CAPS EAST 2018
Regional Conference

Probing the Brain:
Clinical Insights from the World of Neuropsychology

Keynote Speaker: Freeman Chakara, PsyD

Friday-Saturday, October 26-27, 2018
Lancaster Bible College, Lancaster, PA

LANCASTER BIBLE COLLEGE
CAPITAL SEMINARY & GRADUATE SCHOOL

LANCASTER BIBLE COLLEGE
CAMPUS MAP 2017-18

1	Good Shepherd Chapel
2	Esbenshade Enrollment Mngt Cntr
3	Public Safety
4	Weber Hall*
5	Weber Hall Apartments*
6	Clemens Hall*
7	Olewine Dining Commons
8	Miller Hall
9	C3 Building
10	Sebastian Academic Center
11	Horst Athletic Center (gymnasium)
12	Peterson Hall*
13	East Hall*
14	Charles Frey Academic Center
15	Teague Learning Commons
16	Softball Field
17	Practice Field
18	Practice Field
19	Competition Field
20	Baseball Field
21	Physical Plant Building
22	Tennis Courts
23	Public Safety Building
24	Bike Path
25	President's Manse
26	Bluegrass Suite

*Residence Halls

901 Eden Road
Lancaster, Pennsylvania
Parking is free in all parking lots on campus!

Friday, October 26

2:00-3:00pm & 6:00-6:30pm Registration - Main Floor Entrance of the Teague Learning Center (TLC)

Your name tag is your "admission ticket" into all sessions. Please wear your name tag at all times. Those without name tags will be asked to produce proof of payment prior to entering sessions.

Poster set up from 2:15 – 5:15pm on the first floor of TLC

3:00-4:00pm 1-hour Breakout Sessions

F1: Brief Intelligence Testing in a Sample of Old Order Amish Adults (1 CE) TLC 302
Ryan Kuehner, PhD, Nastassja Alania, MA and Brent Johnson, MA

We administered the abbreviated version of the WASI (Vocabulary and Matrix Reasoning subtests) to an OOA sample (n=77) consisting of 50 women and 27 men from Lancaster County, Pennsylvania with an age range of 13 to 82. All participants had an 8th grade education. The OOA were also given the Digit Symbol (DS) subtest, from the WAIS-III; a measure of visual information processing speed, learning, memory, and fine motor speed and dexterity (Joy, Kaplan, & Fein, 2004; Wechsler, 2003). The FSIQ for the OOA sample had a mean (M) of 84.9 and standard deviation (SD) of 11.2 (control group FSIQ M=101.5 and SD=16.1. OOA MR scores were M=90.9 and SD=15.5 (controls M=103.5 and SD=15.8). OOA V scores were M=80.3 and SD=15.4 (controls M=97.8 and SD=20.5).DS scores and the OOA RBANS Coding (RBANS-C) subtest scores from Kuehner et al., (2016) were also compared to the current OOA sample. DS scores were not statistically significant compared to the OOA RBANS-C normative sample. Overall, visuospatial IQ results were in opposition to the well-established research pertaining to the absence of significant language effects on spatial tasks as well as findings by Kuehner et al. (2016) thus suggesting the need for more comprehensive intellectual assessment (e.g. WAIS-IV and/or WISC-V) pursuant to replication.

Learning Objective 1: Participants will be able to discuss the multifactorial influence of cognitive development.
Learning Objective 2: Participants will be able to discuss the multifactorial influence of cognitive assessment.
Learning Objective 3: Participants will be able to discuss and enhance existing views of biopsychsociospiritual uniqueness and uniformity of clients from "dominant" as well as "cultural outlier" groups**.**

F2: Value Exploration of the Counselor: A Narrative Approach (1CE) TLC 304
Deedra Mitchel, PhD

As clinicians, in addition to integrating client spirituality into sessions, we are also ethically mandated to explore our own values and beliefs and how they may affect the helping relationship (ACA, 2014). We must challenge ourselves and our supervisees to engage in self-awareness activities that expose personal values and belief systems, affirm those beliefs, and mitigate their imposition onto our clients. This process is often not a smooth one and typically leads to personal and professional value conflicts that the clinician must then resolve (Kocet & Herlihy, 2014). This presentation seeks to review the importance of value exploration; conceptualizing this requirement into three distinct tasks of value clarification, value alignment, and value expression. Attendees will then consider the use of a series of techniques borrowed from Narrative Therapy (White, 2007) to address these

three separate tasks with themselves and with supervisees. Attendees will also have an opportunity to experience the use of these techniques to explore their own value systems with presenter-led activities.

