DIVISION 56
TRAUMA PSYCHOLOGY
AMERICAN PSYCHOLOGICAL ASSOCIATION

NEWS

Considering trauma care as integral to healthcare

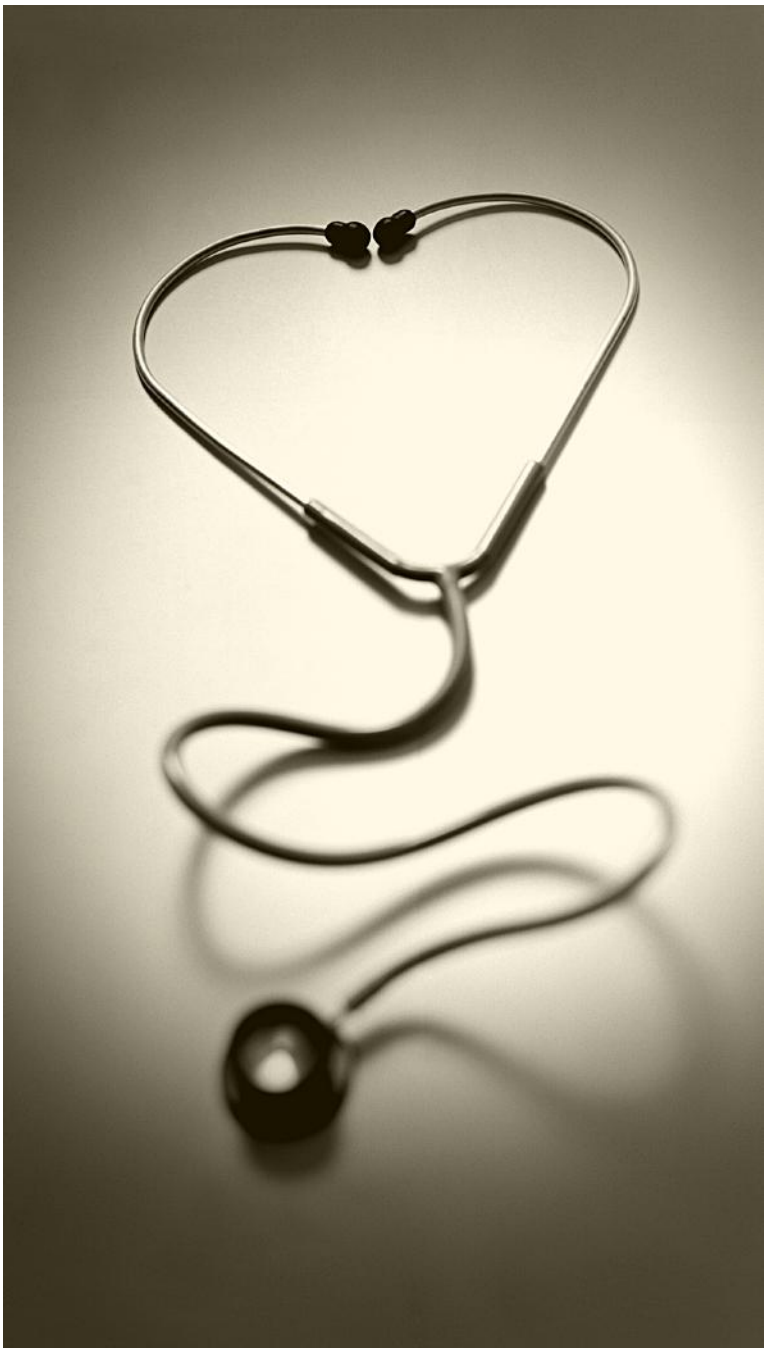
in this issue...

COVER ART
LIGHT PREVAILS
BY: MEGAN MAURILLO

CONTENTS

SPRING 2022 | VOL. 17, ISSUE 1

Considering trauma care as integral to healthcare



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EDITORIAL NOTE

Dear *TPN* friends,

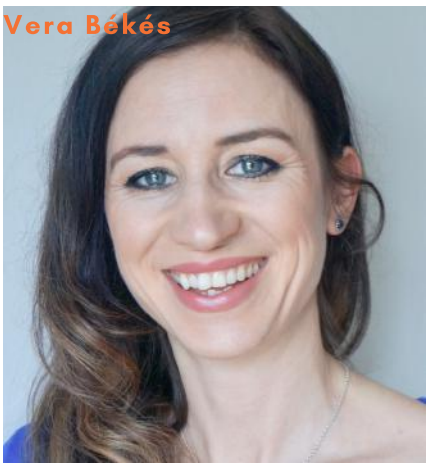
THE EDITORIAL TEAM & I WISH YOU A KIND WELCOME to the *Trauma Psychology News* Spring 2022 issue.

As the two-year mark of the ongoing pandemic passes, we now face a confluence of wars raging across many fronts. The intersection of trauma and health is undeniable. And so, we welcome the re-emergence of our Trauma & Health section. We further welcome Sydney Timmer-Murillo, PhD, the section's inaugural editor, as well as Sharon Y. Lee, PhD, our lead copy editor. With our growing editorial team, we invite you into this issue's theme: **Considering trauma care as integral to healthcare**.

Turning to the content of this Spring issue, we first full-heartedly acknowledge the suffering in Ukraine (**p. 5**), from adults to children, present and future (**p. 22**). We then contemplate the idea of trauma and health as foundations to the human condition (**p. 8**). These psychological wounds are felt by hospital frontline workers (**p. 28**), trafficking survivors entering a hospital system (**p. 36**), Veterans with multiple sclerosis (**p. 20**), and others seen and unseen. May we allow our hearts to grow, in health and in connection with one another, so that we may see ourselves in each other. Megan Maurillo's cover art beckons us, reminding us that *light prevails.*

THANK YOU FOR READING THIS LETTER, for choosing to engage in these words at this time. I look forward to the opportunity to hear, share, and honor your stories in our co-created *TPN* space.

VIANN N. NGUYEN-FENG
Editor-in-Chief



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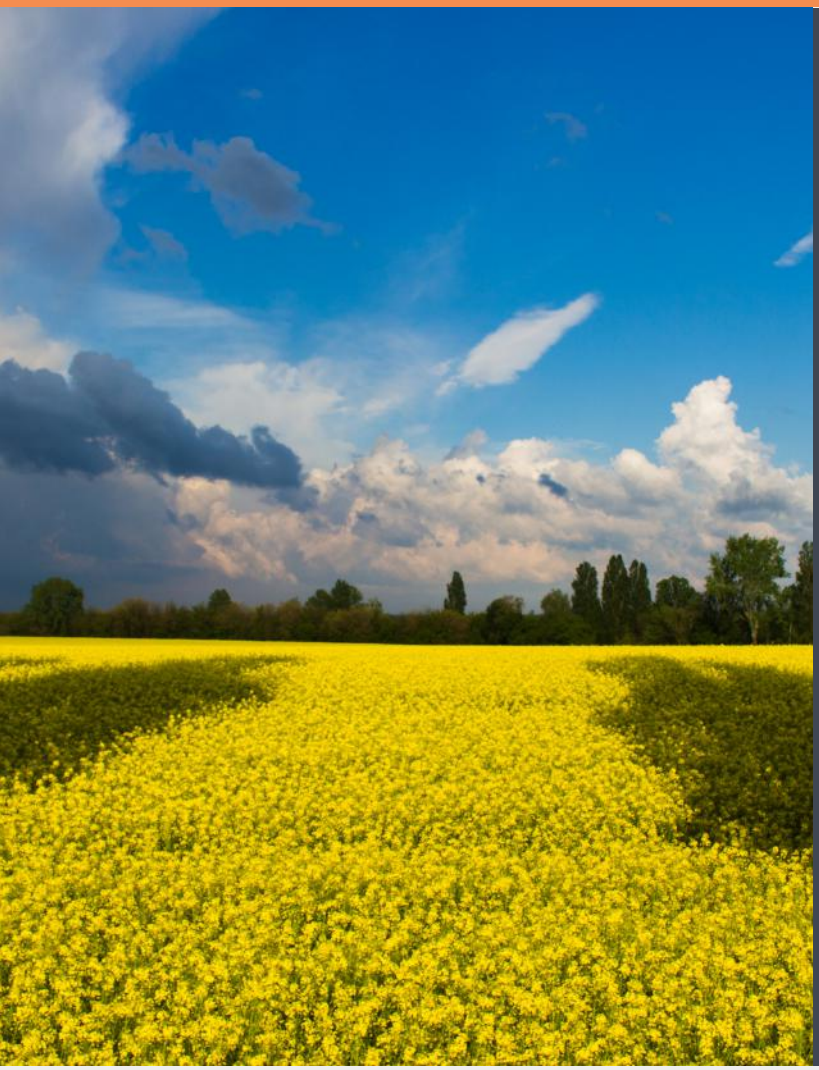
STATEMENT ON UKRAINE

We would like to acknowledge, honor, and hold space for the onslaught of human suffering and oppression happening in Ukraine.

Ukrainian land and its People are being usurped by abusers of power. And human life has, yet again, become an expendable commodity at the hands of tyranny and autocracy.



We acknowledge and stand by Ukrainians' long battle for identity, autonomy, and self-determination. And we honor the many nations, territories, and communities around the world that are still fighting for sovereignty, independence, and liberation.

We also acknowledge the tragic consequences of other wars that happen, and are still happening, every day around the world. Wars that we don't "see" or hear about in the media, such as the humanitarian crises in Yemen, Syria, Myanmar, and Ethiopia, just to name a few. Wars that represent long standing experiences of systemic oppression, victimization, and marginalization; and are the constant reality of so many vulnerable and persecuted individuals and groups of people around the globe, who witness the lives of others being prioritized over their own on a daily basis.

May we continue our joint efforts as an interdisciplinary community of researchers, clinicians, educators, and public policy advocates to center the human experiences of trauma and oppression —as well as the subsequent impacts on communities, relationships, and health and human welfare.

And may this collective space continue to act as a forum for professional and public education that supports a healing environment of collaboration, questioning, and truth-telling, with you, *TPN*'s esteemed readership.

Written by Emily Lapolice & Leila Johnson of *We The Mindful*

PRESIDENT'S COLUMN

Lisa M. Rocchio, PhD

DEAR DIVISION 56 MEMBERS,

Let me start by saying that It is a privilege to have been a member of this division since its inception, and I am honored to serve in the role of president. I especially would like to thank Tyson Bailey, our immediate past president, and Dawn Hughes, our president-elect for their hard work and leadership. I am also thrilled to announce that one of our active members, Thema Bryant-Davis is the APA president-elect, and her initiatives include Healing Trauma and Loss, Spirituality, and Addressing Inequities and Oppression. Congratulations Thema! We are here to support your efforts.

Over the course of the past several years, we have been reminded again and again of the importance of trauma psychology as we experience the repeated impact of collective trauma, which as is so often the case, has a negative and differential impact on our most vulnerable and marginalized communities. We remain in the midst of a pandemic that has taken, and continues to take, so many lives worldwide; we are living in a time where there has been a marked increase in hate crimes of all types; we are bearing witness to the horrors of war and the targeting of refugees and immigrants; legislation and policy specifically targeting members of the LGBTQ communities, their families and health care providers; reproductive freedom; voting rights; and the impact of unprecedented climate change. And this isn't even a complete list! These, and numerous other experiences of collective and societal trauma point to the ever-growing need for practice, research, policy, training, and advocacy in trauma psychology, as well as recognition of Trauma Psychology as a specialty area within psychology.

I want to inform you of a number of important and exciting initiatives that division members are working on at this time. Organizationally, our division is committed to making necessary changes to make it welcoming, inclusive, and accessible to all. To achieve this important goal, in 2021, we retained the consulting firm of Dailey Innovations to work with us toward our goals of addressing diversity, equity, and inclusion and creating systemic change in our structure, governance and activities. I thank Ayli Carrero Pinedo who is chairing the I-DARE task force and those of you who have participated in surveys and focus groups. I hope you will continue to provide feedback and contribute to making systemic change in our structure, governance, and activities. Our Cultivating Healing, Advocacy, Nonviolence, Growth, and Equity (Change) grant has now been fully funded and transferred to the American Psychological Foundation (APF) who will be managing our funds and awarding these Division 56 grants on an annual basis, in addition to our other two division 56 grants (The Trauma Psychology Grant and the Christine Blasey Ford grant) in perpetuity.

