD but share unique features and symptoms that possibly necessitate different approaches to treatment. At present, mental health professions lack a paradigmatic definition and framework of moral injury as an outcome. However, exposure to potentially morally injurious events has been consistently linked with symptoms of ICD-11 PTSD (Litz et al., 2009; Griffin et al., 2020). Further, in keeping with Litz and colleagues' (2009) seminal article, it seems unlikely that a consensus understanding of moral injury will not entail re-experiencing, avoidance, and/or hyper-arousal issues of some sort. There is also natural overlap with DSO symptom domains; when considering the mistrust and social isolation that might characterize betrayal-based moral injury in particular, disturbances in relationships will likely be a core feature. However, even with inclusion of DSO domains, other features of betrayal-based moral injury are likely not captured in the CPTSD diagnosis (e.g., pervasive anger, moral disgust). Once mental health professions agree on a guiding definition and framework, moral injury proponents will then need to demonstrate the validity and utility of any non-overlapping features with other trauma-related conditions.

Depending on what we learn from this research, a second model of the moral injury-CPTSD link would view moral injury as a subtype or theme of CPTSD that captures troubling moral issues that are commonly related to interpersonally-mediated traumatic events. In such a case, clinicians may not view moral injury as a separate condition from CPTSD or other relevant diagnostic frameworks addressing the psychological, relational, and possible spiritual effects of systemic betrayal. Instead, even non-overlapping issues related to moral injury would be viewed as strictly occurring in the context of these conditions. Although proponents of moral injury may not favor this option, the only study of the moral injury-CPTSD link published to date did not yield findings that challenged such a possibility. Whether analyzed categorically or dimensionally, all CPTSD symptoms were strongly associated with moral injury in our aforementioned study with UK veterans (Currier et al., 2021). When considering the similar overlap with DSM-5 PTSD criteria, Litz and Kerig (2019) urged that moral injury proponents "should not assume without evidence that moral injury, as a mental or behavioral health outcome, has explanatory validity and clinical utility beyond concepts more widely recognized, such as PTSD" (p. 344). Existing evidence suggests that moral injury and CPTSD significantly overlap conceptually and are not necessarily distinct.

In conclusion, there is increasing interest in the concept of moral injury although this is not a recognized mental health condition as CPTSD is. (cont.)

CONTACT THE COMPLEX TRAUMA SIG CO-CHAIRS THROUGH THE SIG WEBPAGE TO JOIN NEW OR ONGOING SIG PROJECTS.

MORAL INJURY & COMPLEX PTSD

Joseph M. Currier, PhD & Thanos Karatzias, PhD

Exposure to morally injurious events do not necessarily involve a threat to life but can certainly cause shame and guilt which will ultimately lead to a disrupted sense of self, which is captured in the core symptoms of CPTSD. We recommend further work in this area to explore how and why moral injury and CPTSD overlap in military and non-military populations. This work is essential for the development of new and/or the adaptation of existing therapies for CPTSD, a new condition with limited evidence base for its treatment (Karatzias et al., 2019). It may well be the case that CPTSD following morally injurious events might require special treatment consideration.

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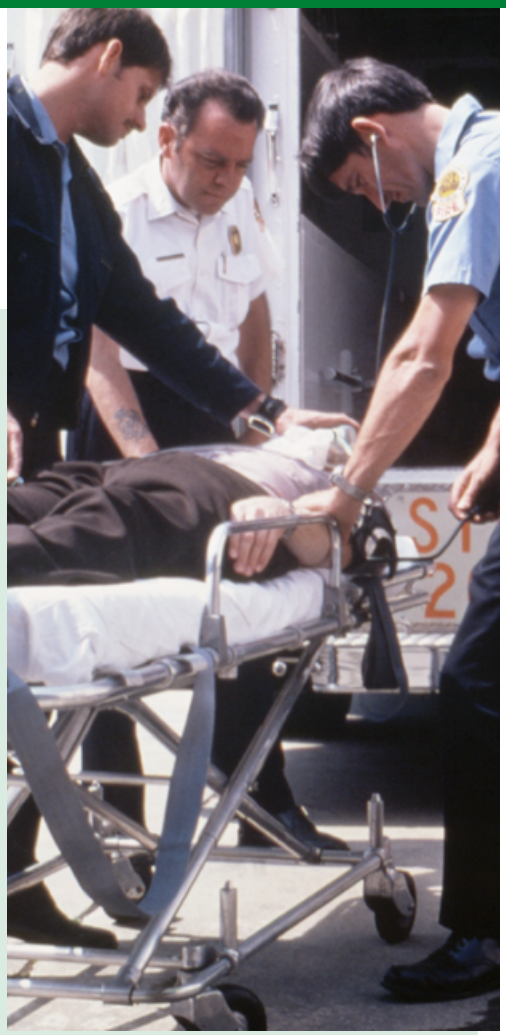
JOSEPH M. CURRIER, PHD

Dr. Joseph Currier is a licensed psychologist who serves as Professor with the Clinical & Counseling Psychology Doctoral Program at the University of South Alabama. His research focuses on trauma and moral injury, spiritually integrated approaches to mental health care, and other topics related to applied psychology of religion and spirituality (e.g., God representations, religious and spiritual struggles). He has published over 100 peer-reviewed articles in support of these lines of research and scholarship as well as two books with American Psychological Association Press, entitled Trauma, Meaning, and Spirituality: Translating Research into Clinical Practice and Addressing Moral Injury in Clinical Practice. He also serves as Clinical Director with Veterans Recovery Resources, a veteran-forward community-based organization in Mobile, Alabama providing evidence-based behavioral health services to persons recovering from trauma, moral injury, and other mental health conditions.

THANOS KARATZIAS, PHD

Professor Karatzias, is the Head of Research in the School of Health & Social Care at Edinburgh Napier University, UK and Clinical & Health Psychologist at the Rivers Centre for Traumatic Stress, Edinburgh, UK. He is the former Chair of the British Psychological Society Scotland Working Party for Adult Survivors of Sexual Abuse (BPSSS) and he was a member of the Committee of the British Psychological Society (BPS) Crisis, Disaster & Trauma Section. He has spent his entire clinical and academic career working in the field of psychological trauma, particularly on interpersonal psychological taruma. In collaboration with national and international research partners he has developed a special interest in the effects and treatment of psychological trauma on physical and mental health; on general, prison and veteran populations as well as on people with learning disabilities. The last few years he works in the area of Complex PTSD, a new condition in the recently published ICD-11. Prof. Karatzias, has published widely in these areas.