Learning Objective 1: Attendees will discuss the ethical mandate of personal value exploration and the mitigation of value imposition onto the client.
Learning Objective 2: Attendees will discuss value exploration conceptualized as separate tasks of value clarification, value alignment, and value expression.
Learning Objective 3: Attendees will identify a series of narrative techniques that aid in exploration of personal values and belief systems and the affect on clients.
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F3: Trauma-Informed Ministry: Applying Clinical Insights to Safe and Effective Care in Church Settings. (1CE)
Rochelle Grady, DA TLC 509
Trauma disturbs, disrupts and overwhelms. The sequelae of psychological trauma are broad in scope, affecting many aspects of survivors? lives. Trauma can undermine foundational beliefs and systems of meaning. For many individuals, religious faith informs their view of self, other and the world. Consequently, it is not surprising that trauma can precipitate intense spiritual struggle. Interpersonal trauma, in particular, can greatly affect a survivor's relationship with God and with their faith community. People of faith will often seek support from their faith communities before turning to professional counseling services. Support from a faith community can facilitate healing and promote growth. However, uninformed intervention can inadvertently cause harm. Churches and ministries that desire to support trauma survivors require education and training. Trauma-informed ministry incorporates clinical knowledge regarding the impact of trauma and safe trauma treatment into outreach to survivors. Equipped clinicians are well positioned to partner with communities of faith to develop safe and effective trauma-informed ministries.

Learning Objective 1: Describe the impact of interpersonal trauma.
Learning Objective 2: List the basic tenets of safe trauma treatment.
Learning Objective 3: Apply knowledge of trauma and trauma treatment to ministry in church settings.

4:15-5:15pm 1-hour Breakout Sessions

F4: Healing the Trauma Brain using Gospel-Centered Psychotherapy: A Redemptive Experiential Approach (1CE) Angela Fung, MA, Lauren Gilbert, MA and Paul Loosemore, MA TLC 302
According to Keller (2010), people were created with a longing for significance and inherent needs that were once fulfilled in the Garden of Eden. These include the need for control, power, approval, and comfort (Keller, 2010). However, the Fall was the first trauma of separation and shame resulting in a universally broken view of self, others, and God. Although psychology can identify and explain pathological symptoms of mankind, it is only the gospel that can address the broken view of self and transform the command center of the human heart. (Redeemer Counseling Services, 2015). Stroope, Draper, & Whitehead (2012) revealed that attachment to a secure base, such as the image of a loving God, promotes mental health. However, not every Christian experiences security in his relationship with God (David, Mauch, & Moriarty, 2013). Individuals who have suffered attachment injuries from parents and authority figures, may transfer their mistrust of caretakers towards God. This results in the need to take matters into their own hands, attempting to redeem themselves from the wounds of trauma. This personal strategy further distances the individual from God, creating an intensified feeling of abandonment and loneliness. Redemptive Experiential Therapy (RET), a gospel-centered psychotherapy created by Redeemer Counseling Services, guides the client to experience Christ amid past

trauma, addressing root wounds through healing attachment injuries. This seminar will explore the dynamic interaction between different brain functions and how this relates to symptoms and the biblical narrative. This will culminate in applying the core concepts of RET to the practical interventions used in the experiential developmental trauma work of EMDR and IFS. We will describe how discerning counselors can integrate the truth of the biblical narrative with effective trauma interventions to shift client's fractured viewpoints and overcome the disruption of shame through building an experiential secure attachment to God**.**

Learning Objective 1: Participants will describe the impact of trauma on the brain.
Learning Objective 2: Participants will analyze the biblical narrative with trauma's impact.
Learning Objective 3: Participants will utilize trauma interventions that include Christ in the healing of the brain.