Sylvia Marotta-Walters and the Commission for the Recognition of Specialties and Subspecialties in Professional Psychology (CRSSPP) task force have completed the application for a trauma specialty and submitted to APA; Christine Courtois and Paul Frewen (former chair of our practice committee) have completed the complex trauma professional practice guidelines, and they have passed APA review and gone through a 60-day period for public comment. Those comments will be responded to and addressed in the final document. The guideline should be presented to the Council of Representatives at their next meeting. Elizabeth Carll has continued as chair of our International Committee and she and Melissa Brymer, chair of our Disaster Response Committee, are working to find ways to support our Ukranian colleagues and refugees and to respond to the refugee crisis in a culturally sensitive manner. Elizabeth has also continued leading the Refugee Mental Health Network, which provides free training and resources for working with refugees. Melissa and her committee will also be working to address the impact of the marked increase in hate crimes across our country. Our journal has continued to thrive under the leadership of Kathy Kendall-Tackett and her editorial team, and our revenue and impact factor have both continued to rise. Our division is in a strong financial position under the stewardship of our Treasurer, Barbara Niles, and we have been able to invest a significant amount of money in a long term investment account. I have recently announced the formation of a Presidential Task Force focused on Memory and Trauma that will produce a white paper about the most recent science and knowledge in the field. It is my hope that by bringing together researchers and practitioners with expertise in the area of memory, we can help to disseminate accurate information and dispel the numerous harmful myths about memory that have made their way into our textbooks, legal system, and training programs.

Finally, and after 2 years of covid isolation, I am excited that APA is holding an in-person convention, and am enthusiastic about our broad and diverse programming in Minneapolis. This year's theme is interpersonal violence across the lifespan – stay tuned for an announcement of our full program, our suite programming, and our invited speaker. We will be hosting a social hour where we will be announcing our award winners and new fellows, and will have time to mingle, talk, and get to know each other. Please plan to attend, and bring a friend! Mary Alice Mills, our new Awards Chair, has sent out a call for nominations for our awards, and you can also find the call on our website. Please consider nominating a colleague. At the convention, we are planning to hold many events in our hospitality suite, where we can hold smaller and more intimate gatherings to talk and share about these important programs, topics of interest, and learn from and get to know each other, and of course, have a little fun! Thanks to our program chair Jessica Punzo for all of her hard work not only as program chair, but as our newly elected ECP representative.

Thank you again for electing me to serve. I am available and happy to receive your questions and concerns so and please reach out to me personally. I encourage all of you to become active in our division and to encourage colleagues to join. The more of us who become involved, the larger and more diverse our organization becomes, the more we can accomplish together. Our website apatraumadivision.org is a great resource, and on it you will find information about division activities and committees. Please reach out to a committee chair, to me, or to any member of our executive committee to express your interest and see how to become more involved. It would not be an understatement to say that I have found my years of participation in the leadership of our division to be one of my most valuable professional activities, and I see Division 56 as my professional home.

Thank you again, I look forward to a very good, albeit complex, 2022.
Warmly,
Lisa

TRAUMA AND HEALTH: THE HUMAN CONDITION

Anna Kharaz
& Emily Lapolice

WHEN WE EXPLORE ANY INQUIRY INTO OUR UNDERSTANDING OF TRAUMA—in the fields of medicine and mental health, as well as public policy and advocacy, we are talking about the human experience. The human condition. We are talking about how the experience of living impacts individuals, communities, cultures, and societal norms and practices—and subsequently how we collectively respond, or more often, react to the lived manifestations of those impacts. The **"experience of living"** varies considerably based on privilege, positionality, access to resources, and where in the world you call home. There are multidimensional intersections that impact the human experience, which also includes exposure to traumatic and oppressive systems. There are also numerous different clinical and humanitarian perspectives and vantage points on these dynamic topics. Here, we offer just one. If you'd like, you're welcome to consider some of these reflections with us.

As we write these words, many of us around the globe are glued to our phones, televisions, newspapers, and many other media outlets, trying to understand the events unfolding in Russia's invasion of Ukraine. However, the way we each interact with these events will vary based on a myriad of factors and conditions. Many of us will turn ***toward*** the suffering happening in Ukraine—our hearts will hurt for the Ukrainian people and its nation under attack—just imagining the horror of unjustifiable violence, whether we have lived through similar experiences or not. And, many of us will turn ***away*** from those experiences of suffering for various reasons. It's possible that some people may have no interest in what is happening in this foreign land with a foreign invader. For others, it may seem all too overwhelming to navigate the complexities of daily life while simultaneously having the capacity to hold the collective experience.

R. J. Clifton, a psychologist studying human response to catastrophe suggests that

"suppression of our natural responses to disaster is part of the disease of our time. The refusal to acknowledge these responses causes a dangerous splitting. It divorces our mental calculations from our intuitive, emotional, and biological embeddedness in the matrix of life"

(as cited in **Wall Kimmerer**, 2020).

In many respects, in order to care about a foreign land, we may need to feel connected to *beings* on that far away soil. And in order to be able to feel connected to others, it can serve us to connect to the entirety of our own humanity - which includes our lived experiences of pain, suffering, and trauma. We may need to be able to connect with our *own* suffering, in order to **meet,** or connect, with the suffering of others. When we don't, we can run the risk of minimizing, deducing, and disconnecting from the experiences of others, which can result in "othering," and focusing on differences rather than similarities. This is the backbone to every type of supremacy and every type of **-ism** that exists in the world today.

And then we might also step into an investigation around our understanding of ***health:*** **What is *health*? How have we come to understand or internalize our notion of it—and who or what (including systems) have contributed to this understanding?** As the result of years of colonial conditioning, it is likely that many of us associate ***heath*** with ***wellness,*** and ***wellness*** with ***positivity*** or ***goodness***. As a consequence of this belief system, there has been a hyperfocus on health, wellness, and the **"pursuit of happiness"** above all else. And what that ***"all else"*** can often include is engagement with, and a stepping *toward* our individual and collective truths—of pain, suffering, and trauma. So when we grapple with the idea of health and wellbeing, it might serve us to widen our understanding of what being **"healthy"** means, or on ***whose terms*****?** As many of us are currently orbiting and operating in the **Western Medical Model**—a model that contains marvels and advancements in research, practices, and policies well beyond our imagination—**could we also, perhaps, recognize or consider the potential limitations to our widely accepted understanding of health and wellbeing?**

Most survivors in the Western world have received a plethora of diagnoses throughout their lives, from mood disorders (such as depression) to personality disorders, such as borderline personality disorder, to anxiety/trauma-related ones, such as posttraumatic stress disorder (**PTSD**). While mental health diagnoses can offer context and validation for some individuals, it is important to remember that these diagnoses exist and were created against the backdrop and systemic norms of the **Western Medical Model. Symptoms,** which are ***internalized and externalized expressions of trauma exposure,*** are pathologized and seen as problematic. In a culture that is fixated on **"happiness," "positivity," and "success"**—one that believes in **"picking yourself up by your bootstraps" and "faking it till you make it,"** it can feel like receiving a diagnosis is a statement that something is inherently flawed or **"wrong with"** an individual. This can significantly rupture one's sense of self, self-worth, and identity, and engender deep feelings of shame and isolation. For example, when someone receives an anxiety disorder diagnosis, they are often guided to engage in cognitive behavioral therapy or cognitive processing therapy, in order to ***understand*** the thoughts that contribute to their anxiety. As well, efforts are made to learn and practice coping strategies in order to mitigate these feelings of anxiety. While this can be incredibly effective for many individuals, it can also increase a sense of guilt and shame—and the message many individuals receive is to make those **"bad"** feelings **"go away."**

The human experience is inherently traumatic in nature. The range of **interpersonal** (relationship to others), **intrapersonal** (relationship to self), and **systemic** variance in those experiences, differs significantly based on a myriad of factors and conditions, including sociocultural and intergenerational impacts. In the aftermath of traumatic experiences, the mind, body, spirit, and emotion embark on a tumultuous journey of survival. For all of us humans who endure terrifying, oppressive, disempowering, or life-threatening events, our entire being works together to ensure that, should we ever face a similar experience (even with the slightest resemblance to the original event or conditions), our nervous system knows exactly what to do. This is a brilliant and adaptive response, passed down from generation to generation, ensuring that we, too, can endure the unendurable. **If there is any one constant in the history of humankind, it is resilience in the aftermath of trauma.**

Our intention is not to minimize or downplay the very real challenges of living with something like PTSD. Trying to go to school, show up to work, raise children, maintain a home, stay connected to your social community, and so many other seemingly regular parts of life can feel impossible when one's nervous system is responding as if the trauma is ongoing. **Yet the experience of PTSD does not mean that there is something wrong with an individual, but rather that they have been wronged.**

One of the greatest injustices in our current medical model is the pathologizing of posttraumatic adaptations. The result is that humans responding to traumatic experiences, exactly as they should, feel immense shame and guilt for the natural ways their system comes to their defense. When they seek help from the healthcare system, they get a diagnosis that often includes the word **"disorder,"** signaling there is something wrong.

But what if the healthiest response in the aftermath of trauma is PTSD? What if we understood "symptoms" to be internal and external manifestations of the nervous system responding in the exact way it was designed to respond?

This shift in perspective has real implications for how we understand ourselves and each other and also how we meet trauma in our offices, emergency rooms, classrooms, relationships, communities, and systems. **Dolezal and Lyons** (2017) write about the often overlooked role of shame in the context of health and medical research, and argue for its consideration as a determinant of health: **"Experiences of chronic shame… cause prolonged stress in the body which has a clear effect on many physiological systems, such as the immune and cardiovascular systems."** Shame is one of the most common emotions that accompanies an individual in the aftermath of trauma. Survivors often feel **"stuck"** in their trauma, alongside a strong desire to be **"over it."** And even when many efforts to **"heal"** have been made and various therapy modalities or medication regimens attempted, the internal narrative that accompanies the suffering is inherently shaming in nature: **"What's my problem? Couldn't I have responded differently? Why didn't I have 'good enough' coping mechanisms in place? Other people handle life better… what's wrong with ME?"** And even before some of these conditioned narratives come into play, receiving the diagnosis itself can bring on feelings of shame that, as **Dolezal and Lyons** share, can have medical and physical implications.

In Dr. **Nadine Burke Harris'** (2014) TED talk titled, "*How childhood trauma affects health across a lifetime,*" Burke Harris shares how she expected the findings of the Adverse Childhood Experiences (**ACE**) studies to revolutionize pediatric medicine, from screening to multidisciplinary treatment teams, to clinical treatment protocols. Dr. Harris posits that the reason the ACE findings are so often marginalized and remain unintegrated into pediatric care is *not* because they don't apply to most of us humans, but rather, that they *do*. Harris argues that

"we marginalize the issue because it *does* apply to us…
We don't want to look at it… We'd rather be sick."

Integrating the revolutionary findings of the plethora of ACE studies would mean taking a long hard look at our own lives and systems, and confronting our individual and collective **"dark pasts"** to wrangle with what can often seem **"unwrangleable."**

So what does this all have to do with health?

In 1938, Harvard University scientists began studying a group of 268 sophomore students to better understand health and happiness over the lifespan, called the **Study of Adult Development** (e.g., **McLaughlin et al.,** 2010). Beginning in the Great Depression, this study followed these men for 80 years, carefully tracking information about their physical and mental health as they aged. Harvard psychiatrist Dr. **Robert Waldinger** (2015) states, "When we gathered together everything we knew about them at age 50, it wasn't their middle-age cholesterol levels that predicted how they were going to grow old. It was how satisfied they were in their relationships. The people who were the most satisfied in their relationships at age 50 were the healthiest at age 80." So **what if we shifted our understanding of health to consider these groundbreaking findings? What if the diagnoses we carry and the medications we take to manage our various "conditions" don't necessarily determine our health—and certainly shouldn't be attached to our sense of self and identity?** Perhaps a better way of understanding health might be engaging in a deeper investigation around our capacity for interconnectedness, as well as what factors and conditions support or deny one of our most innate human functions.

