NACC NEWSLETTER

APRIL - JUNE 2017

Editorial

This year saw our partnership with churches consolidated when we had our 8-week Basic Counselling Skills hosted by FGA KL where more than 20 of their lay leaders participated. The remaining of this batch of 34 participants came from other churches in the Klang Valley. We hope to work with more churches to anchor such training in the near future. We aim to recruit more members to have a stronger representation on social issues, especially those that relate to counselling and mental health. In this respect, we have filed an application with Lembaga Kaunselor Malaysia to be registered as a counselling organisation to facilitate our availability for ministry to the general public and assist in credentialing for counselling graduates from Christian colleges and universities. We seek your prayers and support as we embark on these endeavours.

6TH ANNUAL GENERAL MEETING

The 2017 AGM was a particularly significant watershed as Dr Edmund Ng, the founding president of NACC stepped down after six years at the helm. He hopes to focus more on writing and avail his expertise and services to the wider counselling community, not only locally but also internationally. He will however avail himself in an advisory capacity.

We take this opportunity to introduce the **new board for 2017-2018:**

President: Patrick Cheng
Vice-President: Peter Soo
Secretary: Phua Ah Eng
Treasurer: Sew Yin Yin
Committee Members: Dr Yeo Pei Li, Phoebe Yee and Vincent Lim

We covet your prayers for the new leadership team as we continue the ministry of Christian Counselling.

Dr Edmund praying for the new board.

Patrick (new president) giving a token of appreciation to Dr Edmund (outgoing president) for his services the past 6 years.

NATIONAL ASSOCIATION OF
NACC
Malaysia
CHRISTIAN COUNSELLORS

Council of Reference 2017-2018

Dr Edmund Ng
Dr John Court
Dr Eric Scalise
Dr Evelyn Biles
Dr T. Maniam
Dr Goh Chee Leong
Dr Johnben Loy
Ps Dr Daniel Ho
Ps Dr Chew Weng Chee

NACC Board 2017-2018

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Patrick Cheng

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Dr Yeo Pei Li
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Vincent Lim

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REPORT ON WALKING WITH PEOPLE WITH TRAUMA

Dr Yeo Pei Li began by pointing to the compassion of Jesus (Mark 6:34; 8:2), as our ministry also includes providing basic care, comfort, and support to people who are experiencing trauma-related stress. The workshop helped the participants to understand crisis and trauma, and the impact on self, family, and community. It also enabled them to recognise the symptoms of psychology-related stress and know where to get the necessary assistance. She also taught them how to help and when to refer clients for professional help. Finally, she also talked about the importance of self-care before, during, and after providing support to the survivors.

NACC NEXT BIMONTHLY WORKSHOP

This is an introduction to Addiction Intervention and Counseling / Treatment Plan. It discusses the concepts and dynamics that are involved in the treatment and counseling process with the emphasis on providing a simple yet practical framework for those without much experience in addiction work.

Date: 24 June 2017 (Sat)
Time: 9 am - 12 noon
Venue: NACC Office, Sunway Mas Commercial Centre, PJ

Speaker

Chris Sekar practises as the Addiction Therapist at Gleneagles Medical Centre. Currently, he is the Clinical Director at Solace Sabah (KL) Clinic. He has more than 30 years of counseling experience ranging from substance and behaviour addiction abuse to family issues.

His qualifications include a Postgraduate Diploma in Counseling Psychology, a Master of Arts degree in Counseling from De La Salle University, a Bachelor of Theology degree from Malaysia Bible Seminary, and is a Certified Addiction Therapist (CSAT) from the Asia Pacific Certification Board. Chris currently has a Master (Level 4) in Addiction Therapy and is the former President of the Asia Pacific Certification Board (M).

With a very positive disposition, Chris seeks to integrate the various theories of change with experiential truths. He applies his knowledge of the various models of recovery to meet the patients' particular needs. Hence, Chris is eclectic in his approach to treatment management. His own recovery from drug addiction of ten years enables him to understand the peculiarities of the addiction world. He has been drug free for 35 years.

Chris also lectures on Addiction Counseling/Intervention on a regular basis for the Master in Clinical Psychology Programme in HELP University and for the Advanced Diploma in Counseling Psychology Programme in College of Allied Educators.

ARTICLE: THE NEUROBIOLOGY OF TRAUMA AND TRAUMATIC RELATIONSHIPS

Eric Scalise, Ph.D.