F5: A Re-examination of Depression, Mania and Suffering: Case Studies in the Productivity of Suffering (1CE)
Rodney White, PhD **TLC 304**

Popular media has long questioned the goals of mental health providers and defended the "genius" that is often repressed in those who suffer. In the play "Equus" a psychiatrist discovers worship. In "One Flew over the Cuckoos Nest" the inmates rediscover their freedom. "Silver Lining Playbook" sums up the themes: the dividing line between what's considered normal and what's not can be difficult to discern. Recent brain and gene research has verified what artists claimed long before. For instance: in the last decade a gene, neuregulin 1, was identified as a feature in the lives of "geniuses" and explains some of their destructive behavior. This gene plays a role in brain development and is also associated with mental illnesses like schizophrenia and bipolar disorder (Keri 2009). Christian practitioners walk a fine line between dismissing their clients' spirituality as a manifestation of unconscious, possibly maladaptive, behavior or accepting it without question and colluding with unhealthy denial or unexamined habits. The challenge such clinicians face can be seen when they look back at notable figures from the past through the lens of current therapeutic practices. The spiritual genius can be dismissed as ignorant and mentally ill or accepted as holy, without question. But what if there is a third way? Recent research literature discusses variations and possible implications. This presentation applies this literature to the cases of three notable women from the lists of Christian heroes, who each demonstrate the kinds of psychological problems a clinician might treat. Clinical implications will be examined in the seminar.

Learning Objective 1: Examine recent literature related to the intersection of mania, depression, suffering and brain science
Learning Objective 2: Discuss the findings of brain science and neurotheology with implications for clinical practice
Learning Objective 3: Compare the popular teaching of recent media and hagiography with recent scientific discovery and common best practices in psychotherapy in order to create a deeper approach to creative but troubled clients

F6: Herpes Virus 2 and Personality (1CE) **TLC 509**
Ryan Kuehner, PhD and Dan Jensen, MA

We examined the relationship between Herpes Simplex Virus 2 (HSV-2) and personality using the Temperament and Character Inventory (TCI) in 1000 German participants. Associations between HSV-2 and TCI components were observed and findings suggested HSV-2 positivity was associated with certain personality dimensions of the TCI. In addition, we found sex-specific associations between HSV-2 positivity and TCI personality dimensions. Results raised the bidirectional question of whether HSV-2 seropositivity influences TCI personality dimensions or if TCI personality dimensions influence the contraction of HSV-2.

Learning Objective 1: Participants will be able to discuss research-based personality patterns

Learning Objective 2: Participants will be able to compare scholarly literature concerning disease pathology and behavioral impact
Learning Objective 3: Participants will be able to identify how existing personally held beliefs impact how they view and treat their clients.

5:30-6:30pm Breakout Sessions

F7: Suicide Assessment and Prevention (1CE) **TLC 302**
Gwen White, PsyD and Ingrid Swanson Bretschger, LCSW
This presentation explores the ethical responsibility that mental health professions have to identify risk factors, warning signs, and appropriate treatment planning in relating to clients who present with a suicidal crisis. It includes a summary of the literature on suicidal assessment, prevention, and treatment with a thorough consideration of preventative factors, including the use of spirituality/and religion as a preventative factor in appropriate cases (Dazzi, Gribble, Wessely, & Fear, 2014; Perez et al, 2005; Praag, 2009; Salgado, 2014). A discussion of when not to expand on religion in treatment is also included. The concept of "moral injury" (Worthington & Langberg, 2018) and it's possible theoretical relationship to suicidal crisis will also be considered and discussed.

Learning Objective 1: Discuss prevalence of suicide and describe protective and risk factors and warning signs in clinical settings.
Learning Objective 2: Outline ethical and legal implications in dealing with suicidal clients.
Learning Objective 3: Identify positive aspects of spirituality as a protective factor for some clients and discuss treatment intervention strategies.

F8: Grace Salience and Forgiveness (1CE) **TLC 304**
Rodney Bassett, PhD
This project involved experimentally manipulating grace salience to determine the effect upon forgiveness. There were several reasons for predicting that grace salience might encourage forgiveness. Emmons, Hill, Barrett, and Kapic (2017) noted that grace and forgiveness share a common element of being unmerited. Patrick, Beckenbach, Sells, and Reardon (2012) suggested that acts of grace may include empathy, trust, and forgiveness. And then, the REACH model of forgiveness (Worthington, 2003) conceptualizes granting forgiveness as extending an altruistic gift of forgiveness to the transgressor. Certainly, grace seems to be inherently altruistic. However, it may be that grace salience could also affect other constructs. Bassett and Aubé (2013a, 2013b) pointed out that the motivation for self-sacrifice can be altruistic (UC-other) or egoistic (UC-self). Divine grace and UC-other both seem to share a common concern for the well-being of people. Divine grace involves the extending of unmerited favor to those who receive it. Similarly, UC-other involves benevolent self-sacrifice for those who receive it. So, would enhanced grace salience incline someone toward UC-other relational motivation? It was predicted, it would. Participants were recruited from friends, family, and co-workers of the researchers and were randomly assigned to the control or grace salience conditions. Grace salience did not affect self-sacrifice and decisional forgiveness. However, grace salience did increase tendencies toward emotional forgiveness.