SYSTEMIC BETRAYAL: OUR HELPERS NEED HELP

Kristine Burkman, PhD

"When I was a boy and I would see scary things in the news, and my mother would say to me, 'Look for the helpers. You will always find people who are helping.'" -Mr. Rogers

This quote has been featured on countless memes, typically after a tragedy like a mass shooting, to assuage the fear and helplessness we feel in the face of horror. And in the past year and a half, we have been confronted with all types of horror including a global pandemic that has taken millions of lives and forever changed millions more. Long-standing racial injustices have been further highlighted as increasingly glaring disparities in wealth and resources have played out across education, food justice, community safety, and access to basic needs. We have seen communities and entire regions decimated by wildfires, floods, droughts, and other severe weather events caused by accelerated climate change. We are suffering, scared, and looking for help.

However, as pointed out by Ian Bogolst's article in *The Atlantic*, that famous quote from Mr. Rogers is problematic when applied to adult populations as it reduces our role and sense of responsibility to act. Instead, it encourages regression to a child-like belief that there are *other* people out there who will help—people with the right training, temperament, or calling to be a "helper." They are our doctors, nurses, teachers, firefighters, public defenders, community organizers, police officers, spiritual leaders, child protection case workers, military service members, and more. These roles are often held within large institutions where individuals may be forced to operate in ways that leave them unable to help or even cause harm, placing them at risk of developing moral injury and/or complex trauma.

Moral injury is commonly defined as perpetrating, failing to prevent, or witnessing acts that transgress deeply held moral beliefs and expectations (Litz et al., 2009), as well as betrayal by a leader or trusted authority (Shay, 2014). It has been conceptualized as a biopsychosocial-spiritual phenomena that exists within the context of being inherently interconnected and self-governed by each other as human beings (Farnsworth et al., 2014). When joining a helping profession, many identify shared values and ethical responsibilities that they hold sacred. In daunting circumstances, individuals may betray themselves through a transgression or failure to act in a way that is consistent with their core values or may feel a sense of betrayal by the institution or system in which they work.

While moral injury has been traditionally studied among military and veteran populations (Griffin et al, 2018), there is growing interest in studying moral injury and moral distress in other populations such as healthcare workers (Norman et al., 2021), child protection agencies (Haight et al, 2017), first responders (Lentz et al, 2021), and teachers (Sugrue, 2021). As a mental (*cont.*)

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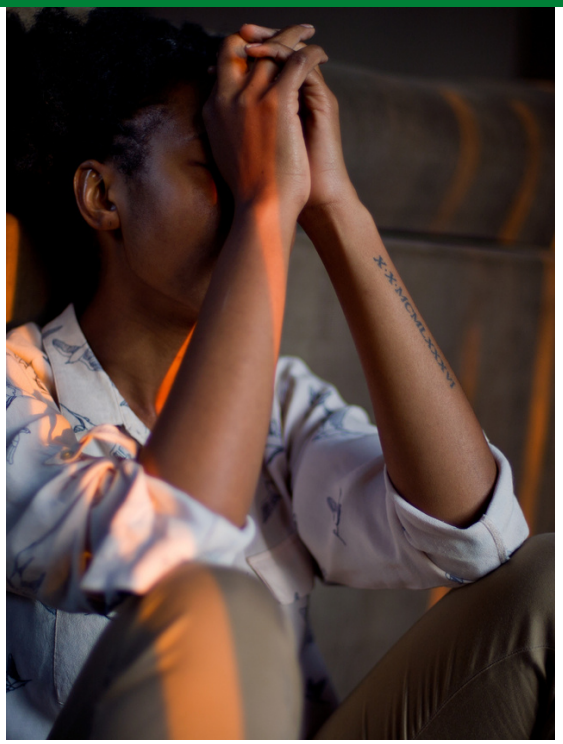
Moral Injury SIG and Complex Trauma SIG meeting dates/times TBD.

We hope to see you there!

SYSTEMIC BETRAYAL: OUR HELPERS NEED HELP

Kristine Burkman, PhD



health field, we remain conflicted about how to best describe and treat moral injury. While there is a strong pull to validate the moral pain and distress being experienced by individuals through inclusion of a diagnosis, there is also concern about pathologizing moral emotions that allows us to deeply connect to and be empathic of each other. Moral injury brings to light the challenge of a society that delegates its largest problems to specific individuals instead of recognizing the collective responsibility required to adequately address human suffering.

Attempts to fit societal problems into the individual is where I believe moral injury meets complex trauma among those in the helping professions. As I quickly learned as I treated combat veterans, there is a double-edged sword with gratitude and appreciation. On the surface, a statement like "thank you for your service" is a grateful gesture from those not on the front lines. However, when heard by those who are morally conflicted about their service, this phrase only exacerbates feelings of alienation, guilt, anger, and despair. As Edward Tick (2012) astutely notes,

Our veterans' terror is real. They come home stumbling out of hell. But we don't see them as they have become. Instead, we offer them beer, turkey dinners, debriefing, and occasional parades…because we as a nation are trapped in a consciousness that cannot acknowledge the abject suffering, especially if we have caused it or contributed to it, we do not see the reality of war. Meanwhile, survivors feel trapped in the apocalyptic reality and rarely try to explain it to people who will not understand.

The pandemic has prompted an outpouring of appreciation for those who help, many who may be experiencing similar social alienation as what we have seen in returning combat veterans. There have been internet memes, lawn signs, evening applause, celebrity-filled charity events and political speeches honoring the sacrifice and service of those in the helping professions. Helpers are propped up, even exalted, but ultimately left to their own devices in systems that are often underfunded, mismanaged, or steeped in avarice—setting them up to fail. And society, at some level, knows this. Phrases like, "I can't imagine doing what you do," or "It takes a very special person to do what you do," reveal some recognition of the struggle. And yet, society's response tends to be a very quick 'thank you,' with minimal to no effort to address the root of helpers' distress. Instead, we reinforce expectations that helpers should be resilient, selfless, and able to manage the crushing weight of slashed budgets, political vilification, and institutional betrayal.

Complex trauma emphasizes the impact of prolonged, interpersonal trauma that is threatening, horrific, and from which escape is difficult or impossible, resulting in problems in affect regulation; persistent beliefs about oneself as diminished, defeated, or worthless with accompanied feelings of shame, guilt, or failure; and persistent difficulties in relationships or feeling close to others (Cloitre et al., 2019). For those who choose to become a member of a helping profession, there is no shortage of exposure to prolonged, interpersonal trauma. And for many, the idea of walking away from their calling feels like abandoning their colleagues and the people that they have dedicated their lives to helping. They feel trapped by their own moral conscience to stay and endure the realities of their field, while ongoing constraints in the system reinforce feelings of helplessness, guilt, shame, and failure.

Our overreliance on professional helpers is an abdication of collective responsibility for our problems and it is dangerous. Without sufficient support, we will ultimately lose those in helping professions to attrition, burnout, or worse. In response to three frontline workers committing suicide in the face of the COVID-19 pandemic, Dean and colleagues (2020) pleaded with leadership to acknowledge the very real challenges healthcare providers face and the system that dissuades and/or invalidates their assertion of pain or trauma: *(cont.)*

SYSTEMIC BETRAYAL: OUR HELPERS NEED HELP

Kristine Burkman, PhD

Health care workers have learned that vulnerability—saying, "I need help"—is yoked to shame, not courage. For physicians, especially, too many would rather die than submit to the trauma of admitting helplessness or weakness. There is no space in our organizations to be vulnerable.