Trauma and its cognitive, neurobiological, emotional and relational consequences have been studied by researchers for decades. The type of trauma affects responses, although this can still vary from individual to individual. Basic trauma can result from natural disasters, accidents, and disease, to name a few. Complex trauma, on the other hand, generally refers to multiple traumatic stressors that involve direct harm and are interpersonal—premeditated, planned, and caused by other humans. A growing segment of scientific inquiry within this field includes the particular impact on brain functioning and relationships.

Judith Herman, professor of clinical psychiatry at Harvard Medical School, first described complex trauma in her 1997 book, *Trauma and Recovery*. Typically, these events, due to a deliberate versus accidental causation, cause more severe reactions in the victim than trauma that is impersonal and serve as precursors to the development of post-traumatic stress disorder (PTSD). They can be a single or isolated event (robbery, physical assault, rape) and perpetrated by a stranger or involve family members and other close relationships (clergy members, teachers, coaches, supervisors). In the latter case, the trauma and subsequent victimization may be repetitive and chronic (sexual/elder abuse, neglect, ritualistic abuse), where the effects are compounded, prolonged, and cumulative over time because perpetrators become increasingly emboldened and compulsive. Distorted trauma bonds may develop between perpetrators and victims leading to general debilitation, despondency, a state of adaption/accommodation as a means of survival, and dissociation. Relatively small events, repeated when an individual is young and most vulnerable, are potentially more toxic than events of greater intensity later in life.

Other diffused, but nevertheless adverse, environments can also represent forms of complex trauma. These include poverty and ongoing economic challenges combined with the lack of essential resources; excessive community violence and the inability to escape from it; homelessness; disenfranchised ethno-racial and religious status/repercussions; incarceration, residential placement and ongoing threat and assault; prostitution, sexual slavery, and sex trafficking; human rights violations, including political repression, genocide, ethnic cleansing, and torture; displacement, refugee status, and forced relocation; war and combat involvement; and exposure to death, dying, and the grotesque in emergency response work. The following observations are based on the work of psychologist and internationally-known trauma expert, Christine Courtois:[1]

- **Alterations in the Regulation of Affective Impulses:** difficulty with modulating anger and tendencies toward self-destructiveness, over-inhibition or excessive expression; pathological self-soothing behaviors and other methods of emotional regulation, even those that are paradoxical, such as addictions and self-harming behaviors; easily-aroused, high-intensity emotions; difficulty describing feelings and internal experiences; chronic and pervasive depressed mood, sense of emptiness or suicidal preoccupation; difficulty communicating wishes/desires; and impulsivity.
- **Alterations in Attention and Consciousness:** amnesias, dissociative episodes and depersonalization; problems with orientation in time and space; auditory/visual perceptual problems; impaired comprehension of complex visual-spatial

patterns; impaired memory function; and the inability to recall or feel certain emotions, vacillating from numbness and detachment to hypersensitivity and flooding.

- **Alterations in Self-perception:** predominantly negative and low self-esteem involving a chronic sense of guilt; ongoing feelings of intense shame; a lack of a continuous and predictable sense of self; the belief that one has been permanently damaged by the trauma; a poor sense of separateness; and body image distortions.
- **Alterations in Perception of the Perpetrator:** incorporation of the perpetrator's belief system; and complex relational attachment systems.
- **Alterations in Relationships with Others:** not able to trust the motives of others; reduced capacity for intimacy; problems with boundaries; distrust and suspiciousness leading to social isolation; unawareness that other people can be benign and caring; uncertainty about the reliability and predictability of the world; difficulty with perspective-taking; and difficulty enlisting other people as resources, advocates, or allies.
- **Somatization and/or Medical Problems:** concerns that involve all major body systems and include pain syndromes, medical illnesses and somatic conditions; sensorimotor developmental issues and problems with coordination/balance; and hypersensitivity to physical contact.
- **Alterations in Systems of Meaning:** feelings of hopelessness; despair regarding recovery from psychic anguish; difficulties in attention regulation and executive functioning; problems focusing on and completing tasks; difficulty planning and anticipating consequences; learning difficulties and problems with language development; and poor object constancy (the ability to see oneself as a separate and unique individual).