Learning Objective 1: Participants will be able to describe procedures for manipulating grace salience.
Learning Objective 2: Participants will be able to describe procedures for assessing self-sacrifice.
Learning Objective 3: Participants will be able to discuss the relationship between grace salience and forgiveness.

F9: Ethically Incorporating Spirituality in Therapy (1CE) **TLC 509**
Kristen Poppa, PhD

When reviewing the literature on spirituality in therapy, two common themes that emerge are that more clinical training is needed and that spirituality often goes unaddressed in therapy (Aten & Worthington, 2009; Carlson & Gonzalez-Prendes, 2016; Carson, McGeorge, & Anderson, 2011). Addressing spirituality in therapy is just one aspect of a holistic assessment but it must be done in a way that is ethically appropriate. One example of this is the spiritual genogram (Limb, Hodge, Ward, Ferrell, & Alboroto, 2018; Wiggins Frame, 2000). Numerous training programs offer instruction on the use of genograms in therapy, but the emphasis is on a standard genogram. While there might be exposure to a topically focused genogram, such as a spiritual genogram, students and clinicians must make inferences on the ethically appropriate use of a spiritual genogram based on their general genogram education. Since more training is needed so that clinicians are competent to incorporate spirituality, this seminar explores how to do so through suggestions from the literature and a clinical case study.

Learning Objective 1: Summarize the current literature on ethically incorporating spirituality in therapy.
Learning Objective 2: Analyze and discuss a clinical case study where spirituality was utilized in therapy.
Learning Objective 3: Identify two spiritual interventions that clinicians can use to offer ethically appropriate services to clients.

6:30 p.m. Welcome and Conference Dinner TLC, 4th Floor

7:30-8:30 p.m. Introductions and Plenary Session TLC, 4th Floor

Keynote Speaker: Freeman Chakara, Psy.D.

F10: Function & Dysfunction: Appreciating the Brain's role in Clinical Work, part 1 (1 CE)

Our work with clients is predicated on unstated assumptions about brain function and dysfunction. We will explore the interactions between the brain's development and the settings in which this organ matures, all toward formulating ways of evaluating and assisting those in our care. We will analyze the role of so-called executive functions and expectations for helping our clients and facilitate scientifically robust and theologically informed integrative engagement. The current presentation examines executive functioning and multifactorial causality. In addition to basic operational definitions of these concepts, attendees will be apprised of the current literature on these constructs, all toward enhancing clinical diagnoses, treatment planning, and managing difficult patients. The presenter will also reflect on theological implications for spiritually informed treatment. Examples will be borrowed from clinical, forensic, and sports neuropsychological assessment with ample opportunities for application to other treatment contexts. The presenter will provide illustrative material that integrates developmental, clinical, and theological themes in a manner that accents the benefits of a full orbed approach to ethically informed clinical care for our clients.

Learning Objective 1: Outline a simple model of brain functioning
Learning Objective 2: Delineate the significance of executive functions
Learning Objective 3: Examine the complexity of multi-causality in clinical formulation / attribution

8:30-9:30pm Dessert Buffet and Poster Session TLC, 1st Floor

Saturday, October 27

8:30-9:00am Registration - Main Floor Entrance of the Teague Learning Center (TLC)

Your name tag is your "admission ticket" into all sessions. Please wear your name tag at all times. Those without name tags will be asked to produce proof of payment prior to entering sessions.
Coffee/tea available