I believe as trauma researchers and clinicians, we are uniquely positioned to help reveal the biopsychosocial-spiritual cost that comes with being a helper. We should continue to expand the study of moral injury across helping professions and work towards developing interventions that will validate their experience and offer support that reflects the realities of their field. This includes examining the impact of additional trauma endured by those in the helping professions who experience discrimination, harassment, or assault based on their racial, ethnic, gender, or sexual identities. Similarly, if an individual in a helping profession identifies as a member of a community that has faced discrimination and oppression and is then unable to help or causes harm to that same community, the severity and impact of moral injury may be compounded. We need to hear directly from those on the front lines to better understand what is needed to transform our society and address our most daunting challenges.

Further, we need to increase our attention on the institutions themselves. In 2020, Dr. Freyd and her colleagues founded a non-profit organization called the Center for Institutional Courage. Their mission is to challenge institutions to show courage, seek out truth and engage in morally reparative action even if difficult or costly in the short-term. In emerging treatments for moral injury among combat veterans, there is often an emphasis on recognizing where an individual's moral value was violated, processing the emotions around that loss or violation, and engaging in moral repair through committed action (Griffin et al., 2018). Freyd and colleagues are offering a similar road map for institutions.

It is not enough to "look for the helpers," we need to encourage collective responsibility for society's problems if we are going to move the needle in moral repair.

KRISTINE BURKMAN, PHD

Kristine Burkman, PhD, is an Associate Clinical Professor at UCSF and a psychologist at the San Francisco VA Health Care System where she specializes in the assessment and treatment of traumatic stress and addiction. Her research focuses on moral injury among combat veterans and cultural adaptations to evidence-based psychotherapies (EBPs) for PTSD. Dr. Burkman also maintains a small private practice in San Francisco where she focuses on burnout, compassion fatigue, and moral injury among healthcare providers as well as intergenerational trauma and acculturation stress.

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CONSIDERING COMPLEX TRAUMA, MORAL INJURY, AND SYSTEMIC BETRAYAL IN LGBTQ INCARCERATED ADULTS

Miranda Galbreath, MA, MA, LPC

I am a Licensed Professional Counselor and have worked in the criminal justice field for almost 20 years. I currently work for the Pennsylvania Department of Corrections as a Psychological Services Specialist, where one of my roles is to advocate for incarcerated LGBTQ individuals. I also work with our Psychiatry, Medical, and PREA (Prison Rape Elimination Act) departments to support transgender individuals who request gender-affirming medical and mental health care. Over the last few years, I have become particularly interested in the experiences and support needs of older LGBTQ adults who are involved with the criminal justice system. I would like to share some of those experiences with you in this article.

Corrections professionals have become increasingly aware of the needs of our aging incarcerated population and the support they require. There is also a growing awareness of the high number of LGBTQ individuals involved with the criminal justice system, though much of the work in this area is focused on juvenile justice populations. However, I have come to realize that there is a large gap in our understanding and treatment of the intersecting needs of older LGBTQ adults involved with the criminal justice system.

I searched to see what, if any, research or other work was being done for these individuals, and who was doing this work. I searched in places I thought would be concerned with their experiences and needs, such as the National Institute of Corrections, American Civil Liberties Union, American Society on Aging, Pennsylvania Prison Society, Human Rights Watch, and relevant peer-reviewed journals. Unfortunately, it was difficult to find any work addressing all aspects of this intersectionality.

I was excited to find one article on this topic by Maschi and colleagues (2016). In this qualitative study, the authors conducted focus groups with 10 formerly incarcerated older LGBTQ individuals. In addition to this one article, I also found a five-minute video and a book chapter on this topic both from these same authors. After buying the giant, expensive hardcover textbook, I found that this book chapter simply contained the same *(cont.)*

CONSIDERING LGBTQ INCARCERATED ADULTS

Miranda Galbreath, MA, MA, LPC

information as the authors' journal article. So, as it currently stands, the one study with ten individuals is the only information we have regarding the experiences and needs of the entire population of incarcerated older LGBTQ individuals. I recently found another book titled, "Aging Behind Prison Walls: Studies in Trauma and Resilience" published in late 2020 and written by the same author as the one journal article which has a chapter on incarcerated LGBTQ older adults. When the book arrived, I discovered it also simply contained the same information as the authors' journal article.

Let's think about this particular group of individuals and the ways they have been affected by traumatic experiences, moral injuries, and betrayal by multiple systems. The vast majority of our aging prison population are individuals of color due to the disproportionate incarceration of black and brown people. Many of these individuals have disabilities or serious chronic illnesses such as HIV/AIDS, cancer, dementia, mental health concerns or substance abuse issues. These individuals came of age before much was known about HIV/AIDS and STIs, and thus they may be more likely to be living with such illnesses, treated or untreated. At the time of the HIV/AIDS crisis, they suffered through high levels of stigmatization and blame, and there was a lack of initial interest in finding treatments for the "gay disease."

Most of these individuals report a history of chronic stress, victimization, and trauma. They also experience grief and loss both prior to and during incarceration related to their race, socioeconomic status, LGBTQ identity, and health status, among other factors. They may not seek health services due to fear of experiencing abuse, harassment, or stigmatization from health providers for being LBGTQ. If they do choose to engage in treatment, they may experience refusal of services, abuse, and most likely also a lack of understanding about their unique combination of intersecting identities.

These are often individuals who did not feel safe to "come out" growing up due to even greater stigmatization then than is typical today. When many of these individuals grew up, their identity was still officially considered a "mental disorder" according to the Diagnostic and Statistical Manual, and simply being themselves was illegal. This is also a population who likely lost many of their friends and loved ones to the AIDS crisis which also limited their social support and was further traumatizing.

What it means to be "out" is often different for older individuals than it is for younger individuals. Older adults are frequently more reluctant to be out and may experience higher levels of internalized shame. When people do come out in the criminal justice system, they are at an increased risk of experiencing victimization and discrimination by peers and staff. As a result, some of these individuals stay closeted while involved with the criminal justice system to stay safe. Yet by doing so, they lose the opportunity to be their true selves and connect with their peers.

Another issue is that their chosen family and supports may not *(cont.)*

CONSIDERING LGBTQ INCARCERATED ADULTS

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be recognized by the criminal justice system. For example, if an incarcerated person's incarcerated partner becomes seriously ill or dies, they may not get any notice and may not have a chance to be involved in their medical care or say goodbye. They may not have an opportunity to take part in a funeral or memorial service. They have no right to information about what is happening with their partner and no right to make choices on their behalf. Their grief will likely not be recognized and may even be mocked or punished.