According to the National Institutes of Health, approximately 25% of all children in the United States will experience at least one significant traumatic event before the age of 16, with 15% of girls and 6% of boys developing symptoms of post-traumatic stress disorder. The recently released *DSM-5* now includes a category for minors under the age of six. Based on the theory of Developmental Trauma Disorder (DTD), this addition to the diagnostic classification system was endorsed because the previous descriptors for PTSD were inadequate in addressing childhood traumatization. Children and adolescents who have experienced sequential (repetitive) trauma suffer greater emotional and physiological dysregulation because there is a chronic activation of certain neurobiological systems that produce stronger and more immediate reactions to emotional stimuli, with the effects often lingering into adulthood.[2] The dysregulation can lead to functional impairment (within familial, educational, and social environments), legal and health related problems, and neurological impairment.[3] It should be noted some researchers have voiced concern that the focus for PTSD primarily emphasizes a psychosocial etiology and does not give enough attention to the biological/genetic factors that may come into play.

What the research has revealed, however, is that the brain is not rigid as once believed, but pliable (defined as plasticity) and can change its structure and function in response to lived experiences. When someone is repeatedly exposed to traumatic stress, disruptions occur in brain functions and structures, endocrinological and immunological function, and central and autonomic nervous system arousal. The hypothalamic-pituitary-adrenal triad—HPA Axis—is responsible for bringing the body back into balance in the face of traumatic events. If the trauma is severe or recurrent, certain chemical responses ensue. For example, catecholamines such as adrenaline and dopamine are chronically increased, which damage memory function and rational thinking, lead to hypervigilence, and compromise the ability to accurately perceive danger. Opioid levels also increase, creating a flat affect; while corticosteroids, in contrast, are chronically lowered and reduce immune system capacity.

Complex trauma results in a lingering over-activation (sensitized neural responses) of an individual's autonomic nervous system, resulting in fight-flight-freeze responses to seemingly random and unrelated cues long after exposure to traumatic experiences have ended.[4] Recent research suggests that for younger children, neuro-psychological development is actually altered, which, in turn, can shift learning patterns, behavior, belief systems, cognition, self-identity, and social skills. The amygdala and the hippocampus, both part of the limbic system and highly sensitive to stress hormones, actually change after exposure to a traumatic event. These changes result in a restricted flow of information from the limbic system and higher cortical levels associated with consciousness and executive function. A person's ability to plan and think objectively is dramatically distorted and the essence of objective thinking and judgment is significantly impaired when a triggering episode occurs.

Intervention and crisis response considerations need to be targeted, such as immediate and/or direct medical attention for self-injury, suicidal ideation/gestures and assaultiveness; contacting emergency 911 and mental health services as warranted; possible hospitalization for reasons of safety and further evaluation; assistance in establishing self-control, emotional self-regulation and self-processing; relational engagement; medication evaluation and proper pharmacological supervision; and an appropriate course of psychotherapy.

In closing, the words of the prophet Isaiah are comforting for all who suffer from trauma, "… Do not fear, for I have redeemed you; I have called you by name; you are Mine! When you pass through the waters, I will be with you; And through the rivers, they will not overflow you. When you walk through the fire, you will not be scorched, Nor will the flame burn you. For I am the Lord your God, the Holy One of Israel, your Savior…" (43:1-3).

Endnotes

[1] Courtois, C.A. & Ford, J.D. (2009). *Treating Complex Traumatic Stress Disorders: An Evidence-based Guide*. New York, NY: The Guilford Press.
[2] Schmid, M., Peterman, F. & Fegert, J. (2013). Developmental Trauma Disorder: Pros and Cons of Including Formal Criteria in the Psychiatric Diagnostic Systems. *BMC Psychiatry*, *13*(3), retrieved from: ncbi.nlm.nih.gov/pmc/articles/PMC3541245/.
[3] Ibid.
[4] Sherin, J.E. (2011). Post-traumatic Stress Disorder: The Neurobiological Impact of Psychological Trauma. *Dialogues in Clinical Neuroscience*, 13(3), 263-278.

Eric Scalise, Ph.D., is the Vice President for Professional Development with the American Association of Christian Counselors. He is a Licensed Professional Counselor, a Licensed Marriage & Family Therapist, the former Department Chair for Counseling Programs at Regent University in Virginia Beach, Virginia, and has more than 32 years of clinical and professional experience in the mental health field. Eric is an author, a national and international conference speaker, and frequently consults with organizations, clinicians, ministry leaders, and churches on a variety of issues.

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