9:00-10:00am 1-hour Breakout Sessions

S1: Neurological Considerations & Multicultural Engagement Related to Trauma (1 CE) TLC 302
Vickey Maclin, PsyD and Casey Bowden, MA
Counselors, pastoral counselors, social workers and psychologists who work with clients who have encountered negative racially motivated behaviors, from people in society, are considering new ways of engaging with these individuals therapeutically. In the past, mental health professionals have not consistently given thought to how negative treatment and threats have psychologically affected underserved populations of people. Therapists now desire to take steps to demonstrate multiculturally sensitive approaches to assist people from diverse backgrounds who have faced traumatic encounters. Mental health professionals need to increase their understanding of individuals experiencing trauma and consider new ways of engaging with these individuals therapeutically. There should be a desire on the part of those in the mental health field to take steps to demonstrate sensitivity to those who deal with traumatic events. The clinicians are recognizing the many diverse clients are experiencing trauma on several different fronts as it relates to the client's social class, ethnicity, race, sexual orientation, religion, immigrant status gender discrimination, prejudice and varying disabilities. The awareness, on the part of the mental health professional, should include how the brain responds to differing levels of trauma and stress. Having this knowledge is a basis for counselors, pastoral counselors, social workers and psychologists to apply to their practice skills that would not disregard the negative effects of traumatic encounters that individuals face. When mental health professionals learn to embrace the client's experience, and consider how the brain may be changed from the experience, they can then take cautious multiculturally sensitive steps in assisting the client. Additionally the treatment interventions will also be important in the considerations of treating the client from a multicultural perspective.

Learning Objective 1: Participants will be able to identify at least 3 traumatic events that different multiculturally diverse populations of people face that can result in traumatic responses.
Learning Objective 2: Participants will be able to compare and contrast brain responses of multiculturally diverse groups of people who encounter trauma and those who experience a TBI.
Learning Objective 3: Participants will be able to examine multiculturally sensitive clinical approaches that have been found to be efficacious in treating traumatic experiences for those who are from multiculturally diverse populations.

S2: Heritability Estimates for Major Depressive Disorder in an Old Order Amish Sample (1 CE) TLC 304
Ryan Kuehner, PhD
The current study sought to further knowledge on MDD by analyzing features of this illness and degree of heritability using the Structure Clinical Interview for the DSM-V Research Version (SCID-V-RV), Beck Depression

Inventory - 2nd Edition (BDI-II), and the Maryland Trait and State Depression Scale (MTSD) in an Old Order Amish (OOA) sample (n=279). Results were as follows: A PPC was determined between BDI-II scores of unaffected OOA and OOA with MDD; r= -0.123). PPCs were also calculated between the state and trait scores of the MTSD between unaffected and OOA with MDD (r=0.399 and r=0.0386, respectively). PPCs were then calculated between two sets of groups: BDI-II scores for unaffected OOA and MTSD state and trait scores for the OOA with MDD (r= -0.061, r= -0.079, respectively); and MTSD state and trait scores for unaffected OOA and BDI-II scores for the OOA with MDD (r=0.137, r=0.121, respectively). The PPCs were also calculated between the BDI-II scores of OOA with MDD and the MTSD scores (state and trait) of OOA with MDD (r=0.609 and r=.166 respectively). The MTSD scores, state and trait, of OOA with MDD were also compared using the PPCC (r=.376). When OOA scores on the BDI-II were compared to the scores of a non-OOA population sample, there was a striking difference within average scores. In studying 278 college students, Sashidharan, Pawlow, and Pettibone (2012) found the average score on the BDI-II was much higher than the average score of OOA people ($\mu 1 = 9.41$ versus $\mu 2 = 5.41$). Yet another study reported the average BDI-II score of 120 college students to be significantly higher than the OOA average scores ($\mu=12.6$; Sprinkle et al. 2002). The severity state depression measures were (moderate and positively) associated with the BDI scores (r = 0.609). Since both the BDI-II and MTSD State measure current depressive symptoms we expected a correlation between these two; yet we found only a nonsignificant correlation between MTSD State and Trait scores (r = 0.376). Perhaps this could be due to the fact that both measure depressive symptoms at different points in life. This could mean that a person does not have to show signs of depression throughout their life to be depressed in the present, and vice versa. We think that participants who scored high on the trait part of the test did not have to necessarily score high on the state part of the test. As well, participants that scored low on the trait part did not have to score high on the state part of the test. Results showed that the BDI-II scores for the OOA were averaging lower scores than non-OOA, possibly owing to stark cultural differences. It is well known that the suppression or minimization of feelings is common in the OOA. Secondly, the BDI-II may not be a clinically sensitive measure of depression in this population. Additionally, simply being a part of the OOA culture naturally lowers depressive symptoms. More studies would be needed to confirm any of these theories. In sum, our results showed a non-significant correlation between BDI depressed OOA and healthy OOA (r= -0.123). There was a weak correlation between the MTSD state depressed OOA and unaffected OOA ((r=0.399)). Additionally, there was no relationship between MTSD trait depressed OOA and unaffected OOA (r=0.0386). Further, there was no relationship between BDI unaffected OOA and MTSD state and trait depressed OOA scores (r= -0.061, r= -0.079, respectively). Lastly, there was no relationship between MTSD state and trait unaffected OOA score with BDI depressed OOA scores (r=0.137, r=0.121, respectively).