These are individuals who have suffered trauma and injury related to their gender identity and/or sexuality, their age, their involvement with the legal system, and often issues of race, socioeconomic status, and other factors. This is all before considering the moral injury that many of these people grapple with related to the crimes they have committed. The crimes they have committed may conflict with their sense of themselves as parents, as loved ones, and upstanding members of society. They struggle to reconcile the person they see themselves to be, and the person criminal justice staff and society has told them they are. They come into incarceration and often seek out spiritual, mental health, or academic answers as to how the person they envision themselves to be could have committed such crimes.

My hope with this article, and with blogs and presentations to community groups, is to raise awareness of the unique needs and experiences of this very marginalized population, and to encourage others to take them into account in their work or volunteer activities. People working within the criminal justice system, with the LGBTQ community, and with older adults may encounter individuals from this group. Considering the totality of their experiences with trauma, moral injury, and past as well as ongoing betrayal by multiple systems can only increase our ability to provide compassionate, competent support and care.

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WHITE FRAGILITY & STATE DEPENDENT FUNCTIONING

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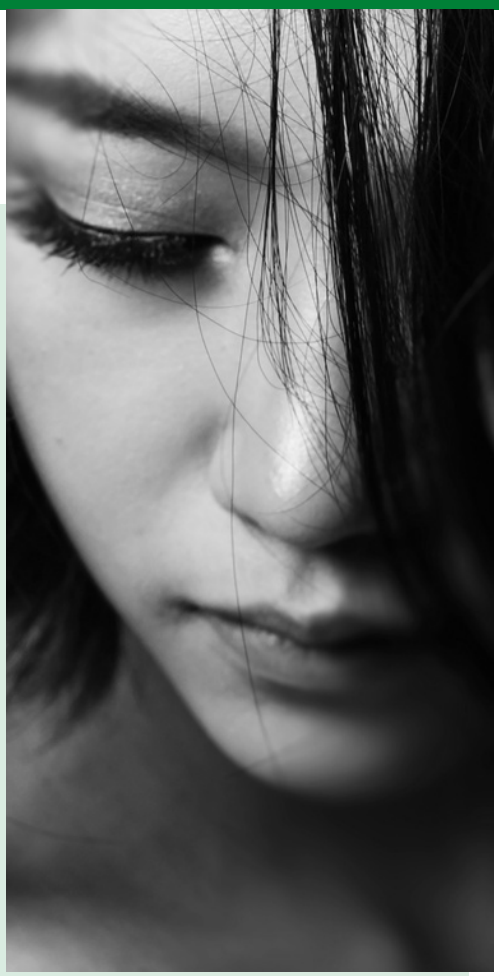

In the course of working with individuals with complex traumatic histories, racism and its effects often emerge in the therapeutic arena and can challenge White therapists. These challenges contribute to the moral injury and / or systemic betrayal for Black, Indigenous, People of Color (BIPOC) clients through a variety of mechanisms, including White therapist silence about matters of race and racism; White therapists turning away from personal accountability as participants in a White supremacist society that adversely impacts BIPOC clients; and other ways that White therapists simply don't ask or even broach the subject of racism with BIPOC clients. In each of these instances, the countertransferential response on the part of the White therapist can be palpable and at times felt on a physical level by BIPOC clients. More importantly however, these moments recapitulate the myriad ways in which BIPOC clients are constrained through commission or omission in a White supremacist society. In the context of therapy, this significantly reduces opportunities for BIPOC clients to give voice to and address their experiences of oppression and traumatization at the hands of structural and institutional racism.

One of the frameworks that is useful to better understand White people's responses to conversations about race and racism – which contribute significantly to moral injury and systemic betrayal in White supremacist societies - is the construct of *White Fragility* (Di-Angelo, 2018). White Fragility is linked to a larger sociological term called *White defensiveness*, which can be described as:

A defensive response by a White person when their Whiteness is highlighted or mentioned, or their racial worldview is challenged, whether this response is conscious or otherwise. (Wikipedia, 2020)

The concept of White Fragility or defensiveness is not new. Ask BIPOC folks, and they will likely cite numerous conversations with White people in which they have witnessed White Fragility or defensiveness. For example, White individuals might shut down attempts by other White people to name the role that racism is playing in various institutional or interpersonal settings or contexts. The phrase "it's not about race, why are you making it about race?" is an example of such shutting down. It exemplifies defensiveness by expressing a desire NOT to consider race and racism. For White-identified clinicians looking to validate the experiences of institutional, interpersonal and historical racism, Dr. DiAngelo's framework of White Fragility encourages them (us) to be aware of their (our) own responses.

As clinicians, recognizing our White Fragility gives us permission to engage with our own physiological countertransferential responses in a meaningful and inquisitive manner. This engagement is critical if we are to begin to address and transform the felt experience of White Fragility and our relationship with it as White people. As therapists, we know that failure to bring our attention to what is happening within our bodies and psyches comes at a cost to ourselves and others. In this instance, the cost of refusing to engage White Fragility includes the furthering of moral injury to BIPOC people and clients. Specifically, the ways in which White Fragility contributes to the turning away from our own internalized White supremacy constitutes yet another betrayal of an opportunity to address and redress racism and its impact on those around us. Gottman and Silver (1999) talk about the cost to relationships of turning away from opportunities for connection; how this erodes and fundamentally starves opportunities for meaningful, embodied engagement and intimacy. It has long been a domain of knowledge of BIPOC writers including James Baldwin (1962) and Ronald Takaki (2000) that there is a cost to *(cont.)*

WHITE FRAGILITY & STATE DEPENDENT FUNCTIONING

Stephen Bradley, LICSW, LMHC

White people of furthering racism by turning away from it. But more important is the way that White peoples' turning away, instead of turning towards, continues to entrench systemic betrayal and moral injury to BIPOC folks. Asking BIPOC folks to carry the weight of discussions about race and racism, rather than turning towards our own internalized White supremacy, exacts a toll. As Tess Martin (2020) writes in her blog post: Racism 101 / White Privilege:

[It] is bone weariness. The kind of weariness you feel after working a long day only to find your car won't start and your phone is dead, meaning you'll need to walk a few miles home in pouring rain and lashing wind. This mental and emotional exhaustion can be all consuming.

The Role of White People in Helping Other White People Work on White Fragility or Defensiveness

It is critically important to note that the primary responsibility of responding to White peoples' fragility and defensiveness rests squarely with other White people, not BIPOC individuals or communities. As Robin DiAngelo stated in an interview (Tippett, 2020), it's important to consider creating spaces where this work can happen without BIPOC individuals or communities having to witness it:

I actually am getting to where I do think that we should not be having these conversations together until we've done a fair amount of our own, personal work, as White people, because we cause so much wounding in these conversations… …we just have a pretty low critical awareness, and we go into these dialogues, and we cause a lot of harm… …But when you suggest, we're gonna separate by race, a really funny thing happens: White people freak out. Like, "What? What? Well, how will I learn about race if [BIPOC people don't] tell me? What do you mean?"