Humans are hardwired not only for survival, but also for connection (Cook, 2013). And this connection might also include connection to ourselves and to our own pain and lived experiences.

When we think about the experiences of unspeakable trauma and atrocity that the Ukrainian people are enduring, we may also bring to mind their astounding resiliency, resolve, and connection to their culture and to each other. There has been considerable footage circling the media of Ukrainians hiding for their survival in bunkers and converted subway stations spontaneously breaking out into song (**Shaw Roberts**, 2022). There are many Indigenous Peoples, First Nations, cultures, and communities all around the world who honor wisdoms and ways of seeing, being, knowing, and doing (**Canadian Council on Learning**, 2009; **Cull et al.**, 2018) that center respect, responsibility, reciprocity, and connection—to ourselves, to each other, and to the Land. They didn't need an academic study to understand the healing power of relationships and interconnectedness. When we make efforts to dismantle and step away from roles such as **"healer/expert"** and **"sick/patient"** to be *in* our individual and collective healing *together* (Henry Vickers, 2022)—**with reverence, humility, and grace, our definitions and understanding of health and wellness can expand exponentially.**

ANNA KHARAZ is a licensed therapist and certified trauma sensitive yoga facilitator. In addition to seeing clients for therapy and yoga, she serves as an adjunct faculty member and supervisor for the Center for Trauma and Embodiment at the Justice Resource Institute. She offers workshops and professional trainings across the United States and internationally to help healthcare providers, educators, mental health professionals, yoga teachers, and body workers better understand the impacts of trauma and implement trauma-informed practices in their work. Her approach to therapy, yoga and education draws from a background in neuroscience, continued education in mental health and psychology, and a lifelong commitment to better understanding human suffering, health and healing.

EMILY LAPOLICE is a Licensed Independent Clinical Social Worker and Trauma Center Trauma Sensitive Yoga Facilitator who specializes in complex trauma and perinatal mental health. She received her Bachelor's degree in Psychology at Providence College in 2003 and Master's degree in Social Work at New York University in 2006, working in day-treatment, inpatient, outpatient, and school-based mental health settings in both New York City and Boston for nearly two decades. Emily is a faculty member at the Center for Trauma and Embodiment at JRI, as a Supervisor and Trainer in the Trauma Center Trauma Sensitive Yoga Program. She is also a writer and contributing author to the book, Embodied Healing: Survivor and Facilitator Voices from the Practice of Trauma-Sensitive Yoga, and is currently working on her first solo book. Emily is on the Editorial Board of the publication: Voices Against Torture: International Journal on Human Rights, and is a lead collaborative partner of We the Mindful, a non-profit community-lead initiative dedicated to transforming colonial impact and helping remove barriers in accessing mental health support. Emily is a mom to two young boys and lives in Arlington, MA, where she maintains a small private practice.

Citation: Kharaz, A., & Lapolice, E. (2022). Trauma and health: The human condition. *Trauma Psychology News, 17*(1), 8-12. https://traumapsychnews.com

DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

INTERESTED IN JOINING THE *TPN* TEAM?

Submit an interest statement and CV

OPEN POSITIONS

- Student Publications Committee Team Members
- Copy Editors
- Public Relations Managers
- Book Reviewers
- Layout Editor
- Website Editor

AYLI CARRERO PINEDO

WHO'S WHO

Oyenike Balogun-Mwangi, submitted photo

WHAT LED YOU TO THIS FIELD AND CAREER PATH?

When I was an undergraduate student, I worked as a Spanish-English hospital interpreter at a rural Nebraska hospital. I witnessed the barriers immigrants faced while navigating the healthcare system, particularly access to culturally sensitive mental health services in their native language. Because my immigrant status changed before I went to college, I promised myself that I would use this new citizenship privilege to help dismantle oppressive systems that hindered equitable care.

WHAT IS THE MOST INTERESTING THING THAT YOU HAVE LEARNED IN YOUR CAREER?

Being busy does not equal being successful. Hustle culture is so embedded in the ethos of higher education that many compromise their values and stray away from their purpose.

AYLI CARRERO PINEDO

she/her

Postdoctoral Fellow in Trauma & Diversity, Women's Health Clinic, Sepulveda VA, VA Greater Los Angeles Healthcare System
PhD, Counseling Psychology, University of North Dakota

Areas of interest and expertise

As a scholar-clinician-advocate, my work is informed by liberation psychology and the intersection of public psychology and public health. I am committed to the healing and wellness of people of color and immigrants. My experiences as a formerly undocumented Peruvian immigrant informs my developing expertise in culturally informed trauma interventions at an individual and systems level. Additionally, I am invested in improving the educational experiences of trainees of color in health service psychology.

Hobbies

Hiking, dancing, sporting events, going to concerts, and playing arcade games

Ayli Carrero Pinedo was nominated as a Who's Who feature in part due to her service as the division's "anti-racism task force coordinator extraordinaire," as quoted from Carolyn Allard's nomination statement.

WHAT HAVE BEEN THE BIGGEST CHALLENGES IN YOUR FIELD SINCE YOU HAVE STARTED?

Navigating the toxicity of academia. The most painful realization is how People of Color (*sometimes*) prefer to be the only one in the room. They lose themselves and become a token to whiteness and white supremacy for self-advancement.

I have encountered situations where PoC are given a seat at the table (e.g., get a faculty position, elected to a leadership role) and rather than destroying the table and/or building a new table, they tell other historically excluded folks the table is full or that they are out of materials to build a new one. In the eyes of white supremacy, they are worthy of promotion and advancement because they are the "least threatening" to the system.

Another example is how people practice 'gatekeeping.' They might be aware of the terms and conditions behind the gates and rather than sharing the hidden curriculum, they keep that information to themselves. They replicate colonial practices by deciding who has access and benefit, instead of using their power to dismantle the status quo. In other circumstances, they might also lock the door behind them and give the keys to people with privilege and systems of oppression.

HOW DO YOU KEEP YOUR LIFE IN BALANCE?

As I progressed in my career, I have been very vocal about setting boundaries and respecting them. Saying "no" has been a skill that has helped me maintain balance in ways I could not imagine.

HOW DO YOU AVOID BURNOUT, COMPASSION FATIGUE, AND/OR VICARIOUS TRAUMA?

Being authentic with my pain and making space for grief has helped me alleviate the racial battle fatigue and vicarious trauma that comes with being an immigrant and woman of color. Sharing our stories is necessary to destigmatize mental health and help communities thrive.

WHAT ADVICE WOULD YOU GIVE TO SOMEONE STARTING OUT IN YOUR FIELD?

Separate yourself from people and institutions who only celebrate you when you are disconnected from your community. At the end of the day, how are you honoring your roots and extending your branches to forge a path for the next generation?

AT THE END OF THE DAY, HOW ARE YOU HONORING YOUR ROOTS AND EXTENDING YOUR BRANCHES TO FORGE A PATH FOR THE NEXT GENERATION?

What else would you like us to know?

I founded #PsychGradWishList, an online mutual-aid movement for incoming psychology interns and postdocs of color. If you are on Twitter or Instagram, please check out @psychgradwish for updates.

DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

Want to see someone featured in *TPN*?
Submit a *Who's Who* nomination on
our online submission form

REFUGEE MENTAL HEALTH RESOURCE NETWORK

AN APA INTERDIVISIONAL PROJECT

Elizabeth Carll
Section Editor; Founder & Chair, Refugee Mental Health Resource Network

THERE IS AN ONGOING NEED for mental health experts to work with refugees, immigrants, and internally displaced peoples (IDPs) which appears to be increasing over the past years, and more recently, as evidenced by conflicts arising in Afghanistan and Ukraine. The lack of an organized initiative to address this need was the impetus for the development of the Refugee Mental Health Resource Network (RMHRN), in 2016 as the Division 56 presidential initiative of Dr. Elizabeth Carll was expanded realizing that the success of the project would require a broader APA and international involvement and it was decided to apply for a CODAPAR grant which was approved in 2016 and implemented in 2017.

The grant facilitated the launch of the Network and underwriting the cost of developing the searchable database of volunteers and beginning the development of webinars to train psychologists. The webinars were important, as working with refugees, including asylum evaluations, were not areas of training in most universities.

This initial APA interdivisional grant was spearheaded by Division 56 (Trauma) and co-sponsored by Divisions 35, 52, and 55. In addition, other Divisions and some state psychological associations were also collaborating. In 2020, RMHRN, demonstrating sustainability over the previous 4 years, received another CODAPAR grant to be led by Division 52 (International) for 2021, in support of the RMHRN with Divisions 52, 56, 7, 35, 38 participating. The grant focused on further upgrading the database and expanding the international outreach of the Network. Currently there are more than 600 volunteers in the database consisting of licensed practitioners, researchers, and students.

Since 2017, there have been 23 webinars organized and conducted for those interested in volunteering with refugees, immigrants and internally displaced people (IDPs). The most recent webinar will be addressing the Ukraine crisis with previous webinars in 2021 including Overview of Issues in Working with Vulnerable Immigrant and Refugee Populations and A Case Study of the Garcia Family; Prospects for Immigrant Children During Times of Covid-19 and Policies of a New Administration; Addressing the Mental Health of Venezuelan Migrant Children and Adolescents in Colombia; and Providing Culturally Responsive Psychological Services and Support to Afghan Adults and Children. With increased focus on international activities, there were attendees present from 17 countries at the recent webinar.

Inquiries arose as to availability of university training and degrees relating to immigration and refugees. Initially in 2017 very few, if any, existed. However, gradually more were established. It is our view that immigration and refugee studies will develop into a specialty within the fields of psychology and mental health. As a result, due to ongoing inquiries and apparent need, a Directory of Advanced University Degrees in Refugee and Migration Studies in United States and International Universities was developed and available on the RMHRN website resource page. We believe this directory is a first of its kind as we were not able to be find one. It includes both U.S and international universities offering Master's degrees. Also included are three university certificate programs which may likely evolve into graduate degree programs.

If you are interested in volunteering to provide pro-bono services to refugees, immigrants, and IDPs, or in participating in webinars, please contact Elizabeth Carll, PhD, Founder & Chair of the Refugee Mental Health Resource Network.
Mail to: ecarll@optonline.net

ANNOUNCEMENT: INTERNATIONAL STUDENT STIPEND FOR THE 2022 APA CONVENTION

To encourage international participation, the APA Trauma Psychology Division (56) has been providing an annual travel stipend to attend the APA Convention for international students who are citizens of developing countries and enrolled in a graduate psychology program in their home country or enrolled in a graduate psychology program in the U.S., and will be presenting a trauma related poster, paper, or a participant in a symposium/panel accepted for the APA convention. Applicants are not required to be current student members of APA or Divisions.

This year, the 2022 APA Convention in Minneapolis, Minnesota is hybrid with both in person and virtual participation anticipated. The award is intended for international students from developing countries (see above) who will be presenting a trauma related poster, paper, or are a participant in a panel/symposium at the 2022 APA Convention. It was recognized by the Division 56 International Committee that support for international students from developing countries, engaged in trauma related research and activities is important to continue, especially given the challenges occurring as a result of the pandemic.

The stipend consists of $1000 to help support the work of international students from developing countries in their graduate programs and participation in the APA Convention program.