Learning Objective 1: Participants will be able to identify genetic and environmental factors associated with heritability for Major Depressive Disorder in the Old Order Amish.
Learning Objective 2: Participants will be able to identify the degree of diagnostic sensitivity for both the BDI-II and MTSD in relation to the SCID-V findings.
Learning Objective 3: Participants will be able to discuss both the universality and relativism of mental illness susceptibility, assessment, and treatment.

S3: Ethical Considerations of Relatedness, Autonomy and Multiculturalism in Clinical Practice (1 CE) TLC 509
Gwen White, PsyD, Akua Opoku-Boateng, MS, Algernon Baker, PhD, Rod White, PhD, Rachael Kerns-Wetherington, PsyD, and Jo Saba, MA
This seminar and panel discussion focuses on the contrasting needs of autonomy and relatedness in clients, particularly in a Christian context where cross-cultural considerations emerge. Ethical and practical applications are discussed with a panel of Christian practitioners offering case study material for further exploration of the implications for ethical practice.

Learning Objective 1: Summarize ethical concerns related to autonomy and its high regard in the development of psychological practices.
Learning Objective 2: Analyze ethical dilemmas and the problems practitioners face when working with the contrasting needs of autonomy and relatedness, particularly in cross-cultural settings.
Learning Objective 3: Evaluate and apply practical solutions to ethical predicaments associated with issues of autonomy in setting psychotherapy

10:15-11:30am Plenary Session TLC, 4th Floor

Introduction with Contemplative Worship

Keynote Speaker: Freeman Chakara, Psy.D.

S4: Function & Dysfunction: Appreciating the Brain's role in Clinical Work, part 2 (1 CE)

This second presentation continues our examination of executive functioning and multifactorial causality in brain function and development. Further analysis of current literature on these constructs is offered. An emphasis on attendees enriching their abilities in clinical diagnoses, treatment planning, and managing difficult clients is included, with multiple examples from clinical, forensic, and sports neuropsychological assessments and a discussion of implications for clinical application. The presenter will provide illustrative material that integrates developmental, clinical, and theological themes in a manner that accents the benefits of a full orbed approach to ethically informed clinical care for our clients.

Learning Objective 1: Delineate and explore multi-causality in clinical formulation / attribution
Learning Objective 2: Examine elements of concussion relative to clinical practice
Learning Objective 3: Analyze an ethically sound, spiritually sensitive approach to helping relationships

11:30am-1:00pm Lunch on your own

There are numerous restaurants close to LBC.

1:00-2:00pm 1-hour Breakout Sessions

S5: Clinical and Ethical Issues in Working with Highly Religious Couples in Therapy (1 CE) TLC 302
Cassie Hall, BA, Jennifer Ripley, PhD and Elizabeth Loewer, BA

The aim of this presentation will be to discuss the research on religious couples, including ethical concerns regarding working with religious couples, and clinical strategies for addressing religion in couples treatment. Many couples seek Christian or religious couples therapy (Ripley, Worthington R., Davis, Leon, Berry, Smith, Atkinson, & Sierra, 2014). Previous research has identified four central themes that commonly distinguishes Christian couple therapy from standard couple therapy (Ripley & Worthington, 1998). Themes are surmised as marriage is a covenant rather than a contract; the Holy Spirit as an agent of change; troubles exist in relationships due to partners (humans) being sinful; and a connection exists between spiritual and couple relationship (Hook, Ripley, Worthington, & Davis, 2011). Notably, limited research and insufficient empirical on Christian couple therapy has posed ethical concerns (Hook et al., 2011). In recent research, religious-accommodative couple therapy was examined and results indicated there was no difference for outcomes of religious versus standard couples therapy (Ripley et al., 2014). While there appears to be no difference in couple outcomes, meta-analytic research suggests individuals may experience improved individual religious outcomes

(Worthington, Hook, Davis, McDaniel, 2011a). Therefore, further discussion and research is needed to understand the potential religious implications of religious-accommodative couple therapy.