Di-Angelo's assertion is critical for White people who are wrestling with internal experiences of White Fragility. We need to do this work for ourselves and learn how to support other White folks who are also doing this work. Part of learning how to attend to, work with, and ultimately change our relationship with our own White Fragility is to make a shift from "what's wrong with me" or "I must be bad if I am enacting racism" (Di-Angelo refers to this as the good / bad binary in her book), to "what's happening within myself right now?" or "How do I work with this so as not to have it become another enactment?" As nuri nusrat notes in a helpful video titled, "What are Obstacles to Accountability" (2019), "In my experience and the experience of people I love and care about, it feels like [White people's] shame gets in the way of [White people being able to engage with] accountability."

White Fragility as a Stress Response

Ask a White person who is experiencing White Fragility or defensiveness what they feel like in their body, and they may begin to describe sensations that are indicative of a heightened stress response. They may note physiological signs such as increased heart rate and breathing, release of glucose, or other sensations indicating activation of core regulatory systems. As DiAngelo (2018) notes, there are many factors that could contribute to a White person experiencing stress when talking about race or racism:

- Social taboos against talking openly about race
- The racist is bad / not racist is good binary (see above)
- The delusion that White people are objective individuals
- Guilt that there is more going on than White people can or will admit
- Deep investment in a system that benefits White people - who have been conditioned to see this system as fair
- Internalized superiority

The idea that White defensiveness may be linked to a stress response leads to a number of questions: What happens to White folks when they begin to experience physiological feelings of White fragility? How do these physiological experiences interrupt their capacity to *(cont.)*

WHITE FRAGILITY & STATE DEPENDENT FUNCTIONING

Stephen Bradley, LICSW, LMHC

participate meaningfully in conversations about race and racism? How might their feelings of threat and arousal – if unexamined and not worked with--actually contribute to aggressions and micro-aggressions? As Menakem (2017) describes,

The deadliest manifestation of White Fragility is its reflexive confusion of fear with danger and comfort with safety. When a White body feels frightened by the presence of a [BIPOC] one—whether or not an actual threat exists—it may lash out at the [BIPOC] body in what it senses as necessary self-protection. Often this is a fight, flee, or freeze response. (p.98)

The Neurosequential Model™ as a Roadmap for Understanding Physiological Stress and State-Dependent Functioning

Over the past couple of decades, another model has been developed called the Neurosequential Model - a framework for understanding how trauma affects peoples' stress response systems (Perry, 2018).

White Fragility and White defensiveness do not constitute traumatic responses. However, viewing White Fragility and defensiveness through a lens of neurobiological stress gives clues as to how to respond when White people are, at least temporarily, captivated by the physiological states of these experiences.

Perry (2017) describes the components of the stress response system as being distributed throughout the brain, with the primary centers for managing stress located in the lower brain regions – the brainstem and diencephalon. Specifically, he talks about the ubiquitous distribution of networks throughout the brain linked to the neurotransmitters serotonin, dopamine, and norepinephrine.

Peoples' bodies and brains continuously monitor the outside world, gathering information and responding to various forms of input. When something potentially stressful is detected, the nervous system automatically (i.e., without conscious thought) begins to mobilize a response to the perceived stress. For instance, a child who has been caught doing something wrong, an adult who encounters a grizzly bear while hiking - or a defensive White person who encounters an interaction where they are being asked to look at their own actions and how they relate to or perpetuate moral injury and systemic betrayal – as enactments of race or racism - will find each of their nervous systems mobilizing and putting their bodies on alert.

Stress primarily manifests in two ways: hyperarousal and dissociation (Perry, 2013a). Hyperarousal may result in externalized manifestations of White Fragility or defensiveness, provoking a White person to argue, become angry, or lash out. Dissociation on the other hand creates shut down, or withdrawal, from the conversation. The dissociative response is akin to the deafening "White silence" that so often occurs when it comes to recognition and discussion of racism (DiAngelo, 2012).

State Dependent Functioning and Stress Response

A core concept of the Neurosequential Model is State Dependent Functioning (Perry, 2014). As individuals' stress levels increase, their brains assess what neurological functions are essential for survival and require activation, and which can be shut down to preserve energy. The upper regions of the brain, which contain the neural networks associated with the limbic system and cortex and coordinate conscious thinking and the capacity for subtle relational attunement, become subdued, while the lower regions, which promote physiological alertness, become amplified. As Perry (2014) puts it, the more stressed we are, the dumber we become. Stressed individuals become more self-focused, ego-centric, defensive, categorical, rigid, and inflexible.

When it comes to White Fragility, the more stressed a person becomes, the less likely they are to be able to navigate complex conversations about race and racism. For clinicians working with BIPOC individuals and race-based trauma, White Fragility and the associated stress response can reduce the capacity for empathy and validation. It's essential that White clinicians self-monitor their own dysregulated states when working with clients.

Strategies for Capacity Building

Addressing and reducing *(cont.)*

WHITE FRAGILITY & STATE DEPENDENT FUNCTIONING

Stephen Bradley, LICSW, LMHC

White Fragility or defensiveness involves understanding how to calm the stress response system and restore reason, what Perry (2020) labels the "Regulate, Relate, Reason" sequence. The sequence begins with regulating activities to soothe the lower areas of the brain where these threat response systems lie through different types of self-soothing activities that incorporate sensory or somatosensory input. Attempting to reason with someone in a hyperaroused or dissociated state, when cortical and limbic systems have shut down, is likely to fail. Helping them recognize and reduce their physiological stress will better equip them to engage in dialogue.

Once a person has sufficiently regulated, or returned to their window of tolerance, it's easier to engage them in a complex conversation. As noted above, the task of helping a person calm down enough to return to a conversation about race should be undertaken by fellow White people – inviting the person to return to and continue the conversation.

When people experience stress in moderate, manageable doses, it increases their capacity to tolerate that stress (Perry, 2013b). Menakem (2017) suggests that White folks can build capacity by putting themselves into BIPOC spaces: "If you're a White person, go someplace where there are gonna be a lot of black bodies, and just feel what happens in your body. And go back again."

When working with BIPOC individuals and communities who are exposed to and traumatized by daily experiences of aggression and micro-aggressions, it is critically important for White therapists to be fluent with their own internal somatic responses. Understanding that a White defensive or fragile response is frequently accompanied by physiological, state-based shifts that compromise self-regulatory, relational and cognitive capacities can help White therapists build capacity to not only tolerate, but also initiate and follow through on anti-racism initiatives.