The deadline for submission: **Sunday, May 15, 2022**

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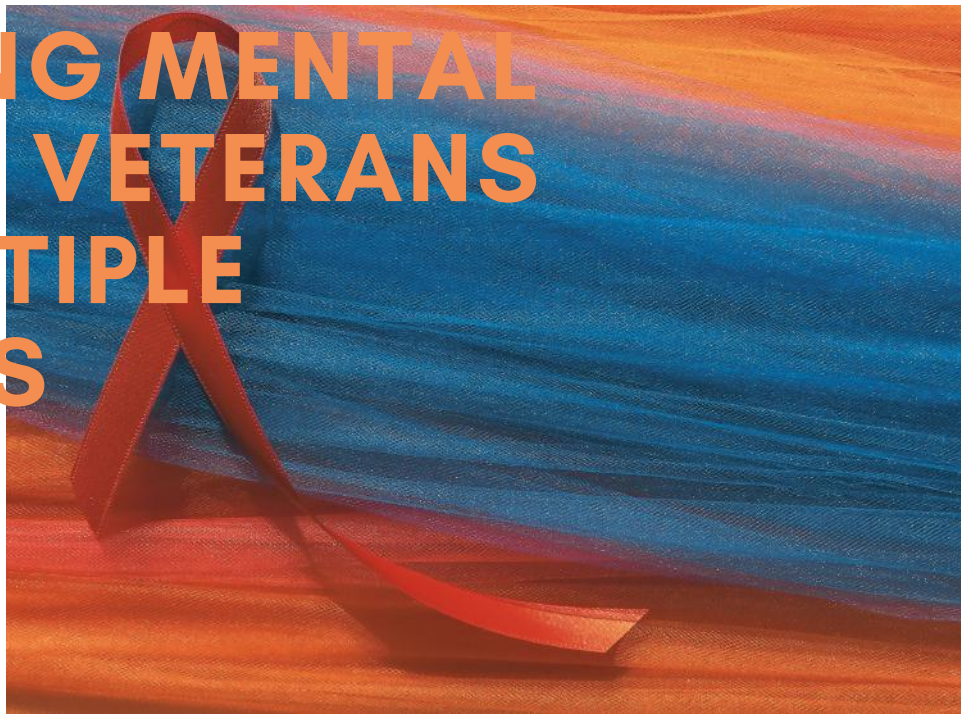
PROMOTING MENTAL HEALTH IN VETERANS WITH MULTIPLE SCLEROSIS



Beatrice Lee
Section Editor: Emre Umucu

WHILE ALMOST ONE MILLION INDIVIDUALS in the United States have multiple sclerosis (MS; National Multiple Sclerosis Society [NMSS], 2022a), there is no accurate estimation of prevalence or incidence for Veterans with MS because only 40% receive their care from the VA Health Care System VHA (NMSS, 2022b). With its variability in symptom manifestation and disease course, MS can also affect various aspects of mental and physical health (Bambara et al., 2011). According to a systematic review and meta-analysis, the prevalence rate of depression was 30.5% and 22.1% for anxiety for people with MS (Boeschoten et al., 2017). Given that depression and anxiety are common in MS (Koelmel et al., 2017) and that the presence of psychological conditions can impact one's disease, well-being, and quality of life (Hanna & Strober, 2020), it is imperative to identify protective positive psychological factors that can promote positive mental health in people with MS. Rather than focusing on deficits and impairments, positive psychology emphasizes the importance of building positive qualities and strengths to allow individuals, communities, and societies to flourish (Seligman & Csikszentmihalyi, 2000).

Researchers have highlighted that strengthening psychological resources are crucial to psychosocial adjustment in people with MS (Calandri et al., 2017; Possa et al., 2017; Strober, 2018). Increasing research has examined the role of positive psychological resources (e.g., resilience, optimism, gratitude, social support) in MS. For instance, my research revealed that gratitude was positively associated with life satisfaction through lower levels of stress and mental health symptoms in people with MS (Lee, 2022). Resilience served as a mediator between social support and subsequent mental health outcomes in people with MS (Koelmel et al., 2017). We also found that optimism is positively associated with mental health and life satisfaction in people with MS (Lee et al., 2022). Perceived social support from friends led to reduced anxiety symptoms, which then decreased depressive symptoms (Henry et al., 2019).

Similarly, growing research has also examined protective factors (e.g., optimism, gratitude, social support) that can promote mental health in the Veteran population. For example, higher levels of optimism were found to be negatively associated with comorbid posttraumatic stress disorder (PTSD) and major depressive disorder in Veterans (Nichter et al., 2020). Gratitude was negatively associated with suicidal ideation in Veterans with mental illness (Umucu et al., 2022). Higher levels of social support were negatively associated with PTSD and depressive symptoms in Veterans (James et al., 2013).

Given that prior research has examined positive psychological factors that can lead to enhanced mental health promotion in both the MS and Veteran population separately, future research should further examine the role of protective positive psychological factors in promoting mental health in Veterans with MS. In a community-based sample of Veterans with MS, the prevalence of major depressive episode (MDE) was 22.2% (Williams et al., 2005). Furthermore, occasional falls, perceived bowel impairment, absence of a marital partner, younger age, unemployment, and low income were associated with MDE in Veterans with MS (Williams et al., 2005). Medical comorbidity and pain intensity were associated with lower levels of mental health in Veterans with MS (Turner et al., 2009). In terms of interventions that can promote mental health in Veterans with MS, prior research has demonstrated that a telephone-administered physical activity counseling intervention was effective in improving physical activity and reducing depression and fatigue in Veterans with MS (Turner et al., 2016). Additionally, greater perceived social support was associated with less depression in Veterans with MS, suggesting the importance of integrating interventions to foster positive social interactions, promote affection, and deepen quality relationships (Bambara et al., 2011). Despite previous research suggesting the integration of physical activity and social support intervention in reducing depression in Veterans with MS, more research is warranted to examine the role of positive psychological factors and positive psychology interventions in facilitating positive mental health outcomes and well-being in Veterans with MS.

BEATRICE LEE, PhD, CRC, LPC (she/her)is an assistant professor in the Department of Counseling, Educational Psychology and Special Education at Michigan State University. Her research focuses on exploring malleable risk and protective factors that can help people with disabilities deal more effectively with stress. She is interested in identifying and bolstering protective positive psychology factors in helping people with disabilities more effectively manage stress and promote their mental health and well-being. In particular, she is interested in examining the extent protective factors can reduce vulnerability to experience stress and foster mental health and well-being in individuals with neurological disorders, such as multiple sclerosis.

Citation: Lee, B. (2022). Promoting mental health in veterans with multiple sclerosis, *Trauma Psychology News, 17*(1), 18-20. https://traumapsychnews.com

CHILDREN LIVING IN TIMES OF WAR

Claire J. Starrs &
Rachel J. Grohbrugge

WHEN ADULTS FIGHT, CHILDREN SUFFER. This is never more true than during armed conflict. Of the approximate 43 million Ukrainian population, 8.75 million are aged between 0-19 years (UN, 2022). Furthermore, an estimated 80,000 births are predicted for the next 3 months (IRC, 2022). As of the second week of the current conflict, the UNHCR estimates that over 2.5 million people have fled Ukraine, and UNICEF suggests this includes over 1.5 million children and teens. Predictions for total population displacement are currently forecast to be 7 million or more for internal displacement and an additional 5 million refugees, the vast majority of whom will be women and children (Associated Press, 2022).

For those of us who are lucky enough to never have had to experience war directly, it is hard to imagine the seemingly impossible decision of whether to stay or to go, as both are fraught with the inevitability of traumatizing experiences. In this article, we hope to provide a brief overview of the impacts for children and teens, the protective interventions happening on the ground, and some of the recommendations for providing psychosocial support to this population. Finally, we will also address recommendations for talking about violence and war with the youth in our lives, be they our own children, or our young clients, and their families.

Impact of Armed Conflict on Children. The effects of armed conflict on children are both direct and indirect. Direct impacts comprise physical injury, maiming, and death, as well as psychological distress including anxiety, PTSD, and depression (Attanayake et al., 2009). Young children (0-6 years) show increased rates of psychosomatic symptoms, as well as increased anxiety, fear, startling, attention seeking, temper tantrums, sadness, and crying, and may also be more aggressive or withdrawn (Slone et al., 2016). The disruption to education and healthcare, and economic sanctions leading to increased poverty and food insecurity, also directly impact child health and development. The mass destruction of infrastructure means that these impacts last long after the official end to hostilities. Additionally, conflict creates conditions that compromise key public health functions, such as vaccine delivery, health surveillance, and disease management, resulting in increased rates of infectious disease transmission and the reemergence of previously eradicated, vaccine-preventable diseases (Akil & Ahmad, 2016). It is unknown at this time, how the current displacement of millions of people will interact with the ongoing pandemic.

Interventions and Psychosocial Support. Psychological First Aid (PFA, NCTSN, 2006), is an evidence-informed intervention package for situations of disaster, conflict, and terrorism, with a specific focus on the needs of youth. PFA is designed to reduce initial distress and to foster short- and long-term adaptive coping. PFA proposes several core actions including practical interventions such as providing for basic needs and comfort and connecting survivors with available services and social support. Specific to psychological needs in such times, the program centers on a non-intrusive, compassionate, and supportive approach, including minimizing the sense of danger for the child, (e.g., explaining what measures are being put in place to protect them), normalizing thoughts and feelings, providing ongoing child-friendly information on the evolution of the situation, and creating opportunities for healthy coping like self-care (e.g. resting, eating), connecting with others, and engaging in normative childhood activities, such as playing, singing, reading, and physical activities. For older children/teens, focusing on something practical can help to reduce feelings of powerlessness, e.g., helping to keep younger children distracted with activities. This approach is at the heart of interventions being implemented by NGOs on the ground.

One of the primary concerns for children and teens in situations of mass conflict is separation from families (UNHCR, 2022). Separated children are at a heightened risk of violence, abuse, and exploitation (UNICEF, 2022). Furthermore, the risk of trafficking also soars in times of mass conflict (UNODC, 2018). Both UNICEF and UNHCR have made specific recommendations to maximize the protection of unaccompanied children, including their immediate identification and registration, the creation of safe landing spaces, and their referral to national child protection services, in parallel with the creation of family tracing and reunification mechanisms. If humanitarian evacuations are necessary, it is critical that consent of parents/guardians be obtained when possible, and under no circumstances should families be separated as a result of relocation or evacuation movements. Regarding children in institutions, establishments must ensure that evacuations follow national authorities' instructions, that movements are reported to competent authorities and as far as possible, children must be evacuated with their identification papers and their medical case files. UNICEF has established a network of safety centers called Blue Dot centers at border entry points and other strategic locations to support the delivery of emergency services to families in transit. From these hubs, they can provide safe respite, current information, psychosocial support, and access to health services, as well as family tracing and reunification services. UNICEF is in the process of setting up 26 Blue Dots, in Moldova, Romania, Belarus, Slovakia, Poland, Hungary and Czech Republic, each with the capacity to support 3,000 to 5,000 people per day (UNICEF, 2022).

Children who are affected by armed conflict need clinicians who are skilled in providing care to children and their families from different cultural and language backgrounds (Lie et al., 2011). Providing trauma-informed care involves making alterations to the care setting, e.g., providing care in situ, with family members present (Marsac et el., 2016). Promoting the active participation of children and their families in their health care plan may help to provide a sense of control, which contributes to healing and avoids exacerbating or causing further trauma (Raja et al., 2015). Regarding psychosocial interventions, once children are in an environment remote from conflict and basic needs and physical healthcare have been met, it is essential to provide routine and engagement in normative childhood activities, especially a return to school. Coordinated psychosocial and mental health interventions in schools during post-conflict times have been shown to be beneficial (Betancourt et al., 2013). School-based programs positively affect self-esteem, motivation, and self-efficacy, as well as providing a more socially acceptable environment for mental-health care provision (Fazal et al., 2016). It is important to note that even in the direst of circumstances, children exhibit immense adaptability, and this resiliency can be cultivated to mitigate the toxic stress effects of armed conflict. Intelligence, emotional regulation, and adaptive coping contribute to resilience and can be promoted through social support, caregiver mental health, community involvement, cultural participation, and access to childcare and schools (Betancourt & Khan, 2008).

Disaster training courses are available for clinicians (e.g., The Institute for Disaster Mental Health). Such courses can be useful for providers who work in conflict settings as well as for clinicians who are involved in the care of children who are refugees.