Learning Objective 1: Describe current research on the topic of Christian couple therapy.
Learning Objective 2: Examine future directions in Christian couple therapy research focused on religious outcomes.
Learning Objective 3: Evaluate ethical considerations in providing religious-accommodative couple therapy

S6: Receiving through Giving: A Case Study in Exoneration (1 CE) TLC 304
Janet Stauffer, PhD
We become who we are through relationships with others. The question of how I give and to whom cannot exist without consideration of what I receive and from whom. One of the gifts of Contextual Theory is the recognition that giving and receiving are deeply embedded in one another. When I genuinely give to another, I also receive merit and grow as a person. When I receive from another with gratitude, I confirm them in their personhood. Life is stymied when the dynamic flow of giving and receiving between members of a family across generations is blocked. The binding pattern of mistrust and hurt is broken as the therapist opens the possibility of relational vitality through new pathways of receiving through giving and giving through receiving in relationship. Video clips of Jenna exonerating her deceased mother will demonstrate the actions of self delineation with due consideration that facilitates reworking loyalty dynamics through exoneration. Finding words to name her childhood pain opens space to ethically imagine the life her mother lived and to explore the meaning of mother's context. Moving beyond a static notion of her mother's failures and her own impotence, Jenna feels she "met" her mother for the first time. Jenna exhibited new freedom and life vitality in her current relationships. As therapists, our family legacy and relational practices deeply influence how we invite clients to turn and face, to give and receive more freely with other members of their family. The dynamic process of giving and receiving generates trustworthiness, laying a foundation for the next generation that flows into the future.

Learning Objective 1: Explain how giving is embedded in receiving and receiving in giving.
Learning Objective 2: Observe demonstration of the process of exoneration.
Learning Objective 3: Delineate three components of exoneration.

S7: Adverse Childhood Experiences – Where Do We Go From Here? (1 CE) TLC 509
Tracy Defina, MA and Cheryl Sparks, PhD
Since Felliti and Anda's 1998 study on adverse childhood experiences (ACEs) and the long term ill health associated with them, the research has exploded (cf. Sciaraffa, M. A., Zeanah, P. D., & Zeanah, C. H., 2018). Our understanding of childhood abuse, neglect and trauma and the mental and physical effects on children as they grow into adults is well-documented. Currently, the literature focuses on the question of where we go from here, and on finding solutions to mitigate the effects and to offer healing to those with a history of abuse. Several approaches will be discussed: understanding toxic stress to better provide services through mental health providers, teachers and parents, including the screening process and resources. Another area of focus is the link to poverty and socioeconomic factors. While not widely accepted as an ACE, research shows that poverty increases the risk of the effects of the ACEs (Braveman et al, 2017). Lastly, we will look at the roles of spirituality, the value of having a consistent, supportive person, and specific individual capacities as protective factors for people with high ACE scores.

Learning Objective 1: Demonstrate understanding of ACEs and the screening too.
Learning Objective 2: Identify 3 potentially protective factors.
Learning Objective 3: Discuss opportunities for building resiliency in our clients.

2:15-3:15pm 1-hour Breakout Sessions

S9: The Impact of Attachment Style on Black Heterosexual Women in Romantic Relationships TLC 302 (1CE) Roslyn Still, PhD

This presentation is designed to explore the impact of a secure or insecure (anxious or avoidant) attachment style on Black heterosexual women's romantic relationships. Research suggests that the historical reality of slavery has initiated intergenerational transmission of attachment trauma which persists within the Black community. This experience of Post Traumatic Slave Syndrome contributes to high rates of insecure attachment within the Black community, and it influences the ways romantic attachment bonds are formed and sustained. Additionally, dynamics such as high rates of Black male incarceration, partner infidelity, and distrust between Black men and women contribute to the expectations that Black heterosexual women have of romantic relationships. By understanding their romantic attachment style and recognizing when their attachment anxiety is activated, Black women are better positioned to navigate the challenges of romantic relationships. They are also empowered to choose how they will be as romantic partners and increase their likelihood of experiencing the romantic relationships that they desire. Furthermore, clinicians who understand the ecological influences that have contributed to the development and maintenance of attachment styles can help Black women understand and address the stigma and shame that they have internalized. Additionally, clinicians will be positioned to be a secure base, thereby increasing the effectiveness of their insight and recommendations when clients—individually or as a couple—seek help. This presentation will outline ways for to develop a collaborative therapeutic/counseling relationship which will serve as a conduit for healing attachment wounds and increasing satisfaction around romantic relationships.