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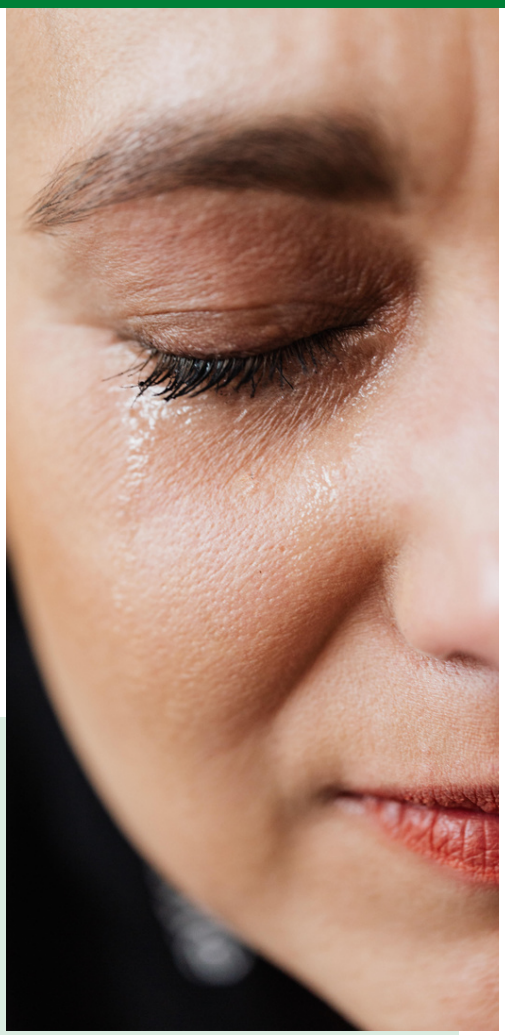

SYSTEMIC BETRAYAL & GASLIGHTING

Sarah Nakonechny

Gaslighting is an epistemic injustice that has a direct connection to the systemic betrayal that countless groups of people have been forced to face for decades without retribution. This phenomenon occurs when an individual engages in a form of emotional manipulation in an attempt to drive their targets crazy. This can happen consciously or unconsciously and is typically done so with the purpose of obtaining a specific end result (Abramson, 2014). This phenomenon has negative effects not only on the individuals who are impacted, but also on the communities that have been targeted. Although individuals may engage in this harmful act unconsciously, it does not excuse the damage that is being done as a result.

One of the most prominent ways this phenomenon unconsciously occurs is through the various system structures we have built. These system structures promote the betrayal of a variety of individuals through the training, behavioural expectations, and ways in which advancements take place. We do not realize that the ways in which we are acting are actions of gaslighting, because we have not learned a different way of behaving. Gaslighting involves emotional manipulation that causes another person to feel as though their senses, perceptions, memories, and/or beliefs are unreliable and do not exist upon any steady foundation to the point where it qualifies them as being unstable (Abramson, 2014). Feelings of distrust for oneself can be instilled by anyone and can result in permanent damage to the victim's feelings of personal autonomy. The breaking of one's epistemic trust is not something that occurs in a single event but something that occurs during multiple incidents over a longer period (Abramson, 2014). The persistence of gaslighting is motivated through present systemic injustice and continues to fuel instances of betrayal. With these acts being built into our system structures, those who perform the gaslighting and those who are victims may not initially be aware that it is taking place.

This type of betrayal calls numerous system structures home: it can be found in any system designed by humans. From mental health services to the legal system, all the way to the education system, we see instances of gaslighting being manifested and taught. As we move through these various systems, what changes is who the targets of this injustice are. The targets can include children, people who live with physical or mental disabilities, those who identify as female, are a member of any other minority group, or any number of combinations of these identities.

We can see illustrations of gaslighting present in different forms of media and entertainment. An example that we can look to is a short story, *The Yellow Wallpaper,* written by Charlotte Perkins Gilman (1985), which illustrates the hardships experienced by the main character, a victim of gaslighting. From beginning to end, the main character (who we believe has postpartum depression) is (*cont.)*

SYSTEMIC BETRAYAL & GASLIGHTING

Sarah Nakonechny

gaslit by her husband and the doctors treating her. Her husband believes that everything she claims to be experiencing is false and that she is improving because of the prescribed treatment plan. By continuously reinforcing the idea that she is improving, which is done not only by her husband but also the doctor, she develops feelings of mistrust towards herself. How much of her own experience can she really trust, and does she have a logical reason to not believe in the medical system that is treating her? Although this is a fictional example, this story mirrors the ways in which women who experienced postpartum depression were often treated by those within the system as well as those with whom they had close relational ties. Spanning from past decades to the present, we can see instances of the phenomenon everywhere.

As we progress forward, we must realize that this is not a problem of the past but rather a current problem for everyone to work on fixing together. Rather than accepting the ways in which gaslighting occurs within our systems, we can actively work against them. Searching for the ways that we are failing so many individuals through the foundation of our systems will allow us to change the unfair practices with greater ease. Changing the systems may involve pointing out when one's thoughts or opinions have been disregarded, ensuring that the voices of children are considered, and making the effort to understand the reasoning behind people's decisions. We are complex individuals with equally complex needs: working on an individual level to try and correct the effects that gaslighting has had up to this point is one of the best ways to move forward. While we cannot destroy the system in its entirety and rebuild it, we can work to improve the situation.

In conclusion, gaslighting is an obvious example of the systemic betrayal that has been built into our society. By observing a variety of groups that experience this phenomenon, we can observe the negative effects it has on their sense of autonomy and the relationship they have with themselves. Moving forward, it is important that we work to consciously break down the ways in which our systems teach us how to gaslight others while also focusing on the inclusion and acceptance of everyone.

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ORGANIZATION SPOTLIGHT: OUT OF THE STORM: THE ENDURING SILENCE OF RELATIONAL TRAUMA

Lori Herod, EdD

Out of the Storm (OOTS) is an online web site and forum for survivors of ongoing Relational Trauma (RT) who suffer from Complex PTSD (https://www.outofthestorm.website/). Since its inception in 2014, over 9,200 people from 47 countries have registered. This is suggestive of a public health crisis on a global scale, a pandemic of relational abuse/neglect which until very recently has been surrounded by an enduring silence.

RT is a form of Complex Trauma involving repeated/ongoing physical, sexual and/or emotional abuse/neglect of an individual by someone with whom they are in a relationship. Complex PTSD develops where there is a degree of dependency on the perpetrator and survivors are or perceive themselves to be trapped. Those who should be trustworthy are not; parent, sibling, spouse or other family member; employer, teacher, coach. Thus, central to RT is a profound sense of interpersonal betrayal.

I founded OOTS in 2014 when I learned I suffer from Complex PTSD via the book "Complex PTSD: From Surviving to Thriving" (Walker, 2013). I was in my mid-fifties. It had taken decades for me to finally discover what was going on, that I had developed a set of strategies to survive the trauma of abuse in my childhood. I immediately recognized myself in the diagnosis and it was such a relief to learn that it wasn't me, it was what happened to me (Courtois, 2014). I started OOTS because I needed information and to talk to other survivors, but there were few resources and no online groups I could find back then.