Talking with Children about Armed Conflict. When conflict erupts across the world, it also creates stress and distress for youth here at home. Exposure through the media to images of families fleeing, mass destruction of homes and cities, and injured civilians, has been shown to significantly impact children's current distress (Pfefferbaum et al., 2020). Furthermore, on the tail end of the current pandemic, many people's coping mechanisms have been deeply taxed, and adults and parents may be struggling to adapt to this additional stressor (Kerr et al., 2021). There are, however, some recommendations for talking to children and young patients, to help them to navigate these difficult times.

Pre-conversation. It is important to take some time, working through our own thoughts and emotions about the war, and how we are going to answer questions before embarking on a conversation. Talking things through with other adults, working on how to word things, and level of emotional expression, beforehand is advised. Having a concerted approach in a parent team can be helpful, as it contributes to keeping the narrative coherent. Even very young children are attuned to adults' feelings and stress, so it is important to be prepared to discuss those (Abrams, 2022).

Conversation. Choose an environment where the child will feel safe. If the child is not interested or comfortable in talking about current events, do not pressure them, rather acknowledge being willing and able to have a conversation when they are ready (AACP, 2020). Some youth may prefer to express themselves through drawing, music, or poetry. Encourage the child to express their emotions in the manner that they find the most comfortable (AACAP, 2020). Begin the conversation by allowing the child to express themselves freely, this will provide insight into their understanding of the situation. Younger children may ask questions that relate to family safety, while older adolescents may have broader questions about death and suffering, as well as concrete questions about how to help (Abrams, 2022). Be as honest as possible when answering questions, whilst being mindful of the child's developmental level and use child-friendly examples and comparisons (AACAP, 2020). For example, young children may not comprehend that the war is far away, using concrete props, such as a map to show them the location of the conflict and explaining that they are safe can be helpful (NCTSN, 2022). Many young people rely on social media for their news, which can be rife with misinformation, so using the opportunity to resolve erroneous facts and misunderstandings is important (NCTSN, 2022). With older teens, it can be helpful to discuss what constitutes reliable sources of information and how to identify propaganda verses news coverage. Encouraging a focus on stories that highlight the organizations that are helping civilians such as UNICEF and Voices of Children (Abrams, 2022), can help to reassure the child that there are other people who are helping. Do not hesitate to share your feeling about the situation. Children learn from how their parents and other adults react and cope (AACAP, 2020). If the child is feeling anxious, perhaps complete a self-care activity together such as going for a walk, coloring, or following a relaxation video. Regarding the length of the conversation, take your cue from the child, younger children may prefer to have shorter but more frequent discussions. At the end of the conversation, make sure the child knows they and their loved ones are safe.

Moving Forward. Consider strategies for limiting the child's exposure to the news and media accounts of the ongoing conflict (APA, 2011). Such things, as limiting the amount of time the television/radio/internet are streaming into the home, can be helpful. This may be more challenging with older adolescents, but it is possible to engage in a conversation with them about how repeatedly being exposed to news of the war (aka doomscrolling or doomsurfing, Anand et al., 2022) will increase their stress (NCTSN, 2022). While it is important for children and adolescents to understand current events, within the limits of their age, repeated exposure to images of violence may heighten their sense of helplessness and anxiety. In particular for older children and teens, finding ways to participate such as raising money, or donating food and medical supplies may help to alleviate helplessness and provide a focus for feelings of compassion and empathy. Younger children can draw pictures and write letters that can be included in donations to such organization as UNICEF. Allowing children and adolescents to take action and participate is encouraging a healthy coping strategy which will also serve them in future difficult situations (Abrams, 2022). An additional important strategy is to develop and maintain a consistent routine (NCTSN, 2022) for the child and for the whole family. Children and adolescents are comforted by schedules and routines, and may be less likely to experience acute negative emotions (APA, 2011).

Although much of the above will also apply, conversations will need to unfold somewhat differently for families directly affected by the war, including those with relatives in Ukraine, military families, and members of mobilized NGOs. It is important to be honest about the uncertainty of the situation, whilst reassuring children that every measure possible to keep people safe is being implemented on the ground, and that you will keep them informed as things unfold (Abrams, 2022).

Children and teens are not the only ones who might feel overwhelmed, stressed, and helpless by the war in Ukraine (Abrams, 2022). The mitigating strategies discussed above, can be equally effective for adults. Limiting time spent on various media outlets can help to reduce distress. Concrete action through donations to NGOs or making dinner for a neighbor who has family in Ukraine, can be effective methods for reducing feelings of helplessness. And most importantly, being patient with oneself and others, recognizing that especially on the tail end of such a difficult two-year period, most people are currently feeling emotionally drained, so taking time to engage in self-care and seeking extra support when needed, are helpful coping strategies.

RESOURCES

- Up-to-date information from NGOs
  - UNICEF
  - Doctors without Borders
  - UNHCR
- Psychology related
  - APA motion on Ukraine
- Multiple resources for donating and information
  - Voice for Ukraine

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RACHEL J. GROHBRUGGE is a senior student at the State University of New York at Potsdam, majoring in Psychology and Music, with a concentration in Music and Special Education. Her research interests focus on resiliency and wellbeing in children and adolescents. For her honors project, she developed a Student Mental Health and Wellbeing assessment, called the Student Carebook. She recently received several prizes for her scholastic and research achievements. She is looking forward to continuing this important work during her graduate studies in the Fall.

Citation: Starrs, C. J., & Grohbrugge, R. J. (2022). Children living in times of war. *Trauma Psychology News, 17*(1), 8-12. https://traumapsychnews.com

DIVISION 56

TRAUMA PSYCHOLOGY

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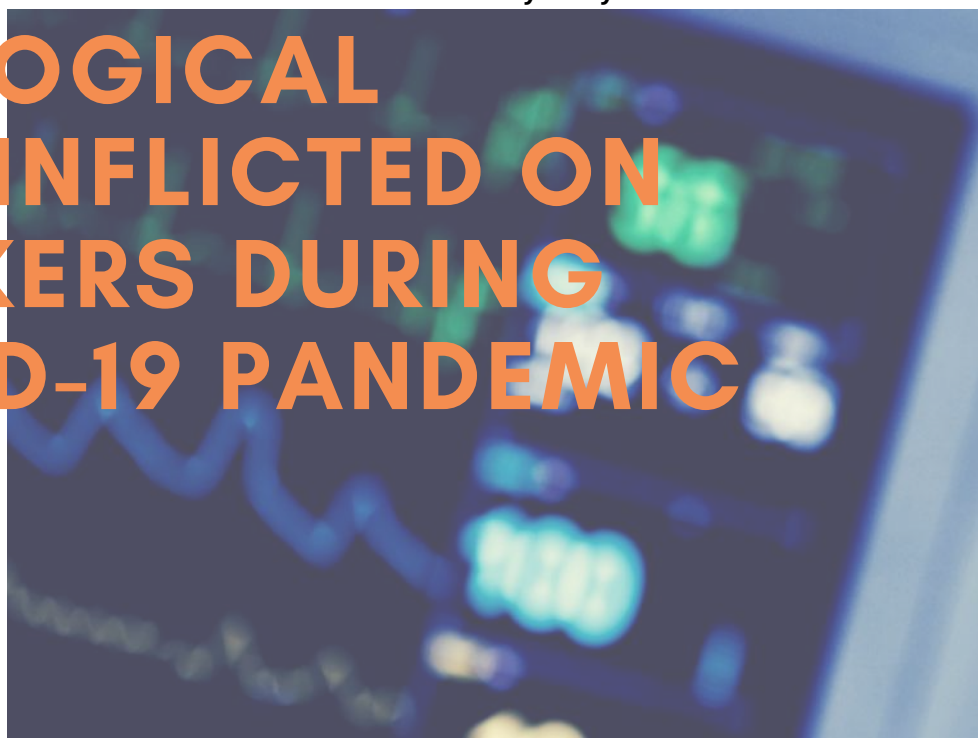
PSYCHOLOGICAL WOUNDS INFLICTED ON ICU WORKERS DURING THE COVID-19 PANDEMIC



Denise Carballea

WORLDWIDE, EMERGENCY HEALTHCARE WORKERS have responded and adjusted to the increased workload and demand across all healthcare provisions. The intensive care unit (ICU) is a setting where staff members are already at risk of experiencing significant psychological distress, which was exacerbated during the Coronavirus-19 (COVID-19) outbreak (Greenberg et al., 2021). Studies have highlighted increased levels of insomnia, depression, anxiety, fear, and posttraumatic stress disorder (PTSD) within this population (Ezzat, 2021; Geoffroy et al., 2020). Increased mental health concerns result from isolation protocols, loss of social support, and constant change within the workplace during the pandemic. Since ICU medical workers are regularly exposed to traumatic situations as part of their jobs, they may be susceptible to predicaments that continue to impact their mental health. It is imperative to recognize stressors experienced by ICU personnel following the outbreak of the COVID-19 pandemic and recognize the mental health implications faced by this population in these unprecedented times.

COVID-19 ICU STRESSORS

Fear of Contraction. ICU employees experience increased worry regarding possible infection and health outcomes. In order to avoid possible contraction and reduce contagion, personal protective equipment (PPE) measures have been set in place. Lack of PPE and the scarcity of intensive care medicine and technological supplies heighten psychological symptoms such as anxiety, depression, insomnia, and feelings of anguish and fear (da Silva & Barbosa, 2021). Those working in the ICU manage critical COVID-19 cases and face the risk of being a carrier or putting others at risk, such as colleagues, family, and friends, which may further contribute to psychological turmoil (Mosheva et al., 2021). The aforementioned experiences and high levels of stress have been identified as factors that lead to increased absenteeism, lower levels of satisfaction with employment, lower self-efficacy, decreased staff morale, and lower overall quality of life (De Hock et al., 2021; Søvold et al., 2021).

Patient Loss. The ICU is reserved for individuals who are critically ill and is considered the highest mortality unit within hospitals. COVID-19 may lead to adverse patient outcomes, and the loss of patients despite providing the most appropriate plan of care could be detrimental to mental health. In a study by Armstrong et al. (2021), mortality rates for patients with COVID-19 within the ICU in the year 2020 was 41.6%. Due to varying rates of mortality following COVID-19 infection, ICU workers face the challenge of providing end-of-life care. Facilitating end-of-life care might be difficult due to safety regulations imposed by the government to avoid spread where visiting restrictions have been implemented. Due to the need for social distancing and visitation restrictions, many patients rely on medical staff for emotional support during this stage of care. In a study by Mosheva et al (2021), workers who witnessed patient death had a four-fold increased likelihood of developing posttraumatic stress symptoms (PTSS). During times of uncertainty, health care providers are exposed to emotionally taxing circumstances, which can augment emotional distress, ultimately leading to a significant adverse impact on their mental health (Lief et al., 2018).

Burnout. ICU personnel not only face physical and mental exhaustion but also an overall sense of burnout. This type of weariness results from prolonged excessive stress that cannot be successfully managed (World Health Organization (WHO), 2019). Burnout can present itself in a state of mental, emotional, and or physical fatigue caused by stressors within multiple domains of life, such as employment, caretaking, or parenting. Many of these individuals are constantly pushing beyond their limits for labor requirements which are constantly transforming. Ezzat (2021) found those who spent an increased number of hours in PPE experienced a rise in depressive and anxious symptomatology, along with PTSD symptoms. Working tirelessly among other healthcare workers and undertaking unimaginable sacrifices such as an increase in workload (i.e., large patient volumes), longer shifts, high pace, and sleep deprivation have continuously permeated their lives since the onset of the pandemic. In many of these settings, employees tirelessly work through multiple tragic situations (i.e., intubation, oxygenation, patient or peer loss) without sufficient time to take a break or process the experience. These experiences could inflict trauma, burnout, and grief reactions on medical professionals. Prior to the pandemic, burnout was noted to be a significant issue for medical practitioners; however, it has been exacerbated due to the surge of stress in the workplace, lack of resources and or support, inadequate staffing, and increased workload (Shah et al., 2021). Other reasons for possible psychological distress and burnout may be new or unfamiliar work environments, lack of experience with pandemics or infectious patients, and feelings of failure due to inability to treat those who are critically ill. These challenging employment conditions create difficulties in employment, deployment, education, retention, and performance within the workforce (Søvold et al., 2021).