Learning Objective 1: Attendees will be able to identify the internalized views of Self and Others which contribute to Black heterosexual women`s experiences in romantic relationships.
Learning Objective 2: Attendees will be equipped to conceptualize Black heterosexual women`s realities in romantic relationships in ways that are supported by the historical and contemporary trauma that this population has experienced.
Learning Objective 3: Attendees will be prepared to apply strategies for building collaborative therapeutic relationships with Black heterosexual women.

S10: Theological Narratives in Rumor: A Christian Psychology Perspective (1CE) TLC 304 Nicholas DiFonzo, Ph.D.

Modern persons swim in a sea of rumor, gossip, innuendo, fake news, and conspiracy theories. Defined by modern psychology as unsubstantiated information in circulation, rumor is brother to gossip (evaluative social chat) and conspiracy theories (rumors about secret, powerful and malevolent groups). This presentation draws upon a Christian Psychological understanding of rumor as "spiritually-dimensioned unsubstantiated shared stories within theological narratives that we embrace or reject." It focuses on how rumors draw their meaning and power from theological narratives, which communicate ideas about God and his relations with the world (e.g., "God judges harshly" vs. "God judges generously"). Theologically resonant rumors may strongly affect psychological well-being and interpersonal relationships. Practical implications are explored for Christians encountering rumor, Christians in ministry and the helping professions, and Christian Psychology researchers.

Learning Objective 1: Identify ways that rumors may affect psychological well-being and interpersonal relationships.
Learning Objective 2: Discuss the motivational underpinnings of people who believe in conspiracy theories and rumors.

Learning Objective 3: Explore clinical ways of helping persons overwhelmed with conspiracist thinking and rumors.

S11: African-American Pastoral Couples and Their Engagement of Psychotherapy (1 CE) TLC 509
Algernon Baker, PhD

African-American pastors and their spouses are esteemed leaders in their congregations and in the African-American community. Currently, there is a dearth of available research on African-American pastors and their help-seeking practices. The deficit increases with regard to African-American pastoral couples (AASPCs) and their help-seeking practices. Previous research related to this influential population has either focused only on clergy or pastors to the exclusion of pastors' spouses. This qualitative study used the transcendental phenomenological method to uncover the lived experience of the factors related to AASPCs' engagement of psychotherapy. Semi-structured joint interviews were conducted with eight African-American senior pastoral couples. Their responses were analyzed and four common themes emerged from the data. They are: (1) psychological and relationship distress (2) use of spiritual disciplines (3) demonstrating transparency, and (4) need for competent therapists. The analysis of the data resulted in a common description of the essence of the pastoral couples' lived experience. Most AASPCs seek psychotherapy when psychological and relationship distress present in ways that AASPCs perceive to exceed the purview of their spiritual disciplines. The most common psychological/relationship factor among AASPCs who utilize psychological services is church-related stress. Social and self-stigma are a threatening reality to the AASPCs' help-seeking attitudes and those who attend psychotherapy do so despite the presence of stigma. While they prefer not to disclose specific symptoms, the couples affirm their willingness to reveal their psychological help-seeking behaviors to colleagues or congregants. AASPCs have a strong preference for seeing a Christian therapist. Additionally, the African-American racial identity of the therapist is meaningful, albeit less significant than the therapists' religious identity. Marriage and family therapists and professional counselors should note that the perception of competent therapists by AASPCs includes both the religious and racial identity of the therapist.

Learning Objective 1: Identify the factors that facilitate or deter AASPCs' engagement of psychotherapy.
Learning Objective 2: Discuss African-American Pastoral Couples` preference for African American Christian Therapists and the clinical implications.
Learning Objective 3: Analyze African-American Pastoral Couples` issues of cultural mistrust of colleagues and congregants

Questions and comments related to the program can be sent to Gwen White at gwhite@eastern.edu

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