At the time I started OOTS, Complex PTSD was not an official diagnosis in either the American Psychiatric Association's (APA) DSM or the World Health Organization's (WHO) ICD. It has since been accepted for the WHO ICD-11 due to the efforts of a group of dedicated clinicians and researchers such as Judith Herman, Julian Ford, Marylene Cloitre, Christine Courtois and many others. A special note of appreciation is offered here on behalf of the OOTS community for their determination and perseverance in pushing for the diagnosis to be made official.

This only happened nearly thirty years after Complex PTSD was first identified by Dr. Judith Herman in her 1992 book "Trauma and Recovery" though. Many survivors consider this protracted unwillingness to legitimize Complex PTSD as a form of *institutional betrayal.* That is, "trusted and powerful institutions (schools, churches, military, government) [act] in ways that visit harm upon those dependent on them for safety and well-being" (Smith & Freyd, 2014).

In the case of Complex PTSD, the betrayal was a failure to act which left survivors to languish. Little was available – treatment, services, resources - to help with what is a profoundly debilitating, impactful and lasting stress disorder. Not only does RT result in the psychological symptoms of ICD-11 Complex PTSD, but also in serious and life-threatening physical illness/disease (Lanius et al., 2010).

This confusion over and reluctance to go firm on the diagnosis meant other important institutions failed us (e.g., medicine, police, justice, social work). So often at OOTS members post about a deep sense of betrayal and abandonment they have felt because of the actions of someone with whom they are/were in a relationship with, and the institutions that were meant to protect them and their well-being.

OOTS serves to counterbalance this to some extent by providing a safe space where members can speak openly about the trauma they've suffered and receive support and encouragement from other survivors who understand and validate their experiences and feelings. The site is not part of or funded by any system/institution and as such, owes no allegiance to any person or body.

OOTS was also meant to fill the gap in resources, support and credible information about RT and Complex PTSD. It is a safe space for survivors to anonymously share, validate *(cont.)*

OUT OF THE STORM: THE ENDURING SILENCE OF RELATIONAL TRAUMA

Lori Herod, EdD

and build knowledge based on their lived experience.

What is unique about OOTS is that it was designed in accordance with self-determination and self-directed learning theory in mind (Deci & Ryan, 2016; Knowles, 1975). That is, the emphasis is on recovery through the development of a sense of agency, shared/expanded knowledge, and belonging by survivors. Members share their lived experience and contribute resources which results in iterative growth of the site and knowledge building by survivors about RT and Complex PTSD (Herod & Kop, 2016). It is intended to help bring a survivor's "learning brain" back online after hijacking by the "survival brain" that is the hallmark of protracted RT (Ford & Courtois, 2020, pp. 35-36)

ISTSS members can support survivors by acknowledging RT as a distinct form Complex Trauma in which an individual is emotionally, physically and/or sexually abused in the context of a relationship (e.g., domestic violence, childhood abuse, stalking, bullying, coercive control). This would serve to distinguish RT from other forms of Complex Trauma such as racism, natural disasters, war. Grouping us under the umbrella of RT makes us a larger, more visible population much like PTSD and soldiers, emergency services/health care workers and police. It would serve to legitimize and empower RT survivors, focus treatment and services, and spur funding, research, and political and social action.

As a small step forward in recognizing and legitimizing RT survivors as a group, it is suggested that ISTSS consider revising its online clinician database. Currently under "Special Interests" PTSD is identified, but RT/Complex PTSD are not. Thousands of RT survivors around the world are looking for clinicians who treat Complex PTSD specifically; why not make this a clear option/focus in the database now that it is an accepted diagnosis by the WHO?

Finally, ISTSS can also support RT survivors by inviting them to become members of the organization, to serve on committees and in special interest groups, and take part in conferences. This will not only go a long way toward identifying/reducing any institutional betrayal but will do much to guide research and practice. (Note: This will require discussion by leadership about much lowered fees given the economic barriers to this particular group.) Inclusion and mutual respect, understanding and collaboration; together we can do better.

LORI HEROD, EDD

Dr. Lori Herod is a survivor of relational trauma and the founder of the online website and forum group Out of the Storm (OOTS) for trauma survivors with Complex PTSD. She is also a former Co-Chair of the ISTSS Complex Trauma Special Interest Group.

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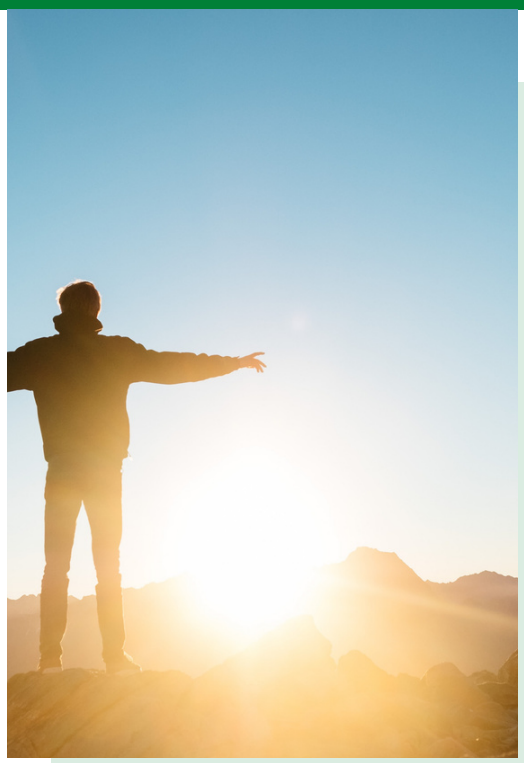

MORAL INJURY SIG: ARTICLE SUBMISSIONS

We invite Moral Injury SIG members to submit relevant articles of no more than 1,500 words.

Submissions may be data-driven, descriptive, theoretical, clinically oriented, etc. provided that they are relevant to the field of moral injury. Consistent with our mission to bring together clinicians and researchers from across healing disciplines and related fields, we hope to consider a range of submissions.

Articles should be no more than 2000 words (including references, tables, and figures). At least one SIG member should be an author on all submissions, though non-members may contribute in any role. As always, collaborations among members are highly encouraged.

Submissions should be addressed to the SIG student co-chairs: Amanda Gentz (agg5225@utula.edu) & Jason Cruze (jcruze@alliant.edu).

LIVED EXPERIENCE: MORAL INJURY & COMPLEX PTSD

Philip Katner

I prepare for an upcoming Master of Social Work internship at the Mental Health Outpatient clinic of our local Veterans Administration. I am compelled to craft my narrative: an autoethnographic essay as a foundation from which I might better see, know, and serve others.