Moral Injury. In addition to fear of contraction, burnout, and patient loss, ICU staff may experience moral injury. Moral injury is conceptualized as psychological distress or pervasive cognitive and emotional response resulting from a situation that contravenes an individual's ethical or moral code (Williamson et al., 2021). Throughout the COVID-19 pandemic, employees within the ICU unit were faced with difficult decisions such as deciding which patient will be provided oxygen or who will be placed on a ventilator. Due to the limited number of equipment during the pandemic, life-saving instruments decisions were at the hands of staff. Søvold et al. (2021) observed that facing these dilemmas results in a negative self-view, guilt, and shame, which could further lead to the development of PTSD, depression, suicidal ideation, and possible renunciation of employment.

RESILIENCE AND INTERVENTIONS

In order to assist ICU personnel, interventions should be tailored to enhancing resilience within their workforce. Evidence-based interventions and organizational measures can assist in protecting and supporting the mental health and overall well-being of ICU staff. Potential approaches to consider for building resilience in these stressful situations should explore the value of implementing and practicing self-care strategies. Since ICU workers are constantly prioritizing the well-being of their patients, at times, they relinquish their own needs. Self-care could assist in coping with workload and demands while helping them obtain greater balance between work responsibilities and their spare time. Examples of self-care tools include practicing self-compassion, relaxation techniques, mindfulness, and meditation.

Additionally, social support is an essential factor during these challenging times, including flexible support from family, friends, peers, and professional and organizational support (Søvold et al., 2021). However, in these trying times, peer support might almost feel like an added burden, leaving many ICU workers questioning who in the workplace to turn to in a time of need. Nonetheless, ICU personnel could benefit from practicing emotional expression with their peers rather than repressing emotions. The mutuality of peers and their shared experiences with stressors can create a sense of collectiveness (Bender at al., 2021). This coping strategy may aid in building emotional resilience and increasing overall mental well-being. Discussing stressors with supervisors, coworkers, and other employees would aid with managing work-related distress. By doing so, individuals will be able to identify factors that cause stress and develop a strategy to work collaboratively to identify possible solutions.

Amidst the chaos brought on by the pandemic, evidence-based interventions could assist with managing high-stress levels constructively. This will ultimately lead to higher levels of compassion, effectiveness, empathy, and sensitivity towards their patients. ICU workers' stressors and psychological needs call for renewed efforts within our healthcare systems, and efforts to reduce the experiences mentioned above should be implemented. During this time, it is imperative to create normalizing discussions regarding mental health within ICU units to reduce its stigma. Mental health and awareness training could facilitate a better understanding and recognition of psychological well-being, which may aid as a coping strategy for ICU personnel.

Medical employees working in ICU settings have faced a great deal of challenges due to the myriad of psychological stressors imposed by COVID-19. Prior to the pandemic, those employed in intensive care units were already known for their work in stressful environments and the high prevalence of mental health concerns (Wozniak et al., 2021). However, it is vital to recognize the constant changes these workers continue to endure during the pandemic and the emotional toll this plays on their mental health. Nearly two years later, procedures should be implemented and tailored to evaluate how workers' resilience has been exhausted and assess how resources should be established to safeguard these individuals from long-term effects of the pandemic on their overall well-being. Shining the light on how ICU personnel are affected during this time is crucial in revealing the vast mental health challenges these professionals face. Promoting the mental health and well-being of healthcare teams is essential.

Citation: Carballea, D. (2022). Psychological wounds inflicted on ICU workers during the COVID-19 pandemic, *Trauma Psychology News, 17*(1), 28-30. https://traumapsychnews.com

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ADVOCATING FOR PEER COUNSELING PROGRAMS AT UNIVERSITIES

TO ADDRESS THE MOUNTING MENTAL HEALTH NEEDS OF STUDENTS

Sarah M. Schenk
Section Advisory Editors:
Jack Lennon &
Emily Rooney

AUGUST OF 2020, I ARRIVED IN NEW YORK CITY to begin my studies toward an MA in Clinical Psychology. I had calibrated my expectations toward a different university experience, one in which the COVID-19 pandemic prevented in-person classes, social gatherings, and greatly restricted access to campus life. The isolation and the difficulties associated with the unprecedented circumstances have led to an increase in mental health problems among the student population. Before March 2020, the exacerbation of university counseling and psychological resources by the growing mental health struggles within university student populations had become a well-known reality. The pandemic has only amplified this treatment gap. My experiences at Durham University in the UK as a trained peer supporter have been incredibly meaningful to me and to others, and present an under-utilized, non-pathologizing, accessible resource for university students in the USA.

Under Durham University's collegiate system, students are allocated to different colleges irrespective of their Majors. Their college, like St. Aidan's College, St. Chad's College, or John Snow College, acts as the communities they are housed in for the duration of their studies. The undergraduate student body within each college forms the Junior Common Room (JCR), with some undergraduates assuming roles of responsibility across a JCR's various committees, including the Welfare Committee. Welfare officers (from here on referred to as peer supporters) are non-professionals trained in active listening skills who hold daily contact hours. During these in-person hours, students can talk to peer supporters about anything and everything – from roommate quarrels to experiences of suicidal ideation – in a confidential, non-directive, non-judgmental environment. Peer supporters do not aim to treat symptoms or crises – in other words, to replace a therapist's role. Rather, to be visible and accessible points of needed community support within the space between everyday life and a therapist's room.

The fact of the matter is, peer counseling programs remain a widely untapped resource. Only a handful of universities support peer counseling programs, including Durham University, Oxford University, University of Reading, Harvard University, Washington University in St. Louis, UC Berkeley, and Johns Hopkins University. While university counseling centers endeavor to offer services outside of short-term individual therapy, including support groups, off-campus referrals, emergency assistance, and online self-help resources, it is important to note that these services fall on one end of the spectrum of mental health support. Namely, support that addresses mental health struggles that are moderate-to-severe, require more immediate attention, and is provided by a professional body. Consequently, an integral part of meeting the spectrum of students' mental health needs is missing. To cover other areas of the spectrum, for example loneliness or boosting community wellbeing, an impressively large number of universities have introduced mental health resources in the form of online platforms, such as Togetherall's online community service where students can anonymously chat with fellow peers about mental health concerns in a safe environment monitored by mental health practitioners. To date, Togetherall provides its service to over 200 post-secondary institutions (Togetherall, 2020). However, the anonymous and online nature of such support services, although extremely valuable, cannot provide some of the extended benefits of in-person, peer-to-peer care.

Despite the concerning rise in students experiencing mental health hardships (Lattie et al., 2019), data collected by the Association of University and College Counseling Center Directors (AUCCCD) indicates that the percentage of students receiving counseling and psychological services has, for the most part, stagnated (AUCCCD, n.d.). Such an alarming finding underscores the need to expand the types of mental health services offered to students. More specifically, peer counseling models would provide needed preventative resources. Indeed, Conley and colleagues (2017) emphasize the important role preventive measures play in building robust campus mental health support systems.

All in all, mobilizing students – individuals who are immensely eager to support mental health movements – as a source of preventative care can help alleviate the overwhelming and underserved client load college counseling centers face.

According to the Center for Collegiate Mental Health 2021 Annual Report, 86% of students who sought counselling services during the 2020-2021 academic year experienced a wait time of 7 calendar days before being seen for their first appointment (CCMH, 2022). Waiting what may be interpreted as one harmless week, however, can be fatal for students in mental health crises, with the most recent national statistics revealing suicide as the second leading cause of death among college-aged individuals (Heron, 2019).

The assets of peer counseling models stretch far beyond dismantling common barriers to accessing mental health services. Peer counseling programs benefit many levels of university populations: firstly, and most expectedly, the students seeking support; following, the peer supporters in the form of a heightened sense of community and belonging (Crisp et al., 2020), validation in their role (Suresh et al., 2021), and increased psychosocial performance, well-being, self-esteem, and confidence (Schwartz et al., 1999; Solomon, 2004); and lastly, the larger university community by positively influencing the student body culture. From a more idealistic perspective, the effects on all three levels may ripple into wider society post-university. For example, peer supporter skills equip more individuals with basic, yet key, listening and holding skills to support their communities, including colleagues, friends, and family members, beyond the university bubble. Peer supporters are valuable resources to university counseling centers, powerfully informing the improvement of university mental health practice and policy via their direct experience with students and immersion in day-to-day student life. Based on a volunteer method, peer counseling services offer free-of-cost support while reducing the financial resources needed by university services to increase their mental health support staff. Peer counseling's self-sustaining model of care (i.e., new students replace peer supporters who graduate) further supports its feasibility. And finally, although research on peer counseling in universities remains limited, studies assessing the outcomes of peer counseling models for adult mental illnesses convey promise. Encouraging results include decreased hospitalizations (Davidson et al., 2012), increased social functioning (Walker & Bryant, 2013), increased quality of life (Bologna & Pulice, 2011) and decreased self-stigma (Corrigan et al., 2013) among service users.

During such unprecedented times, universities have not accounted for the nuances of students' current, and ongoing, psychological distress and hardships. Such a lack of awareness is reflected in largely unchanged well-being policies and support resources. As Haseltine (2021) eloquently highlighted, "As counseling centers remain under-resourced, peer counseling offers a beacon of hope for students and counseling professionals who have struggled with the overwhelming demand for greater mental health resources in the past decade. It is time for college administrations and counseling centers to hear their students and address the need for diversified support systems that are accessible, effective, and can help put an end to this epidemic" (para. 8). The call from students for innovative solutions was loud before the pandemic. Now, it is unignorable.

SARAH M. SCHENK is a second-year Clinical Psychology M.A. student at Teachers College, Columbia University. She recently finished a one-year position as a Research Assistant for the Spiritual Wellness Lab and is a current Research Assistant for the Perinatal Mental Health Lab. As a welfare officer and Nightline active-listening volunteer, Sarah dedicated her undergraduate years to supporting students with mental health hardships. Identifying misconceptions of mental illness and rifts within mental health care, Sarah aims to fill in these gaps via storytelling. Past initiatives include talks, facilitation roles, establishing an annual Durham University Mental Health Awareness art exhibition, and her podcast Let's Get Mental. Via one-to-one work and social activism, Sarah seeks to use her sensitivity and conviction to create sustainable solutions that change one life, or the lives of many.

Citation: Schenk, S. M. (2022). Advocating for peer counseling programs at universities to address the mounting mental health needs of students. *Trauma Psychology News, 17*(1), 32-34. https://traumapsychnews.com

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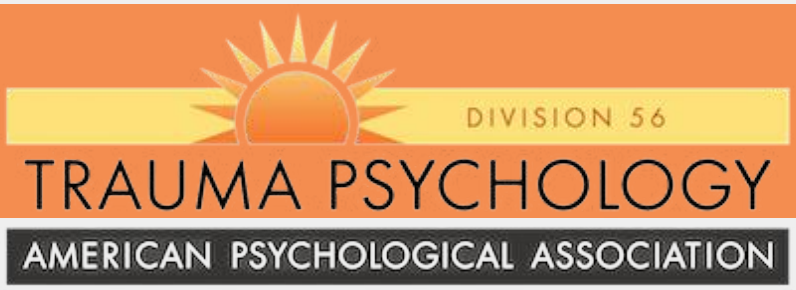

A HOSPITAL-BASED PROGRAM'S EFFORTS TO FILL THE GAP IN CARE FOR SURVIVORS OF HUMAN TRAFFICKING

LESSONS LEARNED

C. Nicole White,
Katherine Robichaux, &
Nancy Herrera

Section Editor:
Shavonne Moore-Lobban

HUMAN TRAFFICKING IS A CRIME OF EXPLOITATION involving the use of force, fraud, or coercion (Administration for Children & Families, 2017; Wilks et al., 2021). Examples include physical or sexual assault (force), lying about the conditions or parameters of employment (fraud), or psychological manipulation (coercion). Texas is consistently one of the leading U.S. states in the number of reported human trafficking cases (Office of the Attorney General, 2020; Powell et al., 2017). From 2006 to 2017, the National Human Trafficking Hotline reported the majority of received calls (3,634) and reported cases of trafficking (1,021) were from Houston, supporting the need for prevention and intervention efforts in the city (National Human Trafficking Hotline, 2017).

In 2016, as part of a city-wide strategic initiative, Baylor College of Medicine (BCM) created a hospital-based anti-human trafficking program to address Houston-area survivors' medical, psychiatric, and socials service needs (see Chen et al., 2021 for an in-depth description of the program). Led by BCM faculty Drs. John Coverdale (inpatient psychiatrist), Mollie Gordon (inpatient psychiatrist), and Phuong Nguyen (inpatient psychologist), the BCM Anti-Human Trafficking Program (BCM A-HTP) was designed to provide inpatient and outpatient mental health services and support to patients identified as having experienced trafficking. Program staff currently include the three BCM clinical faculty, one BCM research faculty, a social worker, and two postdoctoral fellows. Program objectives include

1. train healthcare providers in the identification and treatment of this patient population,
2. address patients' social, medical, and psychiatric needs,
3. advocate for hospital and community-based resources, and
4. contribute to the limited body of literature on the topic.

The BCM A-HTP has three areas of emphasis: education, clinical care, and research. Education efforts are primarily targeted toward healthcare professionals on the identification, treatment, and care of this patient population and have expanded to include national and global educational audiences. All members of the program are involved in conducting educational trainings geared towards increasing knowledge of human trafficking. Inpatient psychiatric services are managed by the two program psychiatrists and referrals are made to outside providers once a patient discharges from the hospital. The remaining clinical care is managed by the program's social worker and postdoctoral psychology fellow(s). Both the social worker and fellows respond to inpatient and outpatient consultations by staffing cases and conducting human trafficking screening; however, the social worker is primarily responsible for case management and the fellow(s) for therapy. Inpatient case management includes completing biopsychosocial assessments, linkage to hospital- and community-based services, and discharge planning (e.g., shelter placement, transportation, linkage to a community case manager). Outpatient case management entails coordinating and ensuring access to ancillary health care services such as primary, specialty, and mental health care. Inpatient therapy services rendered by the fellow(s) can include administration of psychological measures and brief supportive therapy, while outpatient therapy includes longer-term evidenced-based therapies. The faculty psychologist provides ongoing clinical supervision to the postdoctoral fellows. Finally, research is collaborative across team members, other hospital providers, and institutions across the country. All program members are responsible for generating research, publishing, and presenting on behalf of the program.

To date, the BCM A-HTP has received roughly 600 referrals from hospital and community providers for people suspected of experiencing trafficking. Roughly 71% of these referrals were confirmed cases of human trafficking. The remaining cases that did not meet criteria for trafficking were often patients who experienced other forms of trauma such as intimate partner violence. While the program has experienced many successes in the past four and a half years, it is important to critically examine the program to date to improve outcomes. In this article, the program's successes and "lessons learned" from a system, programmatic, and direct services level will be explored. The article authors (BCM A-HTP postdoctoral fellows and social worker) hope sharing this information will benefit (1) the program's continued improvement and (2) other programs hoping to replicate or improve upon this model.

SUCCESSES

The BCM A-HTP was created as part of an innovative municipal response to address human trafficking. Following an analysis by the City of Houston Mayor's Office Anti-Trafficking Division, it was determined a public health approach to addressing human trafficking could help increase identification and reporting, improve access to adequate treatment for survivors, and supplement traditional law enforcement efforts. From this emerged a bidirectional case management model between Harris Health System (one of the countries' largest fully integrated health care systems) and the City of Houston to provide wraparound services to identified survivors.

Systems Level

- **Citywide collaboration.** The relationship between the City of Houston and other community partners and agencies has led to increased access to housing and employment for the patients, which in turn helps them to remain engaged in their physical and mental health care. Additionally, the BCM A-HTP is a member of the PATH Collaborative, a federally funded collaborative of healthcare and community-based organizations committed to the identification and treatment of survivors, as well as the education of healthcare providers. Being a part of the collaborative allows for learning from other providers, opportunities to provide care to patients across systems, and continuity of care for patients who might not qualify for program services (i.e., out-of-county residents).
- **Health system policy.** Prior to the BCM A-HTP, Harris Health System's policy on trafficking was too general and included recommendations that could potentially harm patients (i.e., calling law enforcement immediately following patient disclosure of trafficking). In collaboration with hospital administration and the Forensic Nursing Department, the program helped to reshape the hospital's policy to include more precise definitions of trafficking, a referral pathway, resources, and trauma-informed language and recommendations.

Program Level

- **Education.** Drawing on the program's interdisciplinary approach (e.g., psychiatry, psychology, social work), educational training on trafficking for various audiences was created. Beyond the hospital system, program members have been invited to train community organizations, other hospital systems, national organizations, and international communities of healthcare professionals. As part of the PATH Collaborative, and in accordance with House Bill 2059, a state-approved human trafficking course for healthcare practitioners' licensure requirement has also been implemented.
- **Location.** Given the program's location within an academic medical institution, hospital providers are able to easily access program services in-person or electronically. An open line of communication and growing knowledge base of trafficking has led to over 60% of program referrals originating within the program's hospital system.
- **Program personnel.** BCM A-HTP's leaders serve as program champions in their personal and professional lives, building connections with other professionals and organizations globally. The result is a collaborative interdisciplinary team instead of a traditional hierarchy. For instance, anyone on the team can lead a research idea or training or suggest ideas for program development and improvement. Dedication, passion, and rapport within the team are key to sustainability.

Direct Care Level

- **Crisis support.** Given the location within the hospital setting, the program is able to provide emergency center accompaniment to patients seeking stabilization and crisis intervention. Additionally, if a patient requires emergent stabilization during an outpatient appointment, program members can accompany them to the emergency center or enlist the support of psychiatric technicians and nurses.
- **Patient feedback.** Several patients have described their interaction with the program as the first time they received education on the term "trafficking," or had words to describe their traumatic experience. Patients have reported appreciating the lack of emphasis placed on cooperating with law enforcement, as well as the program not having a faith-based approach. These factors in particular distinguish us from many of the community resources.

LESSONS LEARNED

As with many pilot programs, the BCM A-HTP has had to continuously adapt its operations and service provision when complications or obstacles arise. Though technical and bureaucratic barriers exist in many institutions and complications often arise in new programs, continuous learning to mitigate any hindrance to the program's mission and the care provided to patients is an essential goal.

Systems Level

- **Administrative challenges.** Due to funding constraints and various faculty responsibilities and commitments, BCM A-HTP clinical faculty operate in an entirely voluntary capacity. The program social worker and postdoctoral fellows are completely grant-funded (i.e., private foundations and state/federal grants), which means great effort goes into renewing, and/or seeking additional funding each year. The result is less time and attention devoted to daily program operations.
  - **Possible Solution:** Financial support for faculty's "protected time" would allow for more significant involvement in daily operations such as clinical staffing meetings.

- **Person-based response.** While the program has been well-received by hospital staff, and positive identification rates have increased, staff tend to remove themselves from treatment planning once a referral to the A-HTP has been made. Providers often rely on the program social worker to find unique discharge placements (i.e., residential programs), despite being given many of the same resources in trainings. There is also a reliance on fellows to conduct testing and assessments and provide therapeutic services to all trafficked patients; however, not all patients are clinically appropriate and/or interested in therapy. Inpatient therapy occurs on a consultation basis and consists of assessment, psychoeducation, and brief supportive therapy. Doctors across the hospital submit consultation requests throughout the week with majority coming from the psychiatric unit. An average of 10-20 consultations are received per month, with patients being seen at least once, but often repeatedly throughout their hospital stay. To balance duties related to inpatient work, research, and education, fellows have one and a half to two days designated for outpatient clinic (typically 11-16 patient caseload). For outpatient therapy, patients and referring providers have previously relied on fellows to provide ongoing and indefinite supportive therapy; however, the program has moved away from this model to now provide time-limited (12-20 sessions) evidenced-based treatment for trauma and related issues (i.e. CBT, ACT, CPT, narrative exposure therapy).
  - **Possible Solution:** Create an interdisciplinary team approach across units, wherein ongoing consultation and support is provided by all members of the treatment team. Additionally, providing psychoeducation for medical staff on appropriate mental health referrals.

Program Level

- **Lack of funding for mental health.** Funding for anti-trafficking organizations is largely directed toward services for trafficked youth or focuses on the sex trafficking of women and girls which neglects adults, males, and those trafficked for labor. This often requires program staff to search for more difficult to reach funding sources (i.e., private donors) and collaboration with other non-governmental organizations or healthcare systems.
  - **Possible Solution:** Provide feedback to funding agencies such as the Office on Trafficking and Persons, and publishing in both academic and non-academic outlets regarding the prevalence of trafficking among adults, and the importance of mental health care, to garner greater support.

- **Capacity.** The initial model for the BCM A-HTP was for a postdoctoral psychology fellow and social worker to work in tandem to provide inpatient and outpatient mental health support to patients. At times, fellows have had to shift primarily to outpatient services to meet the growing demand, leaving little time for inpatient consultations, emergency center accompaniments, and brief inpatient therapy services. Additionally, funding constraints have sometimes resulted in periods of time without a fellow on staff.
  - **Possible Solution:** In the past year, the program has addressed this matter by securing funding for two fellows and structuring their time to allow for inpatient service provision and clinical research. Outpatient demand can also be addressed by triaging cases and referring non-acute patients to community behavioral health clinicians.

Direct Care Level

- **Limited financial support for patients.** Upon hospital discharge, patients are given follow-up appointments with medical and mental health providers, but often do not return due to various barriers. Unreliable modes of communication and transportation, housing, and general financial needs make it hard for patients to prioritize their healthcare needs. Attempting to address these barriers using program funds creates budgetary strain as there is not adequate funding for ongoing support of these needs.
  - **Possible Solution:** Small grants to fund patient transportation, medication, prepaid cell phones, and some personal items have been obtained over the years. However, to increase sustainability, it would be helpful to partner with government or community agencies already providing these resources. For instance, a housing assessor could process applications onsite once a month, or a food bank could provide ongoing emergency food kits. With such support, the program could focus primarily on health-related needs.

- **Limited community resources.** The literature has shown survivors of trafficking often require intensive psychological, medical, and social support (Cary et al., 2016; Kiss et al., 2015; Ottisova et al., 2016) to sustain their healing and recovery process. With a lack of housing and substance abuse treatment placements in Houston, patients are sometimes discharged to less than adequate placements with staff with limited or no training in serious mental illness or trauma-informed care. Often the patients either voluntarily leave their placement or are asked to leave. For instance, patients might become distressed when staff and/or residents behave in a way that reminds them of a particular trauma, or patients may become anxious with the lack of structure and impulsively leave.
  - **Possible Solution:** Though shelters and substance abuse facilities have begun to recognize their respective intersections with human trafficking, many lack training in serious mental illness and trauma-informed care. The BCM A-HTP or other service providers could conduct ongoing training on best practices for community agencies. Having licensed mental health staff within these agencies, either full- or part-time, could help cultivate a therapeutic environment and programming.

CONCLUSION

The Baylor College of Medicine Anti-Human Trafficking Program has filled a notable gap in care for survivors of trafficking since its creation nearly 5 years ago. The authors' hope sharing the experiences of creating and implementing this program will allow other healthcare groups to have a foundational model from which they can improve upon, as well as promote continuous improvement within the BCM A-HTP. Although the unique needs of patients will vary by location, recommendations to replicate the BCM A-HTP model are to:

1. examine existing policies and procedures and gaps within the organization to identify, treat, and care for patients with a trafficking history,
2. examine existing community-based organizations for potential partnership,
3. determine necessary program personnel (e.g., psychiatry, primary care, psychology, etc.),
4. present the need for services to administration to determine level of buy-in,
5. secure funding through the organization and from public and private sources as needed,
6. implement clinical, education, and research practices, and
7. evaluate program impact.