Forgiving Me

Traversing the arduous path between the hells of moral injury and complex posttraumatic stress syndrome (CPTSD), I step knowingly the time-worn stones of dissociation, rage, shame, delusion, caretaking, fear, ideation, and addiction. Each comforts me in the familiar: necessary survival instincts fashioned in refuge-seeking flights from neglect, abandonment, betrayal, abuse, and oppression. Stand I, here and now, on saner, adult shores, readily grasping their saving grace: each hewed and hardened the forge of yet another transgression, doled out so readily from family, religion, school, government, and society. The guiltless institutes' justifications prescribed into doctrine, upheld by specious moral authority. Me, their dupe, ignorantly owning each offense then anticipating the next.

The inner child requires no holding. Rather the grownup part of me raging who punched the hole, verbally assaulted…who squeezed the angry trigger. His rage needs loving containment, heartfelt and present. He was doing the best he could, so him I hold. The part of me lost in delusions, weaving sense of situational insanity the emerging mind could not grasp; he needs to be attended such that delusion softens to creativity, to wisdom. Shame's hold, the mercurial witches' brew keeping me forever looped in recriminations and worthlessness, is eased by self-nurture's antidote, which works silently, slowly from a place of patience. His shame recedes into nothingness as I attend to him, accept him, and appreciate him. The once dissociated parts, each retrieved from their fantastical flights to sound places (thankfully) horrors could never harbor, find integration in my loving arms.

No, it's not the child within that requires love so much as the healing man I am today. As trusted an ally as their safe presence affords, the therapist might onboard and disembark me from this rollercoaster: however, the hero's most demanding summits are always soloed. And I can forgive the suffering. And I can forgive the confusion. And I can forgive myself and the manifestations and paths my many fragmented parts took to reconvene here today. I can and I must, and I will, and I do forgive myself. And in this, forgiveness opens the door to love. And learning to love me, how much healthier I love others. My strengths, not their savagery. My saneness, not their absurdity. My integration, not their chaos. My moral compass. My safety. My peace. My self. Me.

LIVED EXPERIENCE: INFLUENCING SYSTEMS FROM WITHIN

Anonymous

Through childhood and adolescence, I was the victim of Munchausen syndrome by parent, and later, by medical and psychiatric systems. I have experienced poisonings, unnecessary medical procedures without anesthesia, organized physical abuse, all forms of psychological abuse, kidnapping, wrongful institutionalization, and one year of highly documented psychiatric malfeasance and abuse. Despite 7 years of psychotherapy and enormous amounts of post-traumatic growth as an adult, I feel extreme hesitation and resentment as I enter this field. It is not merely a "trauma re-enactment" or evidence of "symptoms", rather, I'm already a dissenter. I know things I am not "supposed" to.

When my psychotherapists (several of them academics) and I explore the professional origins for why I fell through the cracks of the system, we consistently find direct links of research psychology's history of failing to acknowledge the existence of complex dissociative processes in children, which then trickles down to less-informed applied settings, leading to misdiagnoses of fad disorders. Beyond disease reification and America's medicalization of the entire human condition (Bartlett, 2011; Frances, 2013), we also see the fields continue to neglect ownership of iatrogenic processes (Hunter, 2018).

Anecdotally, in my undergrad history of psychology course, the instructor was sure to focus on social tolls the deinstitutionalization movement had. Yet no mention of institutional betrayal was made, even with the data showing that over 100,000 individuals were misdiagnosed with schizophrenia during this period (Fulford et al., 2014, pp. 1024-6). Another faculty member implied that so-called "false memory theories" are the final explanation for adult-onset trauma related disorders, when longitudinal research demonstrates otherwise (Howe et al., 2008). There was no mention of Jennifer Freyd's betrayal trauma theory (Freyd, J., 2020; Freyd & Birrell, 2013), which appears to have gone viral during the last decade. In mentioning this person's research during their office hours, I was met with spooked faces and silence. Having digested nearly a thousand articles and dozens of books on complex trauma, and consistent feedback from my providers that I am neither delusional nor malingering, I obviously found these responses confusing. It leads me to wonder, does academia *choose* to not know about complex trauma (Petrucelli, 2010, pp. 83-109)? More outrageously, are there competing tribes of academics seeking to systematically cover up the misuse of power as to minimize the dissonance? Perhaps there's a simpler answer.

Much like how complex trauma survivors ultimately develop a phobia of affect and ultimately self-hood through an overwhelmed nervous system, dissociation, and excessive compartmentalization (Ford & Courtois, 2020, pp. 40), clinical psychology and research psychiatry appear to have a similar "deficit": they are incapable of *feeling or expressing* the outrage, *(cont.)*

COMPLEX TRAUMA SIG

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

MORAL INJURY SIG: NOMINATIONS FOR SPOTLIGHT

The Moral Injury SIG welcomes nominations for students, researchers, and clinicians, and anyone advancing the moral injury field to be "spotlighted" in an upcoming newsletter.

Nominations should include a brief nominating statement and the CV of the nominee. Self-nominations are encouraged. Nomination materials should be addressed to the SIG Chairs: Amanda Gentz (agg5225@utula.edu) & Jason Cruze (jcruze@alliant.edu).

LIVED EXPERIENCE: INFLUENCING SYSTEMS FROM WITHIN

Anonymous

shame, or guilt necessary for owning up to their dark history. They've created a culture for which to merely experience extreme distress is to be stigmatized by colleagues (Hinshaw, 2008). Notice the fields' continued obsession with ABC-like cognitive therapies, that primarily focus on folk categories or beliefs as "entities" to delete – and not the experiential component of emotions in an ecological context. Or the fact that cognitive neuroscience and the computer-analogies of consciousness remain more popular than affective neuroscience and research about emotions. Through prophecy, they've created a paradigm that presupposes those with any form of psychopathology are, incorrectly, passive information processing units lacking intentionality, or simple computers to be re-programmed (Panskepp & Biven, 2012). It might explain why many clinicians project their own highly external locus onto "their" subjects during unnecessary psychiatric holds. Indeed, I generally avoid the medical system in crisis states, by not just the advice of my therapists, but experience in knowing I'll likely be treated as if I were a robot of sorts that requires isolation or one-way "programming", instead of normal human connection and understanding.

In having such views, I'm faced with R.D. Laing's dictum about the politics of experience: to be successful in academia or the mental health field, I must pretend not to know what I know I know but am not supposed to know (Petrucelli, 2010). These only feed more mental contaminations of betraying my "selves", scrupulosity, loneliness, and resentment. And while I metacognitively know I am bright, that the imposter syndrome is earned, it *feels* (emphasis away from thoughts) as though I'm living in a literal horror movie. Only recently I've realized, from an evolutionary lens, to have what amounts to a shape-shifting personality also means to possess enhanced ability to infiltrate rival territory. It'll be interesting where this fire goes.

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BIBLIOGRAPHY OF SYSTEMIC BETRAYAL WITH COMPLEX TRAUMA & MORAL INJURY

This compilation of articles is offered for those interested in exploring intersectionalities between the fields of complex trauma and moral injury, as they relate to the phenomenon of systemic betrayal. While not an exhaustive list, we hope it will offer some useful examples as a starting point for further study.

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