Changes at the policy, program, and direct care level require adjustments from the organization, other institutions, community agencies, and the government. Although the suggested solutions may be considered long-term or ideal goals, and require the participation and collaboration of other systems, the health and wellness of the patients served are worth the endeavor.

Citation: White, C. N., Robichaux, K., & Herrera, N. (2022). Lessons learned: A hospital-based program's efforts to fill the gap in care for survivors of human trafficking. *Trauma Psychology News, 17*(1), 36-41. https://traumapsychnews.com

ANNOUNCING NEW FELLOWS

Section Editor: Priscilla Dass-Brailsford

The Fellow's Committee is pleased to announce the newest Fellows of Division 56. Drs. Brand, Kerig, Morrisette are new Fellows to APA and the Division of Trauma Psychology. Dr. Marotta-Walters is an existing Fellow of APA but a new Fellow in Division 56. Congratulations to each of you for this major accomplishment!

DR. BETHANY BRAND is a full, tenured Professor of Psychology with 30 years of clinical, research, and teaching experience and the Director of the Clinical Focus program at Towson University. Dr. Brand's highly visible accomplishment is her large scale, ongoing research project in the Treatment of Patients with Dissociative Disorders (TOPDD). This innovative program of research documents the therapeutic progress of clients with severe dissociative disorders. More specifically, Dr. Brand has been a major researcher investigating the trauma versus fantasy models of dissociation and has conducted a series of studies on genuine versus feigned dissociative identity disorder. Five primary areas distinguish her research and practice: treating dissociative disorders; distinguishing dissociative disorders from malingered presentations of dissociation; investigating the claims of the "trauma" versus "fantasy" models of dissociation; training clinicians about trauma; and assessing the accuracy and adequacy of textbooks' information about trauma. Her expertise in distinguishing genuine versus malingered dissociation has led to international recognition as a trauma expert.

ANNOUNCING NEW FELLOWS

DR. PATRICIA KERIG is a tenured full professor at the University of Utah. Her contributions in research, clinical work, and service to the professional and educational community have advanced the field of trauma psychology. More specifically, her research-related contributions are exemplary for scientific, methodological, and theoretical rigor, translational value, and impact on the field. Over the past decade, Dr. Kerig's influential research on trauma among high-risk, under-served youth involved in the juvenile justice system has set the standard for quality and clinical relevance. Dr. Kerig's work on the role of emotional numbing and dysregulation in juvenile delinquency has shifted the perception of troubled youth as unsuitable for psychological interventions, to their having the potential for resilience and recovery from trauma. Evidence of the impact of Dr. Kerig's work among practitioners, clinicians, and policy makers is indicated by the extremely high rates of downloads of her work amongst those seeking to create trauma-informed systems of care for youth in the juvenile justice system.

ANNOUNCING NEW FELLOWS

DR. SANDRA MORRISETTE is Professor of Psychology, interim Chair of the Psychology Department, and Associate Dean for Research in the College of Liberal and Fine Arts at the University of Texas at San Antonio. Dr. Morrisette's research focuses on the complex interaction of trauma exposure and the onset of addictive behaviors such as alcohol and cigarette consumption. A cohort study, Project Serv, represents an investigation of military veteran's post-discharge, developed a national reputation on the importance of longitudinal vs. cross sectional studies. Dr. Morrisette was the first Core Leader for the VISN 17 Center of Excellence for Research on Returning War Veterans, in Texas and in this role launched the Assessment Core of the Center of Excellence (CoE). She excelled in this capacity and launched the SERVE family of studies, the single largest clinical science contribution the CoE has made to the field. A major impetus in Dr. Morrisette's work is the training and career development of the future generation. For example, the aim of the SERVE program she developed was to foster training and professional development of students and junior investigators dedicated to studying PTSD, co-occurring conditions, and functional recovery.

ANNOUNCING NEW FELLOWS

DR. SYLVIA A. MAROTTA-WALTERS is past-President of Division 56. Since 2014, she has served as Associate Editor of the Division 56 Journal, Psychological Trauma: Theory, Research, Practice, Policy. In this role she contributed to the literature by managing the peer review process on topics such as combat veterans, resilience, psychotherapy, and measurement issues in trauma psychology. She dealt with almost 600 submissions. Dr. Marotta-Walters has stressed the importance of mentoring junior scholars in the writing process, by encouraging senior reviewers to work with their advisees so that the journal has a pipeline of new reviewers. She has also encouraged international authors to work with collaborators whose first language is English, to enhance international perspectives on the treatment of PTSD.

During her presidential year, she proposed developing the trauma competencies that were constructed by the New Haven Conference, into a trauma subspecialty. She now chairs a national level committee, which has drafted behavioral anchors for each of the competencies. Dr. Marotta-Walers currently serves as the Treasurer of ABPP.

Webinar Summary

Annual Program of the Trauma Work Group in the NGO on Mental Health at the United Nations *Knowing and Not Knowing About the Climate Crisis: Through the Lens of Trauma and Dissociation.*

Irit Felsen

The Trauma Work Group at the NGO on Mental Health in Consultative Relationship to the United Nations is a group that focuses on issues that are close to the hearts and minds of the members of the Trauma Division. We welcome new members and hope some of the readership of the TNL will join our ranks. Our group, the Trauma Work Group, presents a program once a year, on the second Thursday in February. This year, our topic was "Knowing and Not Knowing About the Climate Crisis: Through the Lens of Trauma and Dissociation" a title that harkens back to one of Dori Laub's most influential papers, "Knowing and Not Knowing Massive Psychic Trauma" (Laub and Auerhahn, 1993).

Dori Laub was a dear friend, mentor, and the closest thing to family for me in the USA, since I came to do my postdoctoral training at Yale University and until his death in 2018. Dori was a child survivor of the Holocaust. He spent his professional life working with trauma survivors, doing clinical work and research, and teaching about the far-reaching effects of trauma and its intergenerational transmission. He worked first with Holocaust survivors and their families, and then was one of the earliest psychiatrists to campaign for what we now call 'trauma-informed treatment' for survivors of other mass traumatic events, including Vietnam War veterans and survivors of the genocide in Rwanda.

For many years, up to the mid 1980s, the trauma endured by the survivors of the Holocaust received little attention in our professional journals (Laub and Auerhahn, 1993). It was minimized and even denied by some psychiatrists who were assigned by the German government to assess the physical and mental damage suffered by survivors who applied for reparation funds (Felsen, 2017). This was but one more example in a long line of historical large-scale traumatic events, where the pervasive and often long-lasting impact of trauma was "not seen" by mental health professionals and by society at large. After massive trauma such as WWI and WWII, important lessons had been learned and excellent descriptions written of what we now would recognize as the symptoms of Post-Traumatic Stress Disorder (PTSD), a diagnostic category that finally made its way into the DSM system in 1980. However, after each World War, the important knowledge about the impact of trauma was "forgotten." The outbreak of WWII caught American military psychiatry unprepared for combat stress reactions despite the experience in diagnosing and treating it gained by military psychiatrists during WWI. American psychiatry then made significant contributions to the study of combat psychiatry during WWII, (Crocq & Crocq, 2000). Yet, once again, by the Vietnam War, the lessons of

WWII were again forgotten. In 1968, just as soldiers were beginning to return home, the DSM-I diagnostic category of "Gross Stress Reaction," which included combat stress reactions, was dropped from the DSM-II. In an article in the American Journal of Psychiatry, an American military psychiatrist mistakenly wrote that the numbers of psychiatric casualties were surprisingly low, and even most of these were unrelated to the direct stress of combat (Bourne, 1970). These statements had to be retracted shortly thereafter when the real extent of the problems suffered by returning veterans began to be evident (Bourne, 1972). What this review of the history shows is a consistent pattern of denial of trauma and its aftermath, a denial that defies scientific knowledge.

In his paper "Knowing and not knowing massive psychic trauma" (Laub and Auerhahn, 1993) Laub wrote: "It is the nature of trauma to elude our knowledge because of both defense and deceit… We defend against intense feelings of rage, cynicism, shame, and fear by not knowing them consciously" (p.288). In other words, we dissociate.

Dissociation is a division within the personality between parts, or aspects of functioning that adaptively cope with daily living, and aspects which contain experiences, memories, and perceptions of potentially traumatizing events which overtax our capacity to integrate them. "Not knowing" trauma, not seeing what is staring us in the face, can be a phenomenon shared by an entire culture or society in their relation to a perceived threat. We are witnessing a current socio-cultural movement in which the ways through which we "know" our world, our reality, are dangerously impacted by denial and dissociation. Positivism in the 19th century was a movement that marginalized religion and emphasized the role of science in society, and 20th century post-positivism attenuated this optimism by introducing the constructivist view as to the veracity of our concepts and measurements. The 21st century seems to herald a movement that attempts to marginalize science and the scientific method, which relies on verifiable evidence, and instead determine what is 'knowledge' and what is 'true' according to political and populist interests, satirically captured by the film "Don't Look Up!" This denial is used to defy medicine and science as these pertain to the global Covid-19 public-health measures, and to avoid dealing with the impending catastrophic climate crisis. Denial and deceit are used in blatant disregard for truthfulness and accountability and have already constituted a real danger to the fundamental tenets of democracy, as reflected in the persistent denial of the results of the 2020 presidential elections and the insurrection on January 6, 2021. In all of these aspects, we are witnessing a 'culture of uncare' (Weintrobe, 2018) and an epoch of nihilism, or 'denial-hism'.

In his description of the actors that set the stage for trauma, Ferenczi highlighted the unwarranted feelings of security that precedes trauma: "One had to have lived under the delusion that such things could not happen, not to me" (1930-1932 p. 254 in Frankel, 1998). The climate crisis, according to scientists from multiple disciplines, is rapidly reaching critical and irreversible points that will have disastrous implications across the globe. We, as trauma psychologists, must address the dissociation that allows the continued illusion that "it could not happen to me." It can, and it is, happening to us.

Webinar available on the NGO Committee on Mental Health's YouTube Channel

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DIVISION 56 was founded to keep trauma and its effects at the forefront of the conversation within the American Psychological Association. We are focused on bringing together clinicians, researchers, educators, and policymakers to ensure this goal is met across all domains of practice. **Join us and contribute to this conversation** by submitting to one of our publications, posting on social media, participating in one of our committees, or running for a leadership position.

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Trauma Psychology News (*TPN*) is the official membership publication of the American Psychological Association's Division of Trauma Psychology (Division 56). *TPN* is produced three times a year and provides a forum for sharing news and advances in practice, policy, and research as well as information about professional activities and opportunities within the field of trauma psychology.

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- Summer — Late July
- Fall — Late October

ACCURACY OF CONTENT & COPY INFORMATION

In an effort to minimize the publication of erroneous information, each advisory editor of a section is responsible for factual information on anything related to their content. The Editorial Trio and Web Editors will only accept materials coming from Section Editors. Anything else will be sent to the Section Editor in question for fact checking. Authors of independent articles and submissions are responsible for their own fact checking; this will not be the responsibility of the editorial staff.

ADVERTISING POLICY, RATES, & QUERIES

The appearance of advertisements and announcements in *TPN* is not an endorsement or approval of the products or services advertised. Division 56 reserves the right to reject, edit, omit, or cancel announcements or advertising for any reason, including but not limited to legal, professional, ethical, and social concerns.

Ad size & rate:

- Inside Back Cover (full page) $700
- Full page $500
- Half page $300
- Quarter page $200

15% discount for multiple insertions, per publication year, of single ad that are committed and paid in full with initial submission. Inquiries about advertising rates, guidelines, and/or submissions should be emailed directly to the Editor.

DIVISION 56 LOGO INFORMATION

Requests for permission to use the Division Logo and information should be obtained from the Editor. Credit for logo design should be given to Janet Perr whenever the Division logo is used.

Send your submission ideas directly to a Section Editor or via the submission form on the *TPN